State of Maine

Dirigo Health Agency

Revised Response to Solicitation for State Proposals to Operate Qualified High Risk Pools

Dirigo Health Agency

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Section B - Technical Approach

C.4.1 Instruction / Question
Describe in detail the State proposal for establishing and providing for the ongoing administrative functions of operating a high risk pool program. The description should describe how the State proposes to make the high risk pool program operational, including all sub-contracting relationships that may be included in the implementation plan and a proposed timeline for the implementation of the high risk pool program that includes the first date on which the program will accept enrollments and the first date on which the program will provide coverage for enrollees. If the State operates another high risk pool, describe how the State will segregate funding and expenditures for the two programs and track enrollees separately across all benefits and services. If the proposal is to delegate the operation to a nonprofit entity, the State should clearly indicate if it proposes that HHS contract with the State (that will subcontract with the nonprofit) or proposes that HHS contract directly with the nonprofit high risk pool. If the State proposes that HHS contract directly with the nonprofit high risk pool, provide copies of all governing authorities of the nonprofit entity, including statutes, regulations, governance, and plan of operation. As part of the technical approach, the State or its designated entity may subcontract with either a for-profit or nonprofit entity.
C.4.1 Response
Maine proposes to create a High Risk Pool program within its subsidized health insurance plan, DirigoChoice, offered by Harvard Pilgrim Health Care (HPHC). The applicant, the Dirigo Health Agency (DHA), a state agency, is an eligible entity (Sec. 1101(b)(2)(A) of the Patient Protection and Affordable Care Act (PPACA)) and meets all the requirements for a Qualified High Risk Pool (Sec. 1101(c)(2)(A-D)). The program will serve eligible individuals (Sec. 1101(d)) who are citizens, nationals of the United States, or lawfully present in the United States who have not had creditable coverage for 6 months and have a pre-existing condition. To meet the intent of the law to provide

"immediate access to insurance for uninsured individuals with a pre-existing condition" (Sec. 1101), Maine will use its existing infrastructure to provide coverage, thereby reducing administrative costs and ensuring immediate coverage for eligible individuals on August 1, 2010 or sooner. That coverage will meet all the requirements of Sec. 1101. To do so, DHA will support a risk sharing arrangement to ensure the adequacy of rates.

Maine has already adopted guaranteed issue and rate reforms in advance of the requirement to do so in PPACA; it does not have "uninsurable" population. Maine can meet the requirements of a High Risk Pool and serve eligible individuals without establishing a traditional High Risk Pool and can do so more quickly and at less cost than by establishing a traditional High Risk Pool. In short, Maine is uniquely positioned to implement the provisions of the High Risk Pool program immediately.

C.4.2 Instruction / Question

In response to the questions below, describe how the State will design a high risk pool program that will meet the basic requirements to operate the program as described in A.4.2 of the Statement of Work.

C.4.2 Response

The State proposes to build on our existing Dirigo Health program, which currently covers uninsured persons with pre-existing conditions through its subsidized insurance program DirigoChoice. Maine will ensure maintenance of effort in our current program and use federal funds to extend coverage to those uninsured for at least six months who also have pre-existing conditions.

DirigoChoice is a private health coverage plan administered by HPHC under contract to the State through DHA. The State provides eligible DirigoChoice enrollees premium and cost sharing subsidies based on income.

The Dirigo Health program is the only plan in the individual market that has no waiting period for pre-existing conditions, provides mental health parity and covers preventive services with no cost sharing. Through guaranteed issue protection and

subsidies for premiums and out-of-pocket costs, we have established a program that serves the same individuals targeted under the high-risk pool program. Maine has also achieved most of the rate reforms proposed in the PPACA. We believe our current Dirigo Health program meets the requirements in the Act because it:

a) Does not impose any pre-existing condition limitations on coverage for eligible individuals;

b) The issuer's share of cost is not less than 65% of the actuarial costs of benefits;

c) Out-of-pocket limits are no greater than those permitted under the rules for health savings accounts ($5,950 for individual coverage; $11,900 for family coverage);

d) Premiums will be the standard premiums for the Dirigo individual population;

e) Age rating is less than 4 to 1.

The State proposes to use the funds made available through this contract to construct a risk sharing arrangement with HPHC (an "experience modification program" – EMP) to pay for the claims costs of eligible high-risk individuals beyond that of the experience of the current DirigoChoice population.

Because the State is leveraging an existing program, we are able to accept applications for uninsured, high risk applicants starting July, 2010 with an effective date of coverage for August 1, 2010.

C.4.2 (1) Instruction / Question

Describe the eligibility criteria that the qualified high risk pool will use to determine if individuals are eligible to enroll in the proposed high risk pool program.

C.4.2 (1) Response

The eligibility criteria that the qualified high risk pool will use to determine if individuals are eligible to enroll in the high risk pool program are described in section

1101 of the Patient Protection and Affordable Care Act (Public Law 111-148). Eligible individuals must:

- Be a citizen or national of the United States or lawfully present in the United States;
- Not have been covered under creditable coverage (as defined in Section 2701(c)(1) of the Public Health Service Act) for the previous 6 months before applying for coverage; and
- Have a pre-existing condition, as determined in a manner consistent with guidance issued by the Secretary.

C.4.2 (2) Instruction / Question

Describe the coverage and benefits to be offered by the qualified high risk pool. At a minimum, the response to this question must address the benefits elements contained in A.4.2 of the Statement of Work and include all benefit plan variations that may be proposed by the State.

C.4.2 (2) Response

Please refer to Exhibit 1 – Summary of Benefits

C.4.2 (3) Instruction / Question

How will the qualified high risk pool comply with the requirements to cover pre-existing conditions described in A.4.2.3?

C.4.2 (3) Response

There are no pre-existing condition limitations or exclusions in the DirigoChoice program. Individuals are covered for all services listed in the Evidence of Coverage as of their effective date of coverage.

C.4.2 (4) Instruction / Question

Describe how the qualified high risk pool will derive its premiums, including a description of its methodology in determining the standard risk rate.

C.4.2 (4) Response

Premium rates for the high risk pool will be the same as the rates that apply to DirigoChoice individuals and sole proprietors who are not enrolled in the high risk pool. HPHC develops DirigoChoice rates using its standard rate development methodology. Rates are based on the experience of the DirigoChoice population and target a 90% medical loss ratio. Rates are subject to negotiation with DHA and approval by the Maine Bureau of Insurance. Please refer to the Cost Proposal for additional details.

C.4.2 (5) Instruction / Question

Describe the cost sharing structure of the benefit package(s) proposed to be offered by the qualified high risk pool that complies with the requirements outlined in A.4.2.7.

C.4.2 (5) Response

The aggregate actuarial value of the DirigoChoice plans is 82%, as independently calculated by Gorman Actuarial, LLC. Please see attached Exhibit 2.

DHA offers two plans to enrolled individuals (1750 and 2500 deductibles for non-subsidized enrollees). While the core medical benefits are the same for all enrollees, the specific cost sharing structure depends upon an enrollee's financial status, and ranges from a 72% actuarial value for those members who receive no subsidy to 86% for those who receive the highest subsidy.

Members who are eligible for subsidies also receive premium assistance of up to 84% of the monthly premium cost.

Specific deductibles and out-of-pocket limits for one person policies range from $500 / $700 for those with the highest subsidy to $2,500 / $5,600 for those not eligible for subsidy.

Please refer to Exhibit 6 for a full schedule of premium, deductible, and out of

pocket subsidies and cost sharing.

DHA is not proposing that high risk pool funds be used for DirigoChoice subsidy. DHA will continue to use its existing state funding to pay for these subsidies.

All DirigoChoice plans have a $25 office visit co-pay and 30% co-insurance for claims incurred beyond the deductible up to the out-of-pocket limit.

There is no co-pay for preventative services.

C.4.2 (6) Instruction / Question

If applicable, describe the provider network(s) proposed to be used by qualified high risk pool enrollees and demonstrate that the network(s) has a sufficient number and range of providers to ensure that all covered services are reasonably available and accessible in those networks.

C.4.2 (6) Response

HPHC has a comprehensive, statewide provider network, which is comprised of contractual arrangements with physicians who practice in a variety of settings. In addition, HPHC contracts with health care facilities including integrated delivery systems, hospitals, skilled nursing facilities and ancillary providers. HPHC's network complies with Maine Bureau of Insurance Rule 850 which establishes provider access standards for managed care plans.

C.4.2 (7) Instruction / Question

Describe the appeals and reconsiderations process that the qualified high risk pool proposes to make available to enrollees in the high risk pool program as per the description of section A.4.2.10.

C.4.2 (7) Response

DHA and HPHC have established and maintain procedures for individuals to appeal program eligibility and coverage determinations. The appeals procedures provide

enrollees and potential enrollees the right to a timely redetermination by DHA of a determination concerning program eligibility. Through HPHC members have the right to a timely reconsideration of a coverage redetermination.

Program Eligibility Appeals

An applicant has 30 calendar days from the date of the determination letter to request an independent review of the subsidy determination.

An independent review committee (IRC) must render a written decision within 10 calendar days of receipt of the request for review.

The chairperson is responsible for notifying the applicant in writing of the decision rendered by the IRC and the applicable timeframe for appeal.

An applicant has 15 calendar days from the date of the IRC decision to request an appeal.

The appeals committee must render a written decision within 10 calendar days of receipt of the request for appeal. Members of the appeals committee include the following DHA staff: Executive Director; Deputy Director; and the Operations Director.

The chairperson is responsible for notifying the applicant in writing of the decision rendered by the appeals committee.

HPHC Coverage Appeals

First level appeal: An assigned Appeals Coordinator investigates all initial appeals. Most appeals are resolved within 20 working days. If HPHC cannot reasonably meet the 20 day time frame due to an inability to obtain necessary information from Non-Participating Providers, HPHC will inform the member in writing of the reason for the delay.

