MAINE GUARANTEED ACCESS REINSURANCE ASSOCIATION

Merrill's Wharf
254 Commercial Street
Portland, ME

ANNUAL REPORT TO JOINT STANDING COMMITTEE ON INSURANCE AND FINANCIAL SERVICES

March 15, 2012

I. INTRODUCTION

This report is submitted pursuant to 24-A MRS § 3955(5). Pursuant to that statute, the Maine Guaranteed Reinsurance Association is required to make an annual report to the Joint Standing committee on Insurance and Financial Services by March 15 of each year. The report must include information on the financial solvency of the Association and the administrative expenses of the Association.

The Association is still in its formative stage and has not yet initiated operations. Accordingly, the annual report described in 24-A MRS § 3955(5) has limited applicability to the current status of the Association; however, the Association is taking this opportunity to submit its initial annual report as an update on the status of the formation of the Association and the organizational effort behind the operational launch of the Association on July 1, 2012.

II. BACKGROUND INFORMATION

In May 2011, the Maine State Legislature passed Public Law Chapter 90 "An Act to Modify Rating Practices for Individual and Small Group Health Plans and to Encourage Value-based Purchasing of Health Care Services" (PL90). Included in the many components of PL90 was the establishment of MGARA as a reinsurance program for the higher risk segment of Maine's individual health insurance market. The portion of PL90 establishing Association was codified at 24-A MRS c. 54-A and is referred to herein as the "Enabling Act."

The Board of Directors of the Association ("Board") was appointed by the Superintendent of Insurance effective December 1, 2011. The Board consists of 11 members, with 6 members appointed by the Maine Superintendent of Insurance and 5 members appointed by the member insurers. During its start-up phase, the business of the Association is being conducted through its Board.

The Association was formally organized as a Maine non-profit corporation on January 23, 2012 and has been conducting weekly working sessions and Board meetings since that time in an effort to accelerate the organization and launch of the Association's reinsurance program ahead of its statutorily mandated operational deadline of July 1, 2012.

The Board has developed a Plan of Operation, which was submitted to the Superintendent of Insurance on February 29, 2012, in accordance with the requirements of the Enabling Act. A copy of the initial Plan of Operation is attached hereto as Appendix A and incorporated herein by reference. The Plan of Operation is currently undergoing review by the Superintendent of Insurance pursuant to Section 3953(3) of the Enabling Act. The Association expects to receive comments to its initial submission and develop appropriate revisions in response to the Superintendent's comments.

III. SUMMARY OF KEY DEVELOPMENT ACTIVITIES

The Board is actively engaged in the development of all aspects of the Association's operation. Set forth below in summary format is an overview of each of the key elements of this

effort. Taken together, these summaries present an up-to-date picture of the Association's progress to date and anticipated path toward operation by July 1, 2012.

Mission	As a foundational matter, the Board developed a basic mission statement for the Association to be used as a guide and filter for all major decisions to be made in implementing the reinsurance program required under the Enabling Act. The mission statement has two parts: ➢ To operate the reinsurance program described in the Enabling Act in such manner as to maximize the impact of the Association in lowering the cost of health insurance in Maine's individual market; and ➢ To do so without jeopardizing the solvency of the Association.
Initial Organization	Prior to its formal organization, the Board held several work sessions addressing critical path organizational issues. The Board has been meeting on a regular weekly schedule throughout the months of January, February and March, to date, addressing each of the critical path issues described in this summary. Included in the Board's early decision making was retention of Pierce Atwood LLP as its counsel for organizational purposes. This selection was made on the basis of a Request for Proposals circulated to a number of law firms. Pierce Atwood was selected due to their experience in this area, and in particular, due to the experience of Chris Howard, the partner in charge of the account, whose resume included serving in a legal/executive capacity in connection with the organization and initial operations of MEMIC. Mr. Howard was retained to provide both legal and executive support in connection with the development of the Association's Plan of Operation and start-up of initial operations.
Organizational Assessment	The Association has initiated the process of collecting its initial organizational assessment pursuant to Section 3957(4). The Association initiated this process with the circulation of an introductory letter explaining the Association's organization, mission and the need for the assessment, a copy of which is attached hereto as Appendix B. This letter was followed by the delivery of actual invoices for the assessment. The organizational assessment is due April 30, 2012. The Association is in the process of establishing a line of credit in advance of collecting its organizational assessment in order to fund any current cash flow requirements.

Administrator Selection	The Board selected AmeriBen/IEC Group as its administrator pursuant to Section 3956 of the Enabling Act. This selection was made on the basis of a national search for the best qualified administrator at the lowest possible cost. The Board circulated a Request for Proposals to a number of qualified administrative services providers and selected two highly qualified, price-competitive firms for personal interviews and systems demonstrations. Following those interviews and systems demos, and an extensive reference checking process, AmeriBen was selected due to their experience in this area, their systems capabilities and their pricing. AmeriBen is a nationally recognized TPA and has been the administrator for the Idaho high risk reinsurance pool since its inception. The Idaho pool served as one of the key models for the Association's Enabling Act and AmeriBen's familiarity with that model, and their experience with the launch and operation of the Idaho high risk reinsurance pool, was viewed as highly advantageous. AmeriBen also acts as administrator for the Nebraska Small Employer Health Reinsurance Program. AmeriBen is currently working toward implementation of the reinsurance program set out in the initial draft of the Plan of Operation. Once the uncertainty surrounding LD 1702 and the Plan are finalized, AmeriBen will have a stable platform for implementation of the systems and protocols required to effectively operate the Association's reinsurance program. AmeriBen expects to have its systems fully operational a full 30 days prior to the July 1, 2012 start date specified in the Enabling Act.
Actuarial Services Provider	The Board selected Milliman, Inc. as its actuarial services provider. This selection was made on the basis of a national search for the best qualified actuarial firm at the lowest possible cost. The Board circulated a Request for Proposals to a number of qualified actuarial firms, including local, regional and national/international firms. Milliman is one of the world's leading actuarial firms with offices throughout the globe. They have extensive experience in advising high risk reinsurance pools. The Board believed it was important for the Association to get its own independent actuarial advice, separate and apart from the firm advising the Bureau of Insurance on PL 90 issues, in order to gain a different, independent review of the data, and have a contrasting perspective informing the Board's decision-making. Milliman is working on the following tasks: ➢ Development of the specified conditions list required for mandatory ceding to the reinsurance program. ➢ The health assessment form for the Association.