The Appeals Coordinator will inform the member in writing whether the appeal has been approved or denied.

Second level appeal: If the member is dissatisfied with the decision of the first level appeal process, they may ask that their appeal be reviewed by an HPHC review committee. A review meeting is held within 45 working days of the member request. The decision of the review committee will be sent to the member in writing within 5 working days of the meeting. The decision of the review committee is the final decision of HPHC.

Independent external review of appeals: Appeal decisions involving an Adverse Utilization Determination by HPHC are eligible for review by an independent review organization designated by the Maine Bureau of Insurance. In most cases the member is required to complete HPHC's first and second level appeals process to be eligible for external review. However, this requirement does not apply if:

(1) HPHC has failed to make a decision on the first or second level appeal in the timeframes noted above

(2) the member and HPHC mutually agree to bypass the HPHC Member appeals process;

(3) the member's life or health is in jeopardy

(4) the Member for whom external review is requested has died

Requests for external review must be in writing to the Maine Bureau of Insurance and must be made within 12 months of HPHC's final denial of covered benefits prior to the initiation of the appeals process.

Expedited Review Procedure

If an appeal involves services, including pharmacy, which, if delayed, could seriously jeopardize a member's health or ability to regain maximum function HPHC will provide an expedited review. HPHC will grant an expedited review to any appeal for services concerning (1) an inpatient admission, (2) availability of care, or (3) continued

health care or services for a Member who has received emergency services and has not been discharged from the hospital where emergency care was provided.

HPHC will investigate and decide expedited appeals as quickly as possible, but in all cases will respond within 72 hours of the receipt of the appeal. For expedited appeals involving (1) continued emergency services to screen or stabilize a Member, or (2) continued care under an authorized admission or course of treatment, coverage will be continued without liability to the Member until the Member has been notified of the expedited appeal decision. To ensure a timely response, HPHC may inform the member of the decision on the expedited appeal by telephone. Following telephone notice, HPHC will provide the member with a written decision within two working days of such telephone call. If HPHC denies the first level appeal (standard or expedited) in whole or in part, HPHC will provide the member with a written decision that includes: (1) the names, titles and credentials of the reviewers who decided the appeal; (2) a statement of the reviewers' understanding of the issues and all the relevant facts; (3) the reviewers' decision and the basis for that decision; (4) a reference to the evidence or documentation used as the basis for the decision; (5) notice of the member's right to contact the Maine Bureau of Insurance by telephone at 1-800-300-5000 (within Maine) or 1-207-624-8475 (outside Maine) or by mail at 34 State House Station, Augusta, ME 04333 as required by Maine law; (6) a description of the process to obtain a second level review; and (7) a description of the process to obtain an independent external review.

C.4.2 (8) Instruction / Question

Describe the premium grace period and non-pay termination appeal process

C.4.2 (8) Response

The premium grace period is the 15 days that begins with and follows the due date of an unpaid premium.

Reinstatement in the program is processed when the receipt of the member's outstanding balance is received at DHA. DHA will grant reinstatement twice within any

consecutive 36 month period.
C.4.2. (9) Instructions / Question
Provide the actual initial 2010 premium rates, by age
C.4.2. (9) Response
Please see attached Exhibit 7, Dirigo rates by age and area.
C.4.2 (10) Instructions / Question
How often will state propose to adjust premiums for changes in market rates?
C.4.2 (10) Response
Rates are developed on a quarterly basis for subscribers purchasing or renewing coverage during the quarter. Premium rates remain in effect for a 12 month period for subscribers purchasing or renewing coverage during any given month, provided, however, that premium rates may be revised during a 12 month policy period if there is a change in law or regulation increasing HPHC's cost of providing DirigoChoice coverage.
C.4.2.(11) Instructions / Question
Is the state proposing to accept premium payments from third party payers? If so please describe which major entities, organizations and agencies such payments are received
C.4.2.(11) Response
No. The State plans to only accept premium payments from enrolled members.
C.4.2 (12) Instructions / Question
Is the state's proposed plan year on a calendar year basis for accumulation of member deductibles and out of pocket limits, or some other time period?
C.4.2 (12) Response

The proposed plan year for accumulation of member deductibles and out of pocket limits is on a calendar year basis.

C.4.3 Instruction / Question

Describe the qualified high risk pool's proposed eligibility determination and enrollment standards as outlined in Section A.4.3.

C.4.3 (1) Instruction / Question

How will the qualified high risk pool develop and utilize an eligibility determination process that will ensure that only individuals eligible for coverage, as described in Section A.4.2 of the Statement of Work, receive benefits from the program?

C.4.3 (1) Response

DHA will modify (or add to) its existing DirigoChoice Discount Application and the Certification Statement to capture information relating to the applicant's enrollment in credible coverage for the continuous six months prior to the date for which the applicant is applying for coverage in DirigoChoice, High-Risk conditions, and citizenship status.

DHA will screen all individual DirigoChoice / high-risk applicants for enrollment in credible coverage for the continuous six months prior to the date for which the applicant is applying for coverage in DirigoChoice. DirigoChoice / high-risk enrollees will be required to certify that they have not had credible coverage in the continuous six months prior to the date for which they are applying for coverage (DHA may verify applicant prior coverage status against the State's all-payer claim database).

DHA will require those individual DirigoChoice / high-risk applicants who declare that they were not enrolled in credible coverage to submit a physician attestation indicating their diagnosis for one or more of the following high-risk conditions:

Acquired immune deficiency syndrome (HIV/AIDS)

Angina pectoris

Cirrhosis of the liver

Coronary occlusion

Cystic fibrosis

Friedreich's ataxia

Hemophilia

Hodgkin's disease

Huntington's chorea

Juvenile diabetes

Leukemia

Metastatic cancer

Motor or sensory aphasia

Multiple sclerosis

Muscular dystrophy

Myasthenia gravis

Myotonia

Heart disease requiring open-heart surgery

Parkinson's disease

Polycystic kidney disease

Psychotic disorders

Quadriplegia

Stroke

Syringomyelia

Wilson's disease

Diabetes

Asthma

Coronary Artery Disease

Congestive Heart Failure

Hypertension

DHA will further screen those individuals identified as uninsured and high-risk for citizenship as described in C.4.3 (3).

Those members who:

- Were not enrolled in credible coverage for the continuous six months prior to enrolling in DirigoChoice and
- have a high-risk condition confirmed by physician attestation and
- are citizens, nationals, or lawfully present

will be enrolled in the High Risk program.

C.4.3 (2) Instruction / Question

How will the qualified high risk pool obtain all of the information described in Section A.4.2 of the Statement of Work as part of the proposal process in the high risk pool program?

C.4.3 (2) Response

Please see Exhibit 3, DirigoChoice Enrollment /Change Form, Exhibit 4, DirigoChoice Discount Application, and Exhibit 5, Certification Statement. All applicants are required to complete and submit these forms. DHA will modify (and/or add to) these forms to capture the information described in C.4.3 (1) and C.4.3 (3).

C.4.3 (3) Instruction / Question

Describe the process that the qualified high risk pool will use to confirm that an enrollee is a citizen or national of the United States or an alien lawfully present in the United States.

C.4.3 (3) Response

DHA will screen those individuals identified as uninsured and having high risk conditions (as described in C.4.3 (1) to ensure that these individuals are citizens, nationals of the United States (US) or lawfully present in the US. The screening will include but is not limited to:

- US birth certificate
- US passport
- Record of military service showing citizenship
- Adoption papers showing place of birth
- Verification of Supplemental Social Security Income Benefits (SSI)
- Verification of Social Security Disability Income (SSDI)
- Copy of a Green Card
- Verification via use of the applicant's social security number with the Social Security Administration
- Query to the Office of Vital Statistics

Note: Some of the documents above are already utilized for the DirigoChoice program.

C.4.3 (4) Instruction / Question

Describe the enrollment process that the qualified high risk pool proposes to use.

C.4.3 (4) Response

DHA and HPHC share responsibility for enrollment of members into the program in the manner described below.

DHA responsibilities include, but are not limited to:

- Ensuring completeness of application materials
- Determining eligibility for the subsidy program and other components of plan eligibility
- Determining if the applicant has had credible coverage for the continuous six

months prior to enrolling in DirigoChoice

- Determining if the applicant has a high-risk condition through physician attestation
- Establishing the citizenship of the applicant

HPHC responsibilities include, but are not limited to:

- Providing quotes to new and renewing accounts for the non-discounted cost of coverage
- Enrolling the applicant in the insurance product
- Performing the required compliance checks. Compliance checks include:
    - student verifications,
    - domestic partner verifications; and
    - disabled dependent eligibility.
- Sending the appropriate information to the Member.
- Making all appropriate changes to the account during the plan year
- Filing all required rates and enrollment/renewal materials with the State Bureau of Insurance.

Premium Quotes

New and renewing accounts first obtain a quote for the cost of their coverage from the HPHC.

Submission of Application to DHA

Accounts submit to DHA the completed application packet. The completed packet must be received no later than the fifteenth day of any month to ensure effective date of coverage as the 1st day of the following month (i.e. December 15th for January 1st

coverage; March 15th for April 1st coverage).

Processing of new applications by DHA

DHA processes the subsidy application and notifies the applicant of the subsidy determination. Once the subsidy determination has been made, DHA forwards the subsidy level and relevant application information to HPHC via a secure electronic transmission for processing. DHA does not forward the financial subsidy application or any personal financial information to HPHC.

Effective Date of Coverage

Is the first day of the month following the 15th day of the month that follows receipt of a completed application packet. For example, a member whose application is received on May 6th will be effective on June 1st. A member whose application is received on May 22nd will be effective on July 1st.