	➢ Reinsurance rate development ➢ Effect of Association on the Individual Market in Maine ➢ Financial projections for the Association and development of a dynamic model that will reflect results across multiple scenarios
Banking Relationship	The Association has received a commitment for a $300,000 line of credit as assurance against any delays in collection of its initial organizational assessments.
Plan of Operation	The Board has dedicated a significant level of time, energy and resources assembling its Plan of Operation in time for filing with the Superintendent of Insurance by February 29, 2012, which was the statutory deadline for filing. A copy of the Plan of Operation is attached as Appendix A. This Plan is under review by the Superintendent and the Board is expecting to receive comments on the Plan and make revisions on a "rolling" basis as comments are received over the next several weeks, culminating in a final Plan by mid-to-late April.
Funding Model	Milliman is currently developing a funding model for the Association and a preliminary version of the model is expected on or about April 1, 2012. The finalization of the model is expected mid-to-late April.
Assessment	The Board has made a preliminary determination that the initial regular assessment for 2012 should be $4 per member per month. Following consultation with Milliman and AmeriBen, and extensive deliberation, it was clear that at least the initial assessment should be set at the maximum level allowed under the Enabling Act. This level of assessment is consistent with the Association's mission in that it both maximizes the subsidy provided to the individual health market and aids in assuring the Association's solvency. Until finalization of the Association's funding model, the Board is reserving the prerogative to adjust the initial regular assessment; however, the Board expects its initial decisions will hold, unless new information is forthcoming.
Premium Rate Methodology	The Board has not yet finalized the methodology for establishing premium rates. The Board, together with Milliman and AmeriBen, is currently dedicating substantial resources to this task. Upon completion, the rate methodology will be submitted to the Superintendent pursuant to Section 3958(2) of the Enabling Act.
Health Statement	The Board has created a first draft of its health assessment form, which has not yet been finalized for public distribution. The basic strategy

	behind the form is to achieve at least four objectives: 1. It must be written in a way that applicants will understand the questions so they can answer them accurately and completely. 2. It must be clear to the applicant that the information provided will not affect the applicant's eligibility for coverage or the price they will pay for that coverage. 3. It must enable the carriers to identify applicants who have any of the automatic reinsurance conditions (which have not yet been determined). 4. It must provide sufficient information for carriers to make facultative reinsurance underwriting decisions about other lives to cede to the pool. The Board is in the process of refining the draft health statement, including input from the carriers to evaluate whether the form meets their needs.
Specified Conditions	The Board is in the preliminary stages of developing the list of specified conditions required for automatic ceding to the Association. Because the carriers will have historical experience with their in force block of business, they will be able to make efficient underwriting decisions about which lives to cede to the pool on a discretionary basis. Therefore, a key element in managing the pool in its early years is establishing automatic reinsurance conditions that will assure a sufficiently diverse population of lives will be ceded to the Association's reinsurance program to assure that the program reinsures a sufficient number of relatively healthy lives to mitigate the adverse selection of lives reinsured with the Association through discretionary ceding. The success of the Association's reinsurance program will be dependent in major part upon generating sufficient population within the program to capture this required diversity within its reinsurance base.
Systems	AmeriBen will commence working on systems implementation as soon as the Plan of Operation and LD 1702 are finalized. It is critical that this occur as rapidly as possible in order to provide ample time to set up the necessary systems to operate the reinsurance program.
Organizational Timeline	On a forward looking basis, the Board has established an Organizational Timeline that it reviews and updates on a weekly basis. Attached as Appendix C is the current draft of the Organizational Timeline, which contains some of the more critical dates with respect to the

	implementation timeline for the Association's reinsurance program.

IV. CONCLUSION

Although much work remains to be done, at this point in time, the Board is comfortable that it will be able to implement the program on a timely basis. The Board believes the combination of funding mechanisms provided under the Enabling Act, together with the flexibility to adjust certain critical aspects of the reinsurance program, such as its attachment points, provide the necessary tools to successfully implement the required reinsurance program.

APPENDIX A

MAINE GUARANTEED ACCESS REINSURANCE ASSOCIATION

PLAN OF OPERATION

Effective _____, 2012

Table of Contents

ARTICLE I NAME

1. 1 The Maine Guaranteed Access Reinsurance Association, hereinafter referred to as the "Association," is a Maine mutual benefit nonprofit corporation created pursuant to Title 13-B and Title 24-A, Chapter 54-A of the Maine Revised Statutes.

ARTICLE II ASSOCIATION MEMBERS

2.1 The members of the Association are Insurers (as defined herein) that offer individual health plans and are actively marketing individual health plans in the State of Maine.

ARTICLE III PURPOSE

3. 1 The Association was established pursuant to Maine Public Law Chapter 90, "An Act to Modify Rating Practices for Individual and Small Group Health Plans and to Encourage Value-based Purchasing of Health Care Services" ("PL 90"), exclusively for the purpose of providing a reinsurance program for the higher risk segment of Maine's individual health insurance market in order to reduce insurance costs in that market and assure availability of affordable health insurance to residents of the State of Maine by providing reinsurance of a significant portion of the coverage provided through individual health insurance policies offered by its Member Insurers.

ARTICLE IV DEFINITIONS

4. 1 For purposes of this Plan, the following terms shall have the definition hereinafter set forth:

"Administrator" means the organization selected by the Board for the fair, equitable and reasonable administration of the Board pursuant to the applicable provisions of the Enabling Act.

"Association" is defined in Section 1.1.

"Automatic Ceding" and "Automatic Cede" is defined in Section 10.2.

"Board" is defined in Section 7.2.

"Bureau" means the Maine Department of Professional and Financial Regulation, Bureau of Insurance.