Application Material

DHA and HPHC jointly develop all application and renewal material. HPHC will produce and distribute the application materials for the program to anyone requesting application materials. The complete application packet is the packet of documents that must be signed and submitted to DHA to apply for participation in the program.

All applicants, regardless of whether or not they are applying for a subsidy, must complete the subsidy application. Applicants who are not applying for a subsidy do not need to supply financial information with the subsidy application, but do need to certify that they are not requesting a subsidy.

Changes

DHA notifies HPHC of subsidy changes through the secure electronic file transfer process. HPHC makes these changes effective the date DHA specifies.

Demographic and other non-subsidy changes originate at HPHC. HPHC reports

these changes to DHA via the secure electronic file transfer process.

C.4.3 (5) Instruction / Question

Describe the disenrollment process that the high risk pool plan proposes to use.

C.4.3 (5) Instruction / Question

1. Termination by the subscriber:

Membership may end by submitting a completed Enrollment/Change form to HPHC within 60 days of the date membership is to end.

2. Termination for loss of eligibility:

Coverage in the high risk pool may end for failing to meet any of the specified eligibility requirements, including but not limited to, no longer residing in Maine or obtaining other credible coverage.

The member will be notified in writing if coverage ends for loss of eligibility.

3. HPHC may end coverage for any of the following reasons for cause including:

- Providing false or misleading information on an application for membership
- Committing or attempting to commit fraud to obtain benefits for which they are not eligible
- Obtaining or attempting to obtain benefits for a person who is not a Member.

Misrepresentation or fraud may go back to the Applicants effective date or the date of the misrepresentation or fraud as determined by HPHC. Notice of termination of membership for the other causes will be effective fifteen (15) days after notice. Premiums paid for periods after the effective date of termination will be refunded.

4. Terminations for non payment:

HPHC may end coverage for failure to make required premium payments in a

timely manner.

Termination for failure to make required premium payments will be effective at the end of the payment grace period. Premium payments must be received by HPHC within 15 days of the due date.

C.4.4 Instruction / Question

Describe the customer service functions and standards that will be employed by the qualified high risk pool program. The description should include the qualified high risk pool's proposal for the staffing, hours of operation and service levels that the qualified high risk pool will provide to enrollees in the qualified high risk pool.

C.4.4 Response

DHA and HPHC each operate customer service operations.

DHA's customer service unit provides specific guidance for eligibility criteria, subsidy information, and the enrollment and renewal process. HPHC's customer service unit provides specific guidance for benefit and claim information.

Each unit provides

- live operator assistance between the hours of 8:00 a.m. and 5:00 p.m. Monday through Friday (local time) and 24-hour, seven-day-per-week voice message service for after-hours coverage;
- bilingual and TTY services for Members with special needs and;
- Member Service staff with online access to eligibility, enrollment, and subsidy information to respond to Member inquiries, resolve problems, and make appropriate call referrals when necessary.

HPHC further ensures that after hours, on weekends, and on holidays the Member Service Call Center inbound telephone lines are answered by an automated system with

the capability to provide callers with operating hours and instructions on what to do in cases of emergency. A voice mailbox is available after hours for callers to leave messages. Member calls received by the automated system are returned by HPHC's Member Service representatives on the next working day.

The customer service operations of DHA and HPHC are integrated such that callers face "no wrong door." Service representatives from each organization can effect soft transfers of callers to the other while remaining on the line, so that callers do not have to call a different number to get service. This soft transfer process also ensures that representatives from both organizations can coordinate service for members in real time.

C.4.5 Instruction / Question

Describe the technical support center to respond to health care and pharmacy providers for information that will be employed by the qualified high risk pool. The description should include the qualified high risk pool's proposal for the staffing, hours of operation and service levels that the qualified high risk pool will provide.

C.4.5 Response

HPHC provides the same telephone service to providers as it does to members. The service unit responds to all requests for eligibility verification, claims status and benefits form providers. This service includes:

- "live" operator assistance between the hours of 8:00 a.m. and 5:00 p.m. Monday through Friday (local time) and 24-hour, seven-day-per-week voice message service for after-hours coverage;
- bilingual and TTY services for as needed;
- an automated logging system to track and report telephone service performance (e.g., volume, response time, abandonment rate, etc.), and
- Customer Service staff with online access to eligibility, enrollment and claim information to respond to all, resolve problems, and make appropriate call

referrals when necessary information about the provider appeal process as appropriate.

- After hours, weekends and holidays service is available through an automated system which gives providers the ability to leave messages. Provider calls received in the automated system are returned by the appropriate representative on the next working day.

HPHC also supports the on-line submission of health claims and verification of eligibility and benefits through HIPAA compliant EDI transactions.

HPHC utilizes a service agreement with MedImpact Healthcare Systems to adjudicate pharmacy claims and related tasks. MedImpact has call centers located in San Diego, California, and Tempe, Arizona. In all locations, Customer Service Representatives access the same database to respond to calls received from pharmacies, plan sponsors and members, ensuring consistency. Call centers operate 24 hours a day, 7 days a week, 365 days a year and include more than 100 team members. The MedImpact Customer Service Team also has access to Benefits Specialists and IT support if needed, during normal business hours, as well as after-hours via on call staff. To ensure that high levels of service are maintained, performance guarantees are in place to make certain that callers are able to access a live Customer Service Representative within 30 seconds and that all calls are answered within 30 seconds, resulting in a call abandonment rate of 3% or less. MedImpact consistently meets these guarantees.

C.4.6 Instruction / Question

Describe the qualified high risk pool's system for billing, collecting, and accounting for premiums.

C.4.6 Response

HPHC bills the individual the net amount of their premium after the application of the subsidy on a monthly basis. The individual makes payment to the DHA. HPHC bills DHA for each account, indicating the account charge and the DHA charge. DHA then

remits the entire payment (account and DHA shares) to HPHC.

For example, if an individual has a rate of $450, and the subsidy for the individual is $100, HPHC would bill the individual $350. The individual would remit $350 to DHA. DHA remits $450 to HPHC.

Membership Fees

There is an annual membership fee of $150 for participation in the program which covers a portion of DHA's administrative costs. HPHC incorporates the fee in its monthly billing and forward fees received from accounts to DHA.

Delinquency and Termination

HPHC is responsible for managing the delinquency and termination process for accounts, including mailing dunning notices and notifying DHA when accounts have terminated for non-payment.

Any collection activity HPHC pursues in relation to delinquent accounts is taken with notice to DHA

C.4.7 Instruction / Question

If the qualified high risk pool intends to develop and implement utilization and care management as part of the qualified high risk pool coverage, describe the utilization and care management processes that the qualified high risk pool proposes to use.

C.4.7 Response

HPHC provides case management services and utilization support for members at all levels of care including outpatient services such as diagnostic testing and ambulatory surgeries. Members are identified based upon diagnosis and utilization history. The oversight and coordination of the members care is holistic, addressing educational deficits and providing guidance for imminent testing and procedures. Coaching and support is made available to assist the member with preparation for potential services.

For diagnostic services, HPHC contracts with National Imaging Associates (NIA) for completion of prior authorization review for specific diagnostic services including:

- CT Scans
- PET Scans
- MRI/MRA
- Nuclear Cardiology

HPHC retains oversight of all activities delegated to NIA.

HPHC's Utilization Management and Clinical Policy Committee (UMCPC) meets every two weeks to propose, evaluate and discuss the implementation of new policies relevant to innovative and changing technologies & procedures. As part of the evaluation phase, an analysis of evidence based guidelines and industry benchmarks are completed; draft policies are then vetted by subject matter experts. UMCPC makes recommendations to organizational operations committees, as well as relevant other share holders to implement and communicate changes or updates to services and treatment protocols.

C.4.8 Instruction / Question

Describe the system for processing and paying for health and prescription drug claims that will be implemented by the qualified high risk pool. The description should include the basis for payment rates and the timeliness of payments to providers. The description should also include the point of sale claim system that will be utilized for prescription drug claims.

C.4.8 Response

Payment of the health claims for the members of the qualified high risk pool is based on the negotiated rates in place between HPHC and contracted providers in the State of Maine.

Medical claims are processed on the Healthpac system supported by Eldoroado

Computing, Inc. This system supports all aspects of health insurance claims processing, including fully integrated determination of eligibility, negotiated rates for contracted providers and usual and customary for non-contracted providers, and the appropriate application of benefits.

All medical claims are processed and paid no more than 30 days from the receipt of the claims in the processing center for the qualified high risk pool. Currently, the DirigoChoice medical claims turnaround time is 95.1% within 14 calendar days and 100% within 30 calendar days.

With respect to pharmacy claims, MedImpact processes claims through a powerful, proprietary claims adjudication engine with sub-second adjudication performance. The claims adjudication engine is a real-time on-line claims adjudication system. All pharmacies participating in the MedImpact Pharmacy Network are required to have on-line billing capabilities in the current NCPDP 5.1 format. To ensure that high levels of service are maintained, performance guarantees are in place to make certain that claims adjudicate at an accuracy rate of 99% or better and that system response time on submitted claims is 4 seconds or less on a minimum of 98% of claims submitted. MedImpact performs a standard check cycle every two weeks, which includes invoicing to health plans for claims processed and claims payment to pharmacies. From the time that the health plan is invoiced, remittance to pharmacies normally occurs within 15 business days. Pharmacies are reimbursed based on rates specified in the contract executed between the pharmacy and MedImpact.

C.4.9 Instruction / Question

Describe the qualified high risk pool's proposed efforts to conduct outreach and marketing for the high risk pool program.