"Ceding Notice" is defined in Sections 9.4(a)(i) and (ii).

"Ceding Term" is defined in Section 9.4(e)(i).

"Closed Block" means a block of business that the Member Insurer closes as of July 1, 2012 pursuant to the provisions of PL 90 and that is eligible for reinsurance through the Association's Reinsurance Program pursuant to 24-A M.R.S. §§ 3961.

"Covered Person" means an individual covered as a policyholder, participant or Dependent under a plan, policy or contract of medical insurance.

"Deficit Assessment" is defined in Section 11.3.

"Dependent" means a spouse, a domestic partner as defined in 24-A M.R.S. § 2832-A(1) or a child under 26 years of age.

"Discretionary Cede" or "Discretionary Ceding" is defined in Section 10.1.

"Eligible Health Plan" is defined in Section 9.2.

"Enabling Act" means the Maine Guaranteed Access Reinsurance Association Act, 24-A M.R.S. §§ 3951 et seq.

"Enrollment Report" is defined in Section 9.5(d)(ii).

"Health maintenance organization" means an organization authorized under 24-A M.R.S. Chapter 56 to operate a health maintenance organization in this State.

"Health Statement" is defined in Section 10.1.

"IBNR" means losses that have been incurred but not paid.

"Initial Designation" refers to the initial designation process described in Section 9.4(a).

"Insurer" means an entity that is authorized to write medical insurance or that provides medical insurance in the State of Maine, including an insurance company, a nonprofit hospital and medical service organization, a fraternal benefit society, a health maintenance organization, a self-insured employer subject to state regulation as described in 24-A M.R.S. §2848-A, a Third-Party Administrator, a multiple-employer welfare arrangement, a reinsurer that reinsures health insurance in the State of Maine, a captive insurance company established pursuant to M.R.S. Chapter 83 that insures the health coverage risks of its members, the

Dirigo Health Program established in M.R.S. Chapter 87, or any other state-sponsored health benefit program whether fully insured or self-funded.

"Investment Policy" is defined in Section 12.5.

"Joint Standing Committee" means the joint standing committee of the Maine State Legislature having jurisdiction over health insurance matters.

"Medical Insurance" means a hospital and medical expense-incurred policy, nonprofit hospital and medical service plan, health maintenance organization subscriber contract or other health care plan or arrangement that pays for or furnishes medical or health care services whether by insurance or otherwise, whether sold as an individual or group policy. "Medical insurance" does not include accidental injury, specified disease, hospital indemnity, dental, vision, disability income, Medicare supplement, long-term care or other limited benefit health insurance or credit insurance; coverage issued as a supplement to liability insurance; insurance arising out of workers' compensation or similar law; automobile medical payment insurance; or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

"Medicare" means coverage under both Parts A and B of Title XVIII of the federal Social Security Act, 42 United States Code, Section 1395 et seq., as amended.

"Member Insurer" is defined in Section 2.1.

"Nonprofit Act" means 13-B M.R.S. §§101 et seq.

"Open Block" means a block of business that the Member Insurer is actively offering and is eligible for reinsurance through the Association's Reinsurance Program pursuant to 24-A M.R.S. §§ 3959.

"Organizational Assessment" is defined in Section 11.1.

"PL 90" means Maine Public Law Chapter 90, "An Act to Modify Rating Practices for Individual and Small Group Health Plans and to Encourage Value-based Purchasing of Health Care Services."

"Quarterly Assessment Report" is defined in Section 11.5(a).

"Regular Assessment" is defined in Section 11.2.

"Reinsurance Program" is defined in Section 9.1.

"Reinsurance Reimbursement" is defined in Section 9.6 and refers to the reinsurance proceeds the Member Insurers are entitled to under the Enabling Act upon compliance with the terms and conditions thereof and the terms and conditions of this Plan.

"Reinsurer" means an insurer from whom a person providing health insurance for a resident procures insurance for itself with the insurer with respect to all or part of the medical insurance risk of the person. "Reinsurer" includes an insurer that provides employee benefits excess insurance.

"Renewal/Cancellation Notice" is defined in Section 9.4(e)(ii).

"Resident" has the same meaning as in 24-A M.R.S § 2736-C(1)(C-2).

"Specified Condition" is defined in Section 10.2.

"Superintendent" means the Superintendent of Insurance of the State of Maine.

"Third-Party Administrator" means an entity that is paying or processing medical insurance claims for a resident.

"Transition Period" means the period beginning July 1, 2012 and ending December 31, 2012.

4. 2 Construction.

(a) Headings and the rendering of text in bold and/or italics are for convenience and reference purposes only and do not affect the meaning or interpretation of this Plan.

(b) A reference to an Exhibit, Schedule, Article, Section or other provision shall be, unless otherwise specified, to exhibits, schedules, articles, sections or other provisions of this Plan, which exhibits and schedules are incorporated herein by reference.

(c) Any reference in this Plan to another document shall be construed as a reference to that other document as the same may have been, or may from time to time be, varied, amended, supplemented, substituted, novated, assigned or otherwise revised.

(d) Any reference in this Agreement to "this Plan," "herein," "hereof" or "hereunder" shall be deemed to be a reference to this Plan as a whole and not limited to the particular Article, Section, Exhibit, Schedule or provision in which the relevant reference appears and

to this Plan as varied, amended, supplemented, substituted, novated, assigned or otherwise transferred from time to time.

(e) References to the term "includes" or "including" shall mean "includes, without limitation" or "including, without limitation."

(f) Words importing the singular include the plural and vice versa and the masculine, feminine and neuter genders include all genders.

(g) If the time for performing an obligation under this Plan occurs or expires on a day that is not a Business Day, the time for performance of such obligation shall be extended until the next succeeding Business Day.

(h) References to any statute, code or statutory provision are to be construed as a reference to the same as it may have been, or may from time to time be, amended, modified or reenacted, and include references to all bylaws, instruments, orders and regulations for the time being made thereunder or deriving validity therefrom unless the context otherwise requires.

(i) The designation of Covered Persons to the Association's Reinsurance Program is referred to herein alternatively using the statutory term "designation," "designating" or "designated," as applicable, or using the more commonly used insurance industry term "cede," "ceding" or "ceded," as applicable. All such references have the same meaning and there is no difference or distinction intended as a result of the use of such alternative references.

(j) References to "year" or "years" shall mean calendar years except to the extent otherwise specifically noted.

(k) References to "assessment" shall refer to Organizational Assessments, Regular Assessments and Deficit Assessments, as the context requires.

(l) References to "primary coverage" shall mean the coverage provided by Member Insurer to a Covered Person under an Eligible Health Plan.

ARTICLE V POWERS OF THE ASSOCIATION

5. 1 The Association shall have the powers and authority granted by the Nonprofit Act and the Enabling Act.

ARTICLE VI PLAN OF OPERATION

6. 1 The Association shall perform its functions pursuant to and in accordance with this Plan of Operation and the Enabling Act. This Plan is intended to assure the fair, reasonable and equitable administration of the

Association's Reinsurance Program. This Plan shall be effective upon the adoption by the Board and approval of the Superintendent.

ARTICLE VII GOVERNANCE

7.1 Governing Documents. The activities of the Association shall be governed pursuant to and in accordance with the Nonprofit Act and the Enabling Act, the Articles of Incorporation and Bylaws of the Association, and this Plan. In the event of a conflict between this Plan and any of the Enabling Act, the Nonprofit Act, the Bylaws, or the Articles, then the Enabling Act, the Nonprofit Act, the Articles, or the Bylaws, as applicable, shall control. The Association's Articles of Incorporation are attached hereto as Exhibit A, and its Bylaws are attached hereto as Exhibit B.

7.2 Board of Directors. The Association is governed by a Board of Directors (the "Board") appointed by the Superintendent and Member Insurers as provided in the Association's Articles of Incorporation and Section 3953(2) of the Enabling Act.

7.3 Committees. The Board of Directors may establish and appoint its members (or other persons) to any of the committees described in Article IV, Section 2 of the Association's Bylaws, or otherwise established by the Board. A written record of the proceedings of each committee shall be maintained by a secretary appointed from the membership of the committee. The Board shall, at a minimum, establish the following Committees, which shall have the responsibilities and scope of authority and operation set forth opposite its name below.

(a) Actuarial Committee – The duties of the Actuarial Committee are to:

i. Recommend to the Board appropriate Rating Methodology and reinsurance premium rates;

ii. Review the Reinsurance Reimbursement, reimbursement rates, retention levels and attachment points for the Reinsurance Program and make appropriate recommendations to the Board; and

iii. Review, determine and report to the Board the incurred claim losses of the Association, including amounts for IBNR.

(b) Operations Committee – The duties of the Operations Committee are to:

i. Provide oversight of the Administrator's performance of its functions and responsibilities;

ii. Periodically review this Plan and the operation and implementation of the Association's Reinsurance Program and make recommendations to the Board regarding amendments or changes to this Plan and/or the Reinsurance Program;

iii. Provide administrative interpretation as to the intent of the Plan and provide administrative direction of issues referred to the Board by the Administrator or the Member Insurers; and

iv. Identify items for which operating rules are needed and propose such rules for adoption by the Board.

(c) Audit Committee – The duties of the Audit Committee are to:

i. Develop a uniform audit program to be utilized to conduct a review of agreed upon procedures between the Member Insurers and the Association that assure compliance with the provisions of this Plan;

ii. Establish standards of acceptability for the selection of independent auditors or consultants;

iii. Assist the Board in the selection of an independent auditor for the annual audit of the Association's financial statements; and

iv. Assist the Board in the review of the reports prepared by the independent auditors in conjunction subsections (i) and (iii) above, and any other audit-related matters the Board deems necessary.

7.4 Policies. The Board of Directors shall adopt and implement policies governing the conduct of members of the Board. These shall include the following policies, in addition to any others that may be adopted from time to time at the Board's discretion.

(a) Conflict of Interest Policy. The Conflict of Interest Policy shall be designed to avoid improper conflicts of interest in the actions of and decisions by directors, officers and employees of the Association.

(b) Confidentiality Policy. The Confidentiality Policy shall be designed to protect the Association's confidential information from improper disclosure.

(c) Whistleblower Policy. The Whistleblower Policy shall be designed to protect directors, officers, and employees of the Association from retaliation or victimization for raising, in good faith, concerns or complaints that activities of the Association, or the action or inaction of its directors, officers, employees or contracted agents, are improper or unlawful.

(d) Reimbursement Policy. The Reimbursement Policy shall be designed to reimburse members of the Board for expenses they incur while fulfilling their duties as directors of the Association while limiting costs to the Association and its Members.

7.5 Annual Meeting. An annual meeting of the Board shall be held on the second Tuesday in April of each year unless the Board designates some other date and time. At the annual meeting, the Board shall:

(a) Review this Plan of Operation and submit proposed amendments, if any, to the Superintendent for approval.

(b) Review the annual audited financial statements for the Association and such other annual reports as the Board may require from the Administrator regarding the financial position of the Association, the operation of the Reinsurance Program and all other material matters, as determined by the Board.

(c) Review reports of the committees established by the Board.

(d) Determine whether any technical corrections and amendments to the Enabling Act should be proposed by Association.

(e) Review and due consideration of the performance of the Association in support of its purpose.

(f) Review the rates for the Association's Reinsurance Program.

(g) Review the Association's administration expenses, incurred losses and IBNR and related reserves.

(h) Determine if any Regular Assessment or Deficit Assessment is necessary and establish the rate for such assessments.

(i) Review, consider and act on any matters deemed by the Board to be necessary and proper for the administration of the Association.

ARTICLE VIII ADMINISTRATOR

8. 1 Role. The Administrator performs administrative functions associated with the operations of the Association as delegated by the Board of Directors to the Administrator. The Administrator is responsible, together with the Board of Directors, for the fair, equitable and reasonable administration of the Reinsurance Program.