C.4.9 Response

DHA and HPHC are in the process of developing an outreach plan for the DirigoChoice program. If DHA is awarded a contract for the high risk pool program the outreach for this targeted population will be an extension of the strategies we employ for

the DirigoChoice program at large. To achieve our growth objectives DHA and HPHC may employ the following strategies:

- Develop and maintain an actionable DirigoChoice eligible prospect database
- Utilize database for strategic planning and targeted marketing to DirigoChoice eligible prospects
- Employee promotional program to create awareness and favorability for HPHC brand, products and related services
- Create clear and easily accessible printed and web communications for DirigoChoice prospects and their dependents
- Provide ongoing training, tools and education to Broker distribution channel
- Continue to measure and evaluate effectiveness of sales and marketing plan and adjust for improved performance
- Partner with consumer advocacy groups
- Work with the press to promote the program
- Inform the Legislature
- Conduct educational sessions with a preferred network of brokers

Given the limited availability of funds, DHA does not intend to target providers and pharmacies as part of this outreach effort.

C.4.10 Instruction / Question

Describe the process the qualified high risk pool proposes to use to identify and report to HHS instances in which health insurance issuers or group health plans are discouraging high-risk individuals from remaining enrolled in their current coverage in

compliance with A.4.10.

C.4.10 Response

Individual applicants to DirigoChoice must complete a certification statement (Exhibit 4) that establishes their eligibility for the program. The certification statement precludes employees of businesses that offer insurance from enrolling in DirigoChoice (i.e., employees of these businesses are not eligible). As described in 3.4.3 (2), individuals will also be required to describe their enrollment in credible coverage in the past six months.

Further, consistent with current process in the DirigoChoice program, DHA will work closely with the following entities to review any instances of impropriety which come to their attention:

- State of Maine Bureau of Insurance
- Consumer advocacy groups
- Maine Equal Justice
- State Department of Health and Human Services

If DHA becomes aware of instances where health insurance issuers or group health plans are discouraging high-risk individuals from remaining enrolled in their current coverage through any of these mechanisms, it will immediately report the episode(s) to HHS.

C.4.11 Instruction / Question

Describe the procedures that qualified high risk pool proposes to implement to prevent, detect, and report incidences of waste, fraud, and abuse.

C.4.11 Response

HPHC uses a variety of standard pre-payment practices to assure that a provider is valid, including:

- Validating credentials through the HPHC credentialing process;
- Validating independently the credentials of non-participating providers;
- Identifying questionable procedures in the claim adjudication system that are investigated before the claim is released;
- Sending Explanation of Benefits to member which allows them to verify that the services on the EOB were actually provided to the member.

HPHC has also engaged a Fraud and Abuse Detection partner, Premier Health Exchange, Inc. (PHX), to retrospectively review paid claims for potential fraud problems. Paid claims are sent to PHX each quarter and are screened against the company's proprietary software. Suspect providers and billing practices are identified to HPHC. Once we have reviewed the results, PHX is authorized to notify the provider, review the results of their analysis and recover any money that was paid for inappropriate services. In extreme cases, we work report providers or entities directly to law enforcement agencies for their consideration.

C.4.12 Instruction / Question

Describe the system for routine monitoring and identification of compliance risks.

C.4.12 Response

DHA and HPHC will establish and implement an effective system for routine monitoring and identification of compliance risks, including the designation of a DHA compliance officer and internal monitoring.

Harvard Pilgrim Health Care is committed to providing its enrollees with access to

high quality health care services while complying with all applicable federal and state laws and regulations. HPHC has instituted a Compliance Program, a comprehensive Code of Conduct and other related policies to reflect these commitments.

The Compliance Program sets forth the means by which HPHC will implement the Code and related policies, how it will monitor compliance with the Code, and how it will respond to any Code violations. HPHC's Board of Directors has approved the Code of Conduct and relies on its Audit Committee to provide oversight of the organization's compliance program.

HPHC's officers, directors and employees must comply with all federal and state requirements applicable to the organization's status as a health maintenance organization licensed by the Massachusetts Division of Insurance, the New Hampshire Insurance Department, the Maine Bureau of Insurance, and as a contractor to the federal Centers for Medicare & Medicaid Services under the Medicare Advantage program. Employees must also comply with the requirements applicable to HPHC's affiliates, including HPHC Insurance Company, an indemnity insurance company licensed in Massachusetts. HPHC maintains policies, procedures and standards of conduct for specific business units.

HPHC has designed the Program to meet the requirements of the Federal Sentencing Guidelines and the Office of the Inspector General's Compliance Program Guidance for Medicare+Choice Organizations as a "program that has been reasonably designed, implemented, and enforced so that it generally will be effective in preventing and detecting criminal conduct." The Program includes:

1. Standards of conduct and performance to assist employees in complying with applicable state and federal laws;

2. Designation of a Compliance Officer and Compliance Committee;

3. A system to monitor whether employees and independent contractors have been sanctioned by the Medicare or Medicaid programs or convicted of a felony;

4. Employee education and training programs;

5. A process to report concerns and suspected compliance gaps including procedures to offer anonymity of such reporting and protection of individuals from retaliation due to reporting;

6. A system to respond to allegations of Code violations and procedures describing appropriate disciplinary action for employees who have violated its principles; and

7. Methods to audit and monitor compliance.

HPHC entrusts its supervisory personnel with responsibility for achieving compliance with the Code and other policies. All supervisory personnel must set an example for other employees by conducting their duties in compliance with the Code and related policies. Supervisory personnel are responsible for ensuring the individuals they supervise understand their obligation to comply with the standards contained in the Code and related policies. This includes an expectation of reporting to their supervisor or the Compliance Officer any potential violation and assisting HPHC in the investigation of any suspected violation.

C.4.13 Instruction / Question

Describe the system the qualified high risk pool proposes to implement to coordinate benefits as described in A.4.13.

C.4.13 Response

Benefits will be coordinated to the extent permitted by law with other plans covering health benefits, including: motor vehicle insurance, medical payment policies, workers' compensation insurance; and home owners insurance. Coordination of benefits will be based upon the usual, customary and reasonable charges for any service that is a covered service under the high risk pool benefit plans. If benefits are provided in the form of services, or if a provider of services is paid under a capitation arrangement, the reasonable value of such services will be used as the basis for coordination. No duplication in coverage of services shall occur among plans. When a Member is covered

by two or more health benefit plans, one plan will be primary and the other plan will be secondary. The benefits of the primary plan are determined before those of secondary plan and without considering the benefits of secondary plan. The benefits of secondary plan are determined after those of the primary plan and may be reduced because of the primary plan's benefits.

To determine coordination of benefits HPHC sends a periodic letter asking for other insurance coverage. There are triggers via the data in the eligibility file and the data submitted on the UB-04 and the CMS-1500 claims forms that the claims processing computer system uses to flag and detect potentials for other insurance coverage.

Section C – Cost Proposal

Budget Narrative

The State proposes to use its allocation of high risk pool dollars to promote premium rate stability for both high risk pool eligible individuals and other DirigoChoice members.

Premium rates charged to high risk pool eligible individuals will be the same as the premium rates charged to other individuals enrolled in the DirigoChoice program. Currently, premium rates for DirigoChoice are developed to target a 90% medical loss ratio. Under the risk sharing program, high risk pool funds will be used to make additional payments to HPHC if the medical loss ratio for high risk pool members exceeds 90%.

Initial premium rates for the DirgoChoice program were established based on the prevailing individual market premium rates of the program's prior vendor with appropriate adjustments made based on the program structure. Currently, HPHC develops premium rates for the non-group DirigoChoice product using the actual experience of non-group DirigoChoice members. In recent experience periods, average rate increases for DirigoChoice members have been below anticipated medical trend and have been lower than those filed by the carrier with the largest market share in Maine's individual market.

To develop the budget for the high risk pool program, HPHC developed premium, claim and administrative cost and enrollment estimates. The premium and claim cost estimates are based on reasonable actuarial assumptions regarding health care trends and the anticipated morbidity of high risk pool enrollees. Actual experience may vary from these estimates. Factors that may impact the actual experience include changes in general unit cost and utilization trends in the State of Maine, finalization of eligibility requirements for the high risk pool and the actual morbidity of the enrolled population.

Enrollment estimates were developed using the premium and claim cost estimates and the assumption that $17 million is available for the high risk pool program.

We project that the high risk pool program will be able to serve an average of 920 members each month. Based on the claims projections for this population, $17 million will be used for risk sharing payments over the life of the program. These cost projections are detailed in Table 2, and refer to high risk pool program members only, not the total DirigoChoice population. DHA and HPHC will review and revise membership projections annually and, if necessary, will suspend new enrollment into the program in order to ensure that program spending does not exceed available funding. We anticipate that while the program ends in 2013, a final payment will be made to Harvard Pilgrim in 2014 after all claims for high risk pool program enrollees incurred in 2013 have been adjudicated. We anticipate that approximately $1,000,000 in allowable high risk pool claims incurred in 2013 will be paid in 2014.

Administrative cost estimates are based on HPHC's administrative cost allocation methodology for each of the categories of services listed in Table 1. These costs are for high risk pool members only, not the total DirigoChoice population. The overhead category of services includes governance, real estate, compliance/audit, human resources and certain information technology expenses. The other administrative costs category includes premium taxes and care management expenses. With respect to administrative services provided by DHA, such as eligibility determinations, no additional administrative costs have been assumed as DHA will absorb these expenses within its existing administrative budget.