8.2 Selection. The Administrator shall be selected by the Board through a competitive bidding process and will serve pursuant to the terms of a contract with the Association that complies with the requirements of §3956(2) of the Enabling Act and Section 8.5 hereof.

8.3 Statutory Duties. The Administrator shall perform the following functions under the supervision of, and as directed by, the Board.

(a) Perform all administrative functions relating to the Association, as required or directed by the Board, including the functions more particularly described in Section 8.4 below;

(b) Submit regular reports to the Board regarding the operation of the Association, with the frequency, content and form of such reports to be as determined by the Board;

(c) Following the close of each calendar year, determine reinsurance premiums less any administrative expense allowance, the expense of administration pertaining to the reinsurance operations of the Association and the incurred losses of the year, and report this information to the Superintendent; and

(d) Pay reinsurance amounts as provided for in this Plan.

8.4 Board-Determined Functions. The Board shall, from time to time, in its discretion, assign to the Administrator such functions as the Board determines necessary or appropriate in connection with the proper administration of the business of the Association which may include, but shall not be limited to, the following:

(a) Organizational Assistance. The Administrator will assist the Board and its professional service providers in organizing and establishing the initial operations of the Association in order to achieve full operational capacity on or before July 1, 2012. The Administrator will be charged with working with the Board and other professional service providers to expedite the process of establishing the Association and the Reinsurance Program, including assistance with:

(i) Assist the Board in developing financial modeling and determination of appropriate levels of assessments and premiums;

(ii) Assist the Board in developing appropriate categories of Specified Conditions and development of the Health Statement;

(iii) Assist the Board in selection and development of a work plan for actuarial support;

(iv) Assist the Board in developing rules, protocols and other requirements associated with ceding of Covered Persons to the reinsurance program and payment of claims; and

(v) Analysis of potential reinsurance of the Association's claims exposure and assisting the Board with the structuring of any reinsurance.

(b) Management Services. The Administrator will be responsible for managing all aspects of the Association's Reinsurance Program, under the direction of the Board, and working in conjunction with the other professional service providers retained by the Association, and shall ensure the efficient and effective operation of the Association, respond to the needs of Member Insurers, coordinate service providers and assure compliance with all applicable laws, rules and regulations. The scope of management services shall be determined by the Board from time to time in its discretion, and may include, but shall not be limited to, the following:

(i) Administration of the day-to-day operations of the Association;

(ii) Implementation and oversight of the Reinsurance Program;

(iii) Implementation and oversight of the assessment process, including assessment calculation, billing, processing and collection;

(iv) Work with Member Insurers in the implementation and administration of the Reinsurance Program, including ceding risks and managing the enrollment process, collection of premium, and submission and processing of claims for reimbursement, as more specifically described below;

(v) Assisting the Board and the Association's actuarial consultants in the determination of assessment levels, premiums and all financial modeling associated therewith,

including the provision of all data necessary for actuarial analysis of the Reinsurance Program and determination of appropriate assessments and premiums;

(vi) Establish procedures and install and maintain the systems needed to properly administer the operations of the Association in accordance with the Enabling Act, any rules or regulations issued by the Bureau, this Plan and the directives of the Board;

(vii) Assemble and file all reports required under applicable laws, rules and regulations, together with any other required filings and reports which are not within the expertise or contracted services of any service provider (e.g. any rate and policy form filings with the Bureau);

(viii) Prepare and file for approval all insurance policy forms and endorsements needed from time to time for the operation of the Reinsurance Program, if any (reviewed annually for necessary modifications based on experience, change in operations or change in laws and regulations);

(ix) Monitor and propose to the Board, for its consideration, any needed revisions to this Plan;

(x) Act as a communications resource for Member Insurers regarding the Reinsurance Program; and

(xi) Maintain all records pertaining to the Association and the operation of its business in accordance with record retention policies adopted by the Board.

(c) Financial Services. The Administrator will be responsible for managing the financial affairs of the Association. The scope of financial services shall be determined by the Board, from time to time, in its discretion, and may include, but shall not be limited to, the following:

(i) Provision of all finance and accounting services necessary for the operation of the Reinsurance Program, as described herein;

(ii) Preparation and maintenance of all financial information and reports of the Association, including timely preparation and presentation to the Board of accurate, easy-to-

understand monthly financial reports, and such interim reporting as the Board may direct;

(iii) Maintain general ledger systems and administer all accounts payable and accounts receivable;

(iv) Budget preparation, implementation and monitoring;

(v) Maintenance of and accounting for Association funds;

(vi) Management of billing, payment, collection process for assessments and premiums;

(vii) Working with the Association's independent accountants in the preparation of its annual audited financial statements, and managing the certification and filing with any necessary state and federal authorities;

(viii) Establish on behalf of the Association one or more bank accounts for the transaction of Association business, as approved by the Board. Recommend to the Board and implement, from time to time, appropriate procedures for cash management and short-term investment with the financial institutions(s) designated by the Board. Deposit all cash collected on behalf of the Association in the established bank account(s) on a timely basis;

(ix) Recommend to the Board and apply for, from time to time, appropriate grants or other sources of funding or credits;

(x) Perform Reinsurance Reimbursement for claims paid on Covered Persons ceded to the Reinsurance Program consistent with the timelines established by the Board;

(xi) Issue checks or drafts on and/or approve charges against bank accounts of the Association;

(xii) Collect and provide all information required in order to calculate assessments in accordance with this Plan;

(xiii) Invest available cash in accordance with investment guidelines approved by the Board and report to the Board all cash management and investment activities results;

(xiv) Assist the Association in establishing and maintaining any necessary lines of credit or other credit facilities necessary

for the operation of the Association's business, as determined by the Board; and

(xv) Perform other necessary functions as directed by the Board.