Maintenance of Effort

As noted in the technical proposal, the State proposes to build on the existing Dirigo Health program, which currently covers uninsured persons with pre-existing conditions through its subsidized insurance program DirigoChoice. Dirigo Health is currently

statutorily funded through an annual assessment on health insurance carriers, 3rd-party administrators and employee benefit excess insurance carriers of 2.14% of paid claims (MRSA 24-A §6917 (1)). DHA estimates that this assessment will result in approximately $42.1 million in revenue in State Fiscal Year 2011 (July 2010 – June 2011) and enable the State to provide coverage to approximately 20,000 Maine residents. In addition, DHA currently receives $8.5 million annually from a State Health Access Grant Program (SHAP) from the Health Resources and Services Administration (HRSA). This program allows DHA to extend benefits to an additional 3,000 low-income, part-time, uninsured workers in the State[1]

These funds will allow DHA to meet the maintenance of effort requirement set forth in section 1101(b)(3) of the Affordable Care Act. DirigoChoice is not a traditional high risk pool, but as the State is proposing using the program to insure a high risk population and to meet the requirements set forth in 1101(c)(2)(A-D) of the Affordable Care Act it will apply the maintenance of effort requirements to the program. Existing funding, therefore, will ensure that the existing DirigoChoice population will continue to receive benefits and that the State is agreeing to not reduce the annual amount expended for the operation of DirigoChoice during the year proceeding the year of the contract.

[1] This grant requires annual renewals and may be extended through 2014.

Table 1
Administrative Costs

The administrative costs projected in Table 1 should include all administrative costs that the State anticipates during each calendar year from 2010-2013.

Administrative Costs					
Cost Category	**Annual Administrative Costs**				
	2010	**2011**	**2012**	**2013**	**2014**
Marketing and Outreach	$8,180.65	$17,483.27	$18,616.43	$19,829.96	
Member Materials					
Customer Service	$11,944.75	$25,527.72	$27,182.27	$28,954.18	
Provider Relations					
Information Technology	$11,894.56	$25,420.46	$27,068.06	$28,832.52	
Eligibility/Enrollment	$8,180.65	$17,483.27	$18,616.43	$19,829.96	
Premium Administration	$13,651.14	$29,174.54	$31,065.45	$33,090.49	
Claims Processing**	$15,006.22	$32,070.54	$34,149.15	$36,375.21	
Appeals/Reconsiderations					
Legal Services	$2,910.90	$6,221.04	$6,624.25	$7,056.06	
Accounting Services	$20,878.21	$44,619.88	$47,511.86	$50,608.99	
Actuarial Services					
Procurement	$150.56	$321.78	$342.63	$364.97	
Personnel Expenses					
Overhead*	$95,056.10	$203,149.18	$216,316.03	$230,416.87	
Other Administrative Costs*	$87,527.90	$187,060.28	$199,184.35	$212,168.44	
TOTAL	$275,381.63	$588,531.96	$626,676.90	$667,527.66	

*Provide a detailed description of costs included in this category of administration costs
Other Administrative tax is Premium Tax and Care Management
Overhead expenses include governance, real estate, compliance/audit, HR, as well as HPHC IT expenses

**Including prescription drug point of sale claims

Table 2
Administrative and Claims Costs

Year	Average Enrollment	Premium Revenue	Total Claims	Administrative Costs	Total Claims Against Federal Fund Allotment
2010					
Plan Option 2B	241	$627,633.85	$1,059,132.13		
Plan Option 2C	98	$325,095.85	$548,599.24		
Plan Option 2D	42	$121,534.98	$205,090.27		
Plan Option 2E	22	$68,426.90	$115,470.40		

Plan Option 2F	42	$105,451.89	$177,950.06		
Plan Option 3B	264	$807,399.06	$1,362,485.92		
Plan Option 3C	101	$419,159.86	$707,332.26		
Plan Option 3D	35	$115,251.62	$194,487.11		
Plan Option 3E	19	$63,087.72	$106,460.53		
Plan Option 3F	37	$100,774.62	$170,057.17		
2010 TOTAL	900	$2,753,816.35	$4,647,065.09	$275,381.63	$2,168,630.37
			2011		
Plan Option 2B	261	$1,425,732.16	$2,405,923.02		
Plan Option 2C	98	$681,876.25	$1,150,666.18		
Plan Option 2D	42	$254,915.02	$430,169.10		
Plan Option 2E	22	$143,522.84	$242,194.80		
Plan Option 2F	42	$221,181.35	$373,243.53		
Plan Option 3B	264	$1,693,489.02	$2,857,762.71		
Plan Option 3C	101	$879,171.95	$1,483,602.67		
Plan Option 3D	35	$241,735.92	$407,929.37		
Plan Option 3E	19	$132,324.12	$223,296.94		
Plan Option 3F	37	$211,370.95	$356,688.48		
2011 TOTAL	920	$5,885,319.59	$9,931,476.80	$588,531.96	$4,634,689.17
			2012		
Plan Option 2B	261	$1,518,139.16	$2,561,859.83		
Plan Option 2C	98	$726,071.19	$1,225,245.13		
Plan Option 2D	42	$271,437.01	$458,049.96		
Plan Option 2E	22	$152,825.09	$257,892.34		
Plan Option 2F	42	$235,516.93	$397,434.83		
Plan Option 3B	264	$1,803,250.33	$3,042,984.93		
Plan Option 3C	101	$936,154.36	$1,579,760.48		
Plan Option 3D	35	$257,403.72	$434,368.79		
Plan Option 3E	19	$140,900.53	$237,769.65		
Plan Option 3F	37	$225,070.69	$379,806.79		
2012 TOTAL	920	$6,266,769.02	$10,575,172.72	$626,676.90	$4,935,080.60
			2013		
Plan Option 2B	261	$1,617,101.06	$2,728,858.04		
Plan Option 2C	98	$773,401.09	$1,305,114.35		
Plan Option 2D	42	$289,130.99	$487,908.55		
Plan Option 2E	22	$162,787.20	$274,703.40		
Plan Option 2F	42	$250,869.42	$423,342.14		
Plan Option 3B	264	$1,920,797.58	$3,241,345.91		
Plan Option 3C	101	$997,178.81	$1,682,739.24		
Plan Option 3D	35	$274,182.93	$462,683.69		
Plan Option 3E	19	$150,085.32	$253,268.98		
Plan Option 3F	37	$239,742.22	$404,564.99		
2013 TOTAL	920	$6,675,276.61	$11,264,529.28	$667,527.66	$4,256,780.33

2014					
2014 TOTAL	Run-out of 2013 claims				$1,000,000.00
TOTAL		$21,581,181.56	$36,418,243.88	$2,158,118.16	$16,995,180.48

Notes:

- State should list total administrative costs for each calendar year. Administrative costs do not need to be broken down for each plan option if multiple plan options are offered.
- States may offer one or more plan option. State may add additional plan options following the format in template Table 2.
- Claims against Federal Fund Allotment for each year and for the total contract equal the total administrative and claims expenses, minus the premium revenue.
- The projected total for the term of the contract should not exceed the provided Federal fund allotment.
- States must attest to the actuarial soundness of the projects contained in this table in the budget narrative section of the Cost Proposal.
- DHA and HPHC will review and revise membership assumptions annually based on actual experience.

Exhibit 1 - DirigoChoice Summaries of Benefits

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción.

Translation: If you need Spanish-language assistance to understand this document, you may request it at no additional cost by calling the customer service number on the back of your id card or in your enrollment booklet.

The DirigoChoice PPO Plan
Plan 3 – Group F

HPHC Insurance Company

This is a Summary of Benefits to your DirigoChoice PPO Plan. It is attached to and becomes part of your DirigoChoice Benefit Handbook.

Group Name: **Group Number:** **Effective Date:**

	Cost Sharing	
Calendar Year Deductibles: General Deductible Mental Health (Non-Biologically Based Mental Illnesses)	 $2,500 Individual Deductible $5,000 Family Deductible $150	
Deductible Rollover Your Plan has a Deductible Rollover. This allows you to apply any Deductible amount incurred for Covered Benefits during the last three (3) months of a calendar year toward the Deductible for the next year. In order for the Deductible Rollover to apply, you, or your covered family, must have had continuous coverage under DirigoChoice at the time the charges for the prior year were incurred.		
Calendar Year Out-of-Pocket Limit	$3,500 Individual Limit $7,000 Family Limit	
Lifetime Benefit Maximum	No Limit	
	In-Network Benefit	**Out-of-Network Benefit**
Coinsurance	The Plan pays 70% The Member pays 30% Unless otherwise indicated	The Plan pays 50% The Member pays 50% Unless otherwise indicated
Copayment	$25 Copayment where indicated	$35 Copayment where indicated
Service	**In-Network Benefit The Plan Pays:**	**Out-of-Network Benefit The Plan Pays:**
Hospital Services Inpatient[1] Outpatient	70% after Deductible	50% after Deductible
Emergency Room Services	70% after Deductible	70% after Deductible
Screening Mammograms	100%, no Copayment or Deductible	100%, no Copayment or Deductible
Professional Services Inpatient Outpatient Diagnostic tests, x-rays, and surgery	70% after Deductible	50% after Deductible
Endoscopic Procedures (including Colonoscopies)	70% after Deductible	50% after Deductible
Maternity Pre- & Post-natal Delivery	 $25 Copayment first prenatal visit, then 100% 70% after Deductible	 $35 Copayment first prenatal visit, then 70% 50% after Deductible

[1] Failure to obtain Prior Approval for non-emergency inpatient hospital services may result in services not being covered or a penalty of $150. Please see your Benefit Handbook Section C.4 for further information.

Benefit payments are based on the applicable percentage of the Covered Charge after any Deductible and/or Copayment amount has been deducted.