(d) Technology and Systems. The Administrator will be responsible for installing, managing and operating all information technology and related systems necessary for the effective and efficient operation of the Association's Reinsurance Program. The scope of technology and systems services shall be determined by the Board, from time to time, in its discretion, and may include, but shall not be limited to, the following:

(i) Provide all necessary technology, systems, software and related support required in connection with the Association's operations;

(ii) Create, host, maintain and update the Association's website, with basic public information and public relations data on the Association; and

(iii) Maintain a complete database of all information related to the business of the Association and the Reinsurance Program, including Insureds, Member Insureds, assessments, ceded lives, premium calculation, billing and collection and such other information as is relevant to the Association's operations.

(e) Planning and Compliance. The Administrator will be responsible for assisting the Board with planning and working with the Board and its professional service providers regarding compliance with all applicable laws, rules and regulations, as well as the requirements of this Plan. The scope of planning and compliance services shall be determined by the Board, from time to time, in its discretion, and may include, but shall not be limited to, the following:

(i) Serve the Board in an advisory capacity, developing recommendations and submitting reports as needed or requested.

(ii) Work with the Association's legal counsel to maintain compliance by the Association with all laws and regulations applicable to the Association and the operation of the Reinsurance Program, including without limitation

all filing and reporting requirements, and with the provisions of the Enabling Act, its Bylaws and this Plan.

(f) Government and Public Relations. The Administrator will be responsible for assisting the Board with government and publications. The scope of government and public relations services shall be determined by the Board, from time to time, in its discretion, and may include, but shall not be limited to, assisting the Board with regulatory, governmental and public relations matters, as directed by the Board.

8.5 Administrator Contract. Subject to the provisions of the Enabling Act, the Board shall have responsibility for determining the terms and conditions of the contract with the Administrator, including without limitation the compensation paid to the Administrator for its services. The contract shall provide, at a minimum, for reimbursement to the Administrator for its direct and indirect expenses incurred in the performance of its services, as provided in §3956(4) of the Enabling Act.

8.6 Subcontracted Services. The Administrator shall not subcontract for any services except to the extent expressly permitted pursuant to the terms of its contract with the Association.

8.7 Confidentiality. The Administrator shall retain the confidentiality of all information pertaining to Insurers and/or Covered Persons in accordance with all applicable federal and state statutes, regulations and principles of common law pertaining to confidentiality and trade secrets. Such information shall be used only for the purposes necessary for the operation of the Association and shall be strictly segregated from other records, data or operations of the Administrator. Unless specifically required by this Plan or by the Act, no information shall be retained or used by the Administrator or disclosed to any third party which information identifies a specific Covered Person.

ARTICLE IX REINSURANCE PROGRAM

9.1 Reinsurance Program. The Association shall provide reinsurance in accordance with the requirements of the Enabling Act. Member Insurers shall designate Covered Persons for reinsurance and pay premiums for reinsurance of designated Covered Persons, and the Association shall provide reinsurance coverage to Member Insurers for such persons, in accordance with the provisions set forth herein ("Reinsurance Program"). The Reinsurance Program will commence operation as of July 1, 2012.

9.2 Member Insurer Benefit Plans. Each Member Insurer shall provide to the Association a summary of each plan of Medical Insurance offered by the

Member Insurer from which the Member Insurer desires to have the entitlement to cede Covered Persons for reinsurance by the Association ("Eligible Health Plans"). Effective for calendar year 2013, the Eligible Health Plans and all amendments, changes and revisions to such benefit plans shall be provided at least ninety (90) days prior to the implementation of such plans or amendments thereto. The Association shall not be obligated to reinsure Covered Persons ceded from health plans until the later of ninety (90) days following the identification of that health plan as an Eligible Health Plan, or the last change, amendment or revision to an Eligible Health Plan; provided however, that the Association reserves the right to accept designations for reinsurance for late filed plans, in its discretion. During the Transition Period, the Association will accept designations from all health plans operated by Member Insurers, and Member Insurers shall provide a summary of each such plan to the Association as rapidly as reasonably possible.

9.3 Basis for Ceding. Member Insurers shall cede Covered Persons to the Association on a policy basis, and not individually. This means that, in the event any person covered by an Eligible Health Plan, whether as the policyholder or a Dependent of the policyholder or other person or participant entitled to coverage under an Eligible Health Plan issued by a Member Insurer is designated for reinsurance by a Member Insurer, then all Covered Persons entitled to coverage under the Eligible Health Plan are automatically, and without further action on the part of the Member Insurer, ceded to the Association for reinsurance.

9.4 Designation of Ceded Lives.

(a) Initial Designation.

(i) *Open Block.* For each Covered Person insured through an Open Block initially designated for reinsurance by a Member Insurer (whether an Automatic Cede or a Discretionary Cede), the Member Insurer shall give notice to the Administrator of such designation within sixty (60) days from the date primary coverage for such Covered Person becomes effective ("Ceding Notice"). Such notice shall be in the form required by the Association, containing such information as the Association may, from time to time, specify, and shall be accompanied by either (i) a completed Health Statement for Discretionary Ceding or (ii) for Automatic Ceding, a certification by the Member Insurer that such Covered Person demonstrates the existence or history of a Specified Condition together with identification of the Specified Condition and the basis for such determination.

(ii) *Closed Block.* For each Covered Person insured through the Closed Block initially designated for reinsurance by a Member Insurer, the Member Insurer shall give notice to the Administrator of such designation by October 1, 2012 (also a "Ceding Notice"). Such notice shall be in the form required by the Association, containing such information as the Association may specify from time to time. The Member Insurer may use Health Statements or other questionnaires, claims history, risk scores, or any other reasonable method to make ceding decisions. The notice shall describe in such detail as the Association may require the basis for the Member Insurer's Ceding Decision.

(iii) *Re-designation.* A Member Insurer shall not re-designate a Covered Person for reimbursement for a period of three years following the cancellation of designation of such person pursuant to Section 9.4(e)(ii).

(b) Adding a Covered Person to an Existing Policy. If a Covered Person is added to an Eligible Health Plan providing primary coverage within the Open Block or Closed Block, a Member Insurer shall have the ability to designate such Covered Person for reinsurance by giving notice to the Administrator of such designation within sixty (60) days from the date primary coverage for such Covered Person becomes effective. Such notice shall be in the form described above applicable to initial designations of Covered Persons.

(c) Transfer from Closed Block to Open Block. If a Covered Person enrolls for primary coverage in an Eligible Health Plan that results in transfer of a Covered Person from the Closed Block to the Open Block, a Member Insurer shall have the ability to designate such Covered Person for reinsurance by giving notice to the Administrator of such designation within sixty (60) days from the date primary coverage for such Covered Person becomes effective. Such notice shall be in the form described above applicable to initial designations of Covered Persons.

(d) Covered Person Information Omission or Misrepresentation. If a Covered Person fails to complete the Health Statement, omits material information from the Health Statement or materially misrepresents his or her health status on the Health Statement, a Member Insurer may designate that person for reinsurance within 60 days after the Member Insurer becomes, or reasonably should have become, aware that the person should have been designated.

(e) Automatic Cede Corrections. In the event the Association identifies Covered Persons that should have been automatically ceded pursuant to Section 10.2 hereof at any time within 24 months following the effective date of the Covered Person's primary coverage, then the Association may require that the Member Insurer designate the Covered Person and such designation shall be effective as of the effective date of the primary coverage. In such event, premium for reinsurance shall accrue as of the effective date of the designation.

(f) Designation Records. Member Insurers shall establish, and maintain for seven (7) years following designation of a Covered Person, the records governing the Covered Person's eligibility for reinsurance and the Member Insurer's decision to designate the Covered Person for reinsurance, including the Health Statements or similar questionnaires utilized by the Member Insurer, claims history, risk scores, or any other reasonable information utilized or relied upon in making its Ceding Decisions ("Ceding Records"). The Member Insurer shall provide the Association, the Administrator and its agents and employees, access to all such records upon reasonable advance notice. In addition to the foregoing, the Member Insurer shall electronically transmit to the Association, in the format required by the Association, any Ceding Record as may be requested from time to time by the Association. The Association shall not be required to request or maintain Ceding Records and may rely on each Member Insurer to maintain and provide access to the Ceding Records in connection with any audit or review of such transactions as may be conducted by the Association from time to time, in its discretion.

(g) Term of Designation; Renewal.

(i) *Term of Designation.* Each Covered Person designated for reinsurance shall be reinsured by the Association for a period consisting of (1) from the effective date of the designation (determined pursuant to Section 9.6) through the end of the calendar year in which the Covered Person is initially ceded to the Association (*i.e.*, through December 31st of the year in which such designation is made), and (2) one calendar year thereafter, unless such reinsurance is earlier terminated in accordance with Section 9.6(d) hereof ("Ceding Term").

(ii) *Renewal and Cancellation.* At the conclusion of each Ceding Term, a Member Insurer shall give notice to the

Administrator of such Member Insurer's intention to either (x) renew the designation of such Covered Person for reinsurance, or (y) cancel such designation ("Renewal/Cancellation Notice"). The Renewal/Cancellation Notice shall be provided to the Association for all Covered Persons renewed or cancelled for each year in a single consolidated notice aggregating all Covered Persons whose ceding term is expiring as of the December 31 preceding such year. The Renewal/Cancellation Notice shall be provided to the Association not later than December 31st of the preceding year. Such notice shall be in the form required by the Association, containing such information as the Association may specify from time to time. The Member Insurer's renewal of a Ceding Decision shall be binding for one calendar year (also referred to as the "Ceding Term").

(iii) *Re-designation.* A Member Insurer shall not re-designate a Covered Person for reimbursement for a period of three calendar years following the cancellation of designation of such person pursuant to subsection (ii) above ("Freeze Out Period").

(h) Each carrier reinsuring a Covered Person (including Dependents) is responsible for ascertaining and certifying to the Association that:

(i) The Covered Person is eligible for reinsurance; and

(ii) The reinsurance premium has been correctly determined.

Each carrier must also document these determinations in its Ceding Notice and subsequent Enrollment Reports.

9.5 Premium Calculation and Payment.

(a) Determination of Premium. Tables of reinsurance rates, determined by the Board pursuant to Subsection 9.5(c) below, shall be made available to the Member Insurers. Each Member Insurer shall determine the applicable reinsurance premium for each Covered Person reinsured by the Association based on the reinsurance premium rates in effect on the reinsurance effective date for each Covered Person.

(b) Rate Changes. The initial table of reinsurance rates for the Transition Period shall be provided as soon as reasonably possible

in advance of the July 1, 2012 effective date of the Association's Reinsurance Program. Thereafter, the Association shall provide at least a ninety (90) day advance notice in the event of a change in the table of rates. Unless a different effective date is established by the Association, with the approval of the Superintendent, rate changes shall become effective on the January 1st following notice of the change to Member Insurers. Any change in the reinsurance rates applicable to a Covered Person occasioned by a change in such person's status (e.g. age, geographic location or other criteria allowed under applicable law) shall take effect on the January 1st which falls on or follows the effective date of the change in status.

(c) Methodology for Determining Rates. The methodology for determining rates is a system for classification of persons eligible for coverage that reflects the types of case characteristics used by insurers for Eligible Health Plans pursuant to 24-A M.R.S. § 2736-C. The methodology must provide for the development of base reinsurance premium rates, subject to approval of the Superintendent, set at levels that reasonably approximate gross premiums charged for individual health plans and that are adjusted to reflect retention levels and Reinsurance Reimbursement required under Section 9.6 below and the risk characteristics of Covered Persons ceded for reinsurance ("Rating Methodology"). The Association shall periodically review the Rating Methodology and may make changes to the Rating Methodology as needed with the approval of the Superintendent. The Actuarial Committee shall periodically (and not less often than annually on or before August 31 of each year) make recommendation to the Board regarding the Rating Methodology. The Board shall be required to approve any changes in Rating Methodology. The Board may, from time to time, as it deems necessary or appropriate, provide for adjustments to the premium rates charged for reinsurance to reflect the use of effective cost containment and managed care arrangements by a Member Insurer. The Association's Rating Methodology will be subject to amendment as required to conform to applicable changes in state and federal rating laws, subject to approval of the Superintendent. In addition to the foregoing the Rating Methodology shall include the following:

(i) The Rating Methodology may include an adjustment to account for the varying load requirements between direct insurance and reinsurance.

(ii) The Rating Methodology may include provisions for trend which shall adjust ceding premium rates for reinsurance periods with varying effective dates.

(iii) The Rating Methodology may take into account the differences in structure and benefit levels of the primary Eligible Health Plans.

(d) Billing and Payment.

(i) Payment of Premiums. Member Insurers shall pay all reinsurance premiums due in accordance with this Section 9.5(d). All premium for reinsurance begins to accrue as of the effective date of the designation of the Covered Person for reinsurance, whether such designation is an Automatic Cede, a Discretionary Cede, or is as a result of the correction of errors or omissions pursuant to Sections 9.4(d) or (e) hereof.

(ii) Self-Billing. The payment of reinsurance premiums will be handled on a "self-billed" basis. On or before the 20th day of each month, each Member Insurer shall provide the Administrator with (1) an enrollment report listing of all the Member Insurer's Covered Persons reinsured by the Association during all or any portion of the preceding month; (2) the amount of the applicable reinsurance premium for each Covered Person, together with a certification that the reinsurance premium has been calculated in accordance with the provisions of this Plan; (3) such other information as may be required by the Association; and (4) payment of the applicable premium as provided therein ("Enrollment Reports"). Enrollment Reports and Claims Reports under Section 9.8 hereof shall be submitted together as a single consolidated report in such form as may be required by the Association. Because Member Insurers have 60 days after effective date to cede a Covered Person, there shall be an exception to the payment deadline set forth above for the initial reinsurance premium payment, which shall be considered timely if made together with the notice of the Member Insurer's ceding decision.

(iii) Premium Determination Date. Premium is due and payable on or before the 20th day of each month with respect to each Covered Person reinsured by the Association during any portion of the preceding calendar month. Reinsurance premium amounts are to be paid based on whole month increments only. (Thus, for each Covered Person with respect to whom reinsurance coverage by the Association is effective at any time between the first and the last day of a

given calendar month, premium for that entire month is earned and due in full on or before the 20th day of the following month.) Premium for the entire month is earned notwithstanding termination of coverage at any time during the month.

(iv) Late Premiums. A late charge of 5% of the amount due for each Covered Person reinsured by the Association shall be imposed for failure to pay premium by the applicable due date. In addition, premium not received by the applicable due date shall accrue interest at the rate of eighteen percent (18%) per annum.

(v) Termination for Non-Payment. The Association shall have the right in its sole discretion, but not the obligation, to terminate reinsurance of any Covered Person in the event premium is not paid on or before 30 days following the applicable due date. This right shall be in addition to, and not in limitation of, any other rights or remedies available to the Association with respect to collection of premium due from any Member Insurer.

(vi) Termination for Non-Payment and Reinstatement of Primary Coverage. Member Insurers shall follow requirements of Maine law related to termination for non-payment and reinstatement of a Covered Person. Any reinsurance premium adjustment that is necessary due to termination for non-payment or reinstatement of a Covered Person shall be reconciled at the time of the next monthly payment by the Member Insurer. Unless reinsurance is otherwise terminated, a Covered Person who was ceded for reinsurance shall be automatically ceded again without a lapse in reinsurance in the event of reinstatement. If a Covered Person terminates coverage with Member Insurer by active lapse the Member Insurer will notify the administrator within 60 days of the cancellation. For Covered Persons that do not pay premiums, the Member Insurer will notify the Administrator within 90 days of the non-payment of premium. Such notice shall be in the form required by the Association, containing such information as the Association may specify from time to time.

9.6 Reinsurance Coverage.

(a) Reinsurance Effective Date. Reinsurance for a Covered Person shall be effective on the following dates:

(i) For a Covered Person in the Open Block ceded during the Transition Period, and with a primary coverage effective date after July 1, 2012, the effective date shall be the same date as the primary coverage provided by the Member Insurer for such Covered Person.

(ii) For a Covered Person in the Open Block ceded during the Transition Period, and with primary coverage effective dates prior to July 1, 2012, the effective date shall be July 1, 2012.

(iii) For a Covered Person in the Closed Block ceded according to the Initial Designation process under Section 9.4(a)(ii), the effective date shall be July 1, 2012.

(iv) Beginning January 1, 2013 and continuing thereafter for a Covered Person in an Open Block or Closed Block ceded in the Annual Renewal and Cancellation Notice described in Section 9.4(e)(ii), the effective date shall be January 1 of each year.

(v) For a Covered Person in the Open Block with a primary coverage effective date on or after January 1, 2013, the effective date shall be the same as the primary coverage provided by the Member Insurer for such Covered Person.

(vi) For a Covered Person in the Open Block or Closed Block ceded after being added to an Eligible Health Plan providing primary coverage as described in Section 9.4(b), the effective date shall be the same date as the effective date for the Eligible Health Plan.

(vii) For a Covered Person ceded after being added to a policy, providing primary coverage that results in transfer of such Covered Person from the Closed Block to an Open Block as described in Section 9.4(c), the effective date shall be the same date as the primary coverage in the Open Block provided by the Member Insurer for such Covered Person.

(viii) For a Covered Person ceded pursuant to Sections 9.4(d) or (e), the effective date shall be the effective date that would have applied had the Covered Person been designated on a timely basis.

(b) Level of Coverage. The Association shall reimburse a Member Insurer for claims paid under an Eligible Health Plan with respect to a Covered Person designated for reinsurance by the Member Insurer after the Member Insurer has incurred claims for that Covered Person under the Eligible Health Plan during the Ceding Term in excess of $7,500, at the following rates of reimbursement:

(i) 90% of claims paid in excess of $7,500 to and including $32,500; and

(ii) 100% of claims paid in excess of $32,500.

("Reinsurance Reimbursement"). The Association may annually adjust the initial level of Reinsurance Reimbursement and the maximum limit to be retained by the Member Insurer to reflect increases in costs and utilization within the standard market for individual