Form No. 729

Service	In-Network Benefit The Plan Pays:	Out-of-Network Benefit The Plan Pays:
Physician Office Visits		
Sick Care Specialists	100% after $25 Copayment, Deductible does not apply	70% after $35 Copayment, Deductible does not apply
Routine/Preventive (including any associated diagnostic tests and x-rays)	100%, no Copayment or Deductible	50% after $35 Copayment, Deductible does not apply
Hearing aids For Members through the age limit required by Maine law[2]. Limited to one (1) hearing aid every 36 months, per hearing impaired ear, up to a limit of $1,400	70% after Deductible	50% after Deductible
Other Services		
Occupational, Speech, and Physical Therapies – Combined limit of $3,000 per calendar year	70% after Deductible	50% after Deductible
Chiropractic Care / Manipulative Therapy Combined limit of 40 visits per calendar year	70% after Deductible	50% after Deductible
Skilled Nursing Facility – Up to 100 days per Member per calendar year	70% after Deductible	50% after Deductible
Hospice	100% after $25 Copayment, Deductible does not apply	50% after $35 Copayment, Deductible does not apply
Home Health Care	70% after Deductible	50% after Deductible
Ambulance	70% after Deductible	70% after Deductible
Cardiac Rehabilitation – Up to 24 visits per Member per calendar year	70% after Deductible	50% after Deductible
Durable Medical Equipment – Up to $3,500 per Member per calendar year	70% after Deductible	50% after Deductible
Prostheses (excluding limbs) Prostheses for limb replacement	70% after Deductible 70%, Deductible does not apply	50% after Deductible 70%, Deductible does not apply
Smoking Cessation: Smoking Cessation Program – up to $35 per program /$70 per lifetime	100%, no Copayment or Deductible	100%, no Copayment or Deductible
Physician Office Visits – up to 2 per Member per calendar year	100% after $25 Copayment, Deductible does not apply	70% after $35 Copayment, Deductible does not apply
Smoking Cessation Medications	See the Prescription Drug section for additional information	See the Prescription Drug section for additional information

[2] Effective January 1, 2008, for Members from birth through age 5. Effective January 1, 2009, for Members from birth through age 13. Effective January 1, 2010 and thereafter, for Members from birth through age 18. No coverage for Members over 18 years of age.

Mental Health and Substance Abuse Services		
Mental Health and Substance Abuse services are managed and all Inpatient and Day Treatment services require preauthorization. Failure to comply with the requirements outlined in your Benefit Handbook may result in a penalty up to $150. Coinsurance for Non-Biologically Based Mental Illness services does not count toward meeting the annual Coinsurance limit. Coinsurance continues to apply to these services after the Coinsurance limit is met.		
Service	**In-Network Benefit The Plan Pays:**	**Out-of-Network Benefit The Plan Pays:**
***Biologically Based Mental Illnesses including Substance Abuse services:** Inpatient, Day treatment, Outpatient	70% after Deductible	50% after Deductible
Office Visits	100% after $25 Copayment, Deductible does not apply	70% after $35 Copayment, Deductible does not apply
Home Health Care Services	70% after Deductible	50% after Deductible
Non-Biologically Based Mental Illnesses: Deductible – combined in and out of network	$150	$150
Inpatient – Combined limit of 30 days per calendar year. Two days of Day Treatment equal one day of Inpatient Treatment.	70% after mental health Deductible	50% after mental health Deductible
Outpatient – Combined limit of 40 visits per Member per calendar year	70% after mental health Deductible	50% after mental health Deductible
Home Health Care Services	70% after Deductible	50% after Deductible

Prescription Drug Coverage	
The Plan provides prescription drug coverage with Copayments. The Plan places all covered drugs into one of three levels or "tiers." Each tier has its own Copayment amount. The specific Copayments for prescription drugs that apply to your Plan are listed below. Your Copayments are also listed on your Member ID card. Prescription drugs are not subject to the Deductible. Please see your Benefit Handbook Section O for further information.	
Prescription Drug Tier	**Participating & Non-Participating Pharmacies**
Tier 1	$10 Copayment, up to a 30-day supply
Tier 2	$30 Copayment, up to a 30-day supply
Tier 3	$50 Copayment, up to a 30-day supply

***Biologically Based Mental Illnesses: State of Maine statute requires that benefits be provided at the same benefit level provided for medical treatment for the following Biologically Based Mental Illnesses: psychotic disorders, including schizophrenia; dissociative disorders; mood disorders; anxiety disorders; personality disorders; paraphilias; attention deficit and disruptive behavior disorders; pervasive developmental disorders; tic disorders; eating disorders, including bulimia and anorexia; and substance abuse-related disorders.**

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción.

Translation: If you need Spanish-language assistance to understand this document, you may request it at no additional cost by calling the customer service number on the back of your id card or in your enrollment booklet.

The DirigoChoice PPO Plan
Plan 2 – Group F

HPHC Insurance Company

This is a Summary of Benefits to your DirigoChoice PPO Plan. It is attached to and becomes part of your DirigoChoice Benefit Handbook.

Group Name: **Group Number:** **Effective Date:**

	Cost Shares	
Calendar Year Deductibles: General Deductible Mental Health (Non-Biologically Based Mental Illnesses)	 $1,750 Individual Deductible $3,500 Family Deductible $150	
Deductible Rollover Your Plan has a Deductible Rollover. This allows you to apply any Deductible amount incurred for Covered Benefits during the last three (3) months of a calendar year toward the Deductible for the next year. In order for the Deductible Rollover to apply, you, or your covered family, must have had continuous coverage under DirigoChoice at the time the charges for the prior year were incurred.		
Calendar Year Out-of-Pocket Limit	$5,600 Individual Limit $11,200 Family Limit	
Lifetime Benefit Maximum	No Limit	
	In-Network Benefit	**Out-of-Network Benefit**
Coinsurance	The Plan pays 70% The Member pays 30% Unless otherwise indicated	The Plan pays 50% The Member pays 50% Unless otherwise indicated
Copayment	$25 Copayment where indicated	$35 Copayment where indicated
Service	**In-Network Benefit The Plan Pays:**	**Out-of-Network Benefit The Plan Pays:**
Hospital Services Inpatient[1] Outpatient	70% after Deductible	50% after Deductible
Emergency Room Services	70% after Deductible	70% after Deductible
Screening Mammograms	100%, no Copayment or Deductible	100%, no Copayment or Deductible
Professional Services Inpatient Outpatient Diagnostic tests, x-rays, and surgery	70% after Deductible	50% after Deductible
Endoscopic Procedures (including Colonoscopies)	70% after Deductible	50% after Deductible
Maternity Pre- & Post-natal Delivery	 $25 Copayment first prenatal visit, then 100% 70% after Deductible	 $35 Copayment first prenatal visit, then 70% 50% after Deductible

[1] Failure to obtain Prior Approval for non-emergency inpatient hospital services may result in services not being covered or a penalty of $150. Please see your Benefit Handbook Section C.4 for further information.

Benefit payments are based on the applicable percentage of the Covered Charge after any Deductible and/or Copayment amount has been deducted.

Form No. 724

Service	In-Network Benefit The Plan Pays:	Out-of-Network Benefit The Plan Pays:
Physician Office Visits		
Sick Care Specialists	100% after $25 Copayment, Deductible does not apply	70% after $35 Copayment, Deductible does not apply
Routine/Preventive (including any associated diagnostic tests and x-rays)	100%, no Copayment or Deductible	50% after $35 Copayment, Deductible does not apply
Hearing aids For Members through the age limit required by Maine law[2]. Limited to one (1) hearing aid every 36 months, per hearing impaired ear, up to a limit of $1,400	70% after Deductible	50% after Deductible
Other Services		
Occupational, Speech, and Physical Therapies – Combined limit of $3,000 per calendar year	70% after Deductible	50% after Deductible
Chiropractic Care / Manipulative Therapy Combined limit of 40 visits per calendar year	70% after Deductible	50% after Deductible
Skilled Nursing Facility – Up to 100 days per Member per calendar year	70% after Deductible	50% after Deductible
Hospice	100% after $25 Copayment, Deductible does not apply	50% after $35 Copayment, Deductible does not apply
Home Health Care	70% after Deductible	50% after Deductible
Ambulance	70% after Deductible	70% after Deductible
Cardiac Rehabilitation – Up to 24 visits per Member per calendar year	70% after Deductible	50% after Deductible
Durable Medical Equipment – Up to $3,500 per Member per calendar year	70% after Deductible	50% after Deductible
Prostheses (excluding limbs) Prostheses for limb replacement	70% after Deductible 70%, Deductible does not apply	50% after Deductible 70%, Deductible does not apply
Smoking Cessation: Smoking Cessation Program – up to $35 per program /$70 per lifetime	100%, no Copayment or Deductible	100%, no Copayment or Deductible
Physician Office Visits – up to 2 per Member per calendar year	100% after $25 Copayment, Deductible does not apply	70% after $35 Copayment, Deductible does not apply
Smoking Cessation Medications	See the Prescription Drug section for additional information	See the Prescription Drug section for additional information

[2] Effective January 1, 2008, for Members from birth through age 5. Effective January 1, 2009, for Members from birth through age 13. Effective January 1, 2010 and thereafter, for Members from birth through age 18. No coverage for Members over 18 years of age.

Mental Health and Substance Abuse Services

Mental Health and Substance Abuse services are managed and all Inpatient and Day Treatment services require preauthorization. Failure to comply with the requirements outlined in your Benefit Handbook may result in a penalty up to $150. Coinsurance for Non-Biologically Based Mental Illness services does not count toward meeting the annual Coinsurance limit. Coinsurance continues to apply to these services after the Coinsurance limit is met.

Service	In-Network Benefit The Plan Pays:	Out-of-Network Benefit The Plan Pays:
***Biologically Based Mental Illnesses including Substance Abuse services:**		
Inpatient, Day treatment, Outpatient	70% after Deductible	50% after Deductible
Office Visits	100% after $25 Copayment, Deductible does not apply	70% after $35 Copayment, Deductible does not apply
Home Health Care Services	70% after Deductible	50% after Deductible
Non-Biologically Based Mental Illnesses:		
Deductible – combined in and out of network	$150	$150
Inpatient – Combined limit of 30 days per calendar year. Two days of Day Treatment equal one day of Inpatient Treatment.	70% after mental health Deductible	50% after mental health Deductible
Outpatient – Combined limit of 40 visits per Member per calendar year	70% after mental health Deductible	50% after mental health Deductible
Home Health Care Services	70% after Deductible	50% after Deductible

Prescription Drug Coverage

The Plan provides prescription drug coverage with Copayments. The Plan places all covered drugs into one of three levels or "tiers." Each tier has its own Copayment amount. The specific Copayments for prescription drugs that apply to your Plan are listed below. Your Copayments are also listed on your Member ID card. Prescription drugs are not subject to the Deductible. Please see your Benefit Handbook Section O for further information.

Prescription Drug Tier	Participating & Non-Participating Pharmacies
Tier 1	$10 Copayment, up to a 30-day supply
Tier 2	$30 Copayment, up to a 30-day supply
Tier 3	$50 Copayment, up to a 30-day supply

***Biologically Based Mental Illnesses: State of Maine statute requires that benefits be provided at the same benefit level provided for medical treatment for the following Biologically Based Mental Illnesses: psychotic disorders, including schizophrenia; dissociative disorders; mood disorders; anxiety disorders; personality disorders; paraphilias; attention deficit and disruptive behavior disorders; pervasive developmental disorders; tic disorders; eating disorders, including bulimia and anorexia; and substance abuse-related disorders.**

Exhibit 2 – Gorman Actuarial, LLC DirigoChoice Summary Actuarial Value Calculation

		Non Group HPHC					
Plan	Income Category	Office Visit Copay	Deductible	In Network Coinsurance	Out Network Coinsurance	OOP Max	Actuarial Value
1750	B	25	500	30%	50%	1600	0.824
1750	C	25	800	30%	50%	2600	0.787
1750	D	25	1125	30%	50%	3600	0.758
1750	E	25	1450	30%	50%	4600	0.735
1750	F	25	1750	30%	50%	5600	0.716
2500	B	25	500	30%	50%	700	0.862
2500	C	25	1000	30%	50%	1400	0.814
2500	D	25	1500	30%	50%	2100	0.779
2500	E	25	2000	30%	50%	2800	0.751
2500	F	25	2500	30%	50%	3500	0.727
Total							0.818

HPHC Insurance Company
DirigoChoice PPO Plan
Enrollment / Change Form

PO BOX 5255 • WESTBOROUGH, MA 01581
1-877-213-5225 www.healthplansinc.com

REASON FOR SUBMISSION (PLEASE CHECK ALL THAT APPLY)

☐ ENROLLMENT
- ☐ NEW HIRE ☐ COBRA
- ☐ ANNUAL OPEN ENROLLMENT £ RENEWAL
- ☐ LOSS OF INSURANCE DATE _____ (ATTACH DOCUMENTS)
- ☐ P/T TO F/T DATE _____

☐ CHANGE
- ☐ CHANGE COVERAGE TYPE
- ☐ ADD DEPENDENT LISTED BELOW
- ☐ TERMINATE DEPENDENT LISTED BELOW
- ☐ NAME/ADDRESS CHANGE
- ☐ LOSS OF INSURANCE DATE _____ (ATTACH DOCUMENTS)
- ☐ MARRIAGE DATE _____
- ☐ NEWBORN DATE _____

☐ TERMINATION
- ☐ LEFT EMPLOYMENT ☐ NO LONGER ELIGIBLE
- ☐ VOLUNTARY CANCELLATION ☐ DECEASED DATE _____
- ☐ MOVED FROM SERVICE AREA
- TERMINATION DATE _____

TO BE COMPLETED BY HPHC ONLY.	GROUP / COMPANY NAME (IF APPLICABLE)	DATE OF HIRE	GROUP #/DIVISION (IF APPLICABLE)	EFFECTIVE DATE
H H D				

APPLICANT NAME

FIRST MIDDLE LAST

ADDRESS

APT. NO. STREET PO BOX

CITY STATE ZIP COUNTY

TELEPHONE (HOME) ( )

TELEPHONE (WORK) ( )

TYPE OF COVERAGE
- ☐ INDIVIDUAL ☐ 2-PERSON
- ☐ FAMILY ☐ OTHER _____

PLEASE USE THE CODES LISTED BELOW TO COMPLETE DEPENDENT RELATION BLOCK

02 SPOUSE / DOMESTIC PARTNER
03 DEPENDENT CHILD UNDER 23
04 STEPCHILD UNDER 23
06 HANDICAPPED (VERIFICATION REQUIRED)

FIRST MI LAST (IF NOT SAME AS APPLICANT)	LANGUAGE CODE	DATE OF BIRTH MO DAY YR	SEX		RELATION CODE	SOCIAL SECURITY NUMBER
APPLICANT		- -	M	F	01	- -
SPOUSE		- -	M	F		- -
DEPENDENT		- -	M	F		- -
DEPENDENT		- -	M	F		- -
DEPENDENT		- -	M	F		- -
DEPENDENT		- -	M	F		- -

LANGUAGE CODES (OPTIONAL)

WHAT LANGUAGE DO YOU SPEAK MOST OFTEN? PLEASE LIST THE APPROPRIATE CODE AFTER EACH MEMBER'S NAME. THIS INFORMATION WILL HELP US WORK TOWARD BEST MEETING YOUR NEEDS.

AS American Sign Language · CA Cantonese · CV Cape Verdean · EN English · FR French · HA Haitian · HM Hmong · IT Italian · KH Khmer · LO Laotian · MN Mandarin · PT Portuguese · RU Russian · SP Spanish · VI Vietnamese · OTHER ☐ _____ Specify

HAVE YOU EVER BEEN A MEMBER OF HPHC, HPHC OF NE, OR HPHC INSURANCE COMPANY? ☐ YES ☐ NO

IF YOU WOULD LIKE TO RECEIVE A MENU OF ELECTRONIC WAYS TO INTERACT WITH US, LIST YOUR E-MAIL ADDRESS HERE.

E-MAIL ADDRESS: _____ (OPTIONAL)

YOUR E-MAIL ADDRESS WILL BE STORED IN A PROTECTED DATABASE AND WILL REMAIN CONFIDENTIAL.

Membership will become effective upon acceptance by HPHC. Benefits under the Plan will be explained in a separate document. For an explanation of how HPHC may use or disclose your protected health information, please read your notice of privacy practices provided to you by HPHC in your enrollment kit. Please note that the subrogation provision applicable to Maine members, outlined in a separate document, permits subrogation payments on a just and equitable basis. I understand that by signing below, I am agreeing to the terms of the evidence of coverage. All statements and descriptions in this enrollment/change form are deemed to be representations and not warranties. I authorize any health care provider or other health plan to provide medical information and records to HPHC. I also authorize the plan and any health care provider rendering services to me or my dependents to receive copies of my or my dependents' medical records. I understand that any information obtained under this authorization will be used in the delivery of health services, to determine eligibility for benefits (including reimbursement by third parties), in education and research in accordance with government regulations, and in connection with HPHC's professional and utilization review activities. Permission is not given for any re-disclosure of this information other than as specified above. This authorization is valid for the term of the policy and any renewals of that policy. I understand that a copy of this form will be given to me, or my authorized representative, upon request. I understand that I may revoke this authorization, but that a revocation may be a basis for denying insurance benefits. Failure to sign this form may impair the ability of HPHC to evaluate or process your application or claim and may be a basis for denying an application or claims for benefits.

IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS.

THE APPLICANT AND, IF APPLICABLE, THE EMPLOYER MUST SIGN AND DATE THIS FORM FOR ENROLLMENT.

APPLICANT SIGNATURE _____ DATE _____

EMPLOYER SIGNATURE (IF APPLICABLE) _____ DATE _____

DIRIGO CHOICE 09

DirigoChoice

Harvard Pilgrim Health Care

DirigoChoice Discount Application

Information Provided on This Form Is Strictly Confidential

SECTION 1: GENERAL INFORMATION

1. Applicant Information:

Last Name _____ First Name _____

Mailing Address (Street or PO Box) _____

City _____ State _____ ZIP Code _____

If different from your mailing address, write the address where you actually live:

_____

Home Telephone _____ Work Telephone _____

Mobile Telephone _____ Email address _____

Are you a resident of the State of Maine? ❑ Yes ❑ No

1(a). Were you covered by another health insurance plan for all 12 months prior to applying for *DirigoChoice*?
❑ Yes ❑ No *If no, go to **1(e).***

1 b). How much was your deductible on the plan you had before?
Single $ _____ ❑ Unsure Family $ _____ ❑ Unsure

1(c). What was the coverage? Check all that apply:
❑ MaineCare ❑ Military/VA ❑ HPHC ❑ Aetna ❑ Cigna
❑ Anthem Blue Cross /Blue Shield ❑ Other (specify)_____

1(d). Was the coverage offered through your employer? ❑ Yes ❑ No

1(e). If you are applying to cover dependents through *DirigoChoice*, please tell us whether they had health insurance for all 12 months prior to applying for *DirigoChoice*?
Spouse/Domestic Partner: ❑ Yes ❑ No Dependent Child(ren): ❑ Yes ❑ No

2. Discount Request:

❑ I want to apply for a discount.

❑ I **do not** want to apply for a discount. *(If you do not want to apply for a discount, go to SECTION 3. Be sure to sign and date the application.)*

SECTION 2: *DIRIGOCHOICE* DISCOUNT INFORMATION

3. Household members and relationship:

Last name	First name	M.I.	Sex	Relationship to you	Social Security Number	Date of Birth

4. Household Wages:

Attach copies of paychecks, pay stubs, other proof of wages, or a copy of your most recent Federal 1040 tax return. Income information should accurately represent your present income.

What Is Counted	Annual Amount	Where to Find it on Most Recent Federal 1040 Tax Return
4(a). Applicant gross wages, tips and salaries (before any deductions)	$	Recent pay stubs, a signed letter from employer, or a copy of employer payroll. If not available, use Form 1040 line 7 ("wages, salaries, tips, etc.") or wages as reported on W-2. Do not use line 37 ("Adjusted Gross Income"). Multiply weekly income by 52 or bi-weekly income by 26 to get yearly income. Multiply monthly income by 12 to get yearly income.
4(b). Spouse or Domestic Partner gross wages (before any deductions)	$	
4(c). Net self-employment income (gross receipts minus allowable business expenses)	$	Form 1040 Line 12 "Business income or (loss)." We also accept IRS business Quarterly Estimate of Earnings.
Annual Other Income		
4(d). Interest and investment income (savings accounts, dividends from stocks, bonds, trusts, mutual fund shares)	$	Form 1040 Line 8a and Line 9a, or annual interest income statements
4(e). Alimony received	$	Form 1040 Line 11, divorce settlement order or copy of check
4(f). IRA distributions	$	Form 1040 Line 15a, or Line 15b if Line 15a is blank
4(g). Pensions, annuities, 401(k)	$	Form 1040 Line 16a, or Line 16b if Line 16a is blank, or checks, award letters, signed letter from payer

4(h).	Net rental income (gross rents minus allowable expenses), royalties, trusts, etc.	$	Form 1040 Line 17
4(i).	Farm income or loss	$	Form 1040 Line 18
4(j).	Unemployment compensation	$	Form 1040 Line 19, checks, award letters
4(k).	Gross child support received	$	Support orders, checks, check stubs

5. Income Subtotal $

Total of 4(a) through 4(k)

6. Child-Related Annual Allowable Deductions

6(a).	Childcare expenses	$	We allow $200 per child per month if under 2, $175 per child per month if 2 or older. Caregiver must be a person outside the household. Provide a receipt, copy of check, or letter from caregiver.
6(b).	Child support paid out (only allowed for children that will not be covered by the applicant's policy)	$	Checks, check stubs, support orders

7. Deductions Subtotal $

Total of 6(a) and 6(b)

8. Income Total $

(Line Number 5 minus Line Number 7)

SECTION 3: SIGNATURE OF APPLICANT

9. I understand the questions on this form. All statements and answers I have given are true and complete. The *Dirigo Health Agency* may check information submitted on this form. I understand it is a crime to knowingly provide false, incomplete or misleading information on this form and that I could be charged with perjury.

Signature **Date**

DC-U Rev. 10/14/08

DirigoChoice

Harvard Pilgrim HealthCare

Certification Statement

To apply for *DirigoChoice* coverage as Self-employed or as an Individual, you must check one of the boxes below. If you have any questions about this form, please call the Dirigo Health Agency at 1-877-892-8391 toll free in Maine (TTY 207-287-4344).

❑ A. The following statement is true:
I am self-employed and have no employees

❑ B. The following statement is true:
I am unemployed.

❑ C. The following two statements are true:
(1) I do not work more than 20 hours a week for any single employer.
(2) I am not self-employed and I am not the employer of an eligible business of 2 to 50 employees.

❑ D. The following two statements are true:
(1) I am employed in an eligible business of 2 to 50 employees. I am not the employer.
(2) My employer does not provide access for me and my dependent(s) to an employer sponsored health benefits plan and has not done so in the last 12 months.

❑ E. The following two statements are true:
(1) I am the employer or I am an employee of an eligible business of 2 to 50 employees.
(2) *DirigoChoice* was offered to the employees. We were unable to get 75% participation.

Attached is a signed letter detailing efforts specific to offering *DirigoChoice* to the employees. The employer letter includes (a) intended contribution level; (b) the number of hours an employee must work each week to qualify for coverage in the business; and (c) the number of full-time employees working 30 or more hours per week and the number of part-time employees.

❑ F. The following statement is true:
I am an early retiree (*i.e.*, under age 65) who worked for an eligible business of 2 to 50 employees. My former employer does not contribute to early retiree health insurance coverage.

❑ G. All three of the following statements are true:
(1) I am employed by a household and I work more than 20 hours a week (for example: nanny, housekeeper).
(2) I am not self-employed. The household is considered my employer. My employer does not provide access for me and my dependent(s) to an employer sponsored health benefits plan and has not done so in the last 12 months.
(3) I am not the employer of an eligible business of 2 to 50 employees.

❑ H. The following statement is true:
I am eligible to apply for the Health Coverage Tax Credit (HCTC) Program certified under the Trade Adjustment Assistance Act.

In signing this statement I certify:
I meet the eligibility requirements checked above. I reside in the State of Maine and have for at least the last 60 days. As a new enrollee I am not currently eligible for Medicare. My dependent(s) also meet the eligibility requirements if I am covering them. I will contact the Dirigo Health Agency if my circumstances change. I understand that failure to do so may result in loss of coverage. I understand I may be required to recertify my status every six months.

Signature:_____ **Print Name:** _____ **Date:** _____

DirigoChoice is underwritten by HPHC Insurance Company, Inc. (HPHC), an affiliate of Harvard Pilgrim Health Care, Inc.

DC-J Rev. 2/9/09

Exhibit 6 – Subsidy and Cost Sharing Schedule

Federal Poverty Level	150%	200%	250%	300%	300%+
Less than:					
Subsidy Level	B	C	D	E	F
% off Premium	80%	60%	40%	20%	0%

Subsidy Level B			
1750 Plan	Single	$ 500	$1,600
	Family	$1,000	$3,200
2500 Plan	Single	$ 500	$ 700
	Family	$1,000	$1,400
Subsidy Level C			
1750 Plan	Single	$ 800	$2,600
	Family	$1,600	$5,200
2500 Plan	Single	$1,000	$1,400
	Family	$2,000	$2,800
Subsidy Level D			
1750 Plan	Single	$1,125	$3,600
	Family	$2,250	$7,200
2500 Plan	Single	$1,500	$2,100
	Family	$3,000	$4,200
Subsidy Level E			
1750 Plan	Single	$1,450	$4,600
	Family	$2,900	$9,200
2500 Plan	Single	$2,000	$2,800
	Family	$4,000	$5,600
Subsidy Level F			
1750 Plan	Single	$1,750	$5,600
	Family	$3,500	$11,200
2500 Plan	Single	$2,500	$3,500
	Family	$5,000	$7,000

Exhibit 7 - DIRIGO Rates by Age and Area - Effective 10/1/10-12/31/10

Plan 2F

	Age							
County	**<30**	**30 - 39**	**40 - 44**	**45 - 49**	**50 - 54**	**55 - 59**	**60 - 64**	**65+**
Androscoggin	438.30	438.30	453.09	574.17	652.51	657.44	657.44	657.44
Aroostook	438.30	448.71	540.20	657.44	657.44	657.44	657.44	657.44
Cumberland	438.30	438.30	438.30	535.27	608.68	657.44	657.44	657.44
Franklin	438.30	438.30	481.03	609.78	657.44	657.44	657.44	657.44
Hancock	438.30	448.71	540.20	657.44	657.44	657.44	657.44	657.44
Kennebec	438.30	438.30	438.30	550.61	625.12	657.44	657.44	657.44
Knox	438.30	438.30	445.97	565.40	642.10	657.44	657.44	657.44
Lincoln	438.30	438.30	458.02	580.19	657.44	657.44	657.44	657.44
Oxford	438.30	438.30	458.02	580.19	657.44	657.44	657.44	657.44
Penobscot	438.30	448.71	540.20	657.44	657.44	657.44	657.44	657.44
Piscataquis	438.30	448.71	540.20	657.44	657.44	657.44	657.44	657.44
Sagadahoc	438.30	438.30	445.97	565.40	642.10	657.44	657.44	657.44
Somerset	438.30	448.71	540.20	657.44	657.44	657.44	657.44	657.44
Waldo	438.30	438.30	493.08	624.57	657.44	657.44	657.44	657.44
Washington	438.30	448.71	540.20	657.44	657.44	657.44	657.44	657.44
York	438.30	438.30	438.30	535.27	608.68	657.44	657.44	657.44

Plan 3F

	Age							
County	**<30**	**30 - 39**	**40 - 44**	**45 - 49**	**50 - 54**	**55 - 59**	**60 - 64**	**65+**
Androscoggin	438.54	438.54	453.34	574.49	652.88	657.82	657.82	657.82
Aroostook	438.54	448.96	540.51	657.82	657.82	657.82	657.82	657.82
Cumberland	438.54	438.54	438.54	535.57	609.03	657.82	657.82	657.82
Franklin	438.54	438.54	481.30	610.12	657.82	657.82	657.82	657.82
Hancock	438.54	448.96	540.51	657.82	657.82	657.82	657.82	657.82
Kennebec	438.54	438.54	438.54	550.92	625.47	657.82	657.82	657.82
Knox	438.54	438.54	446.22	565.72	642.47	657.82	657.82	657.82
Lincoln	438.54	438.54	458.28	580.52	657.82	657.82	657.82	657.82
Oxford	438.54	438.54	458.28	580.52	657.82	657.82	657.82	657.82
Penobscot	438.54	448.96	540.51	657.82	657.82	657.82	657.82	657.82
Piscataquis	438.54	448.96	540.51	657.82	657.82	657.82	657.82	657.82
Sagadahoc	438.54	438.54	446.22	565.72	642.47	657.82	657.82	657.82
Somerset	438.54	448.96	540.51	657.82	657.82	657.82	657.82	657.82
Waldo	438.54	438.54	493.36	624.93	657.82	657.82	657.82	657.82
Washington	438.54	448.96	540.51	657.82	657.82	657.82	657.82	657.82
York	438.54	438.54	438.54	535.57	609.03	657.82	657.82	657.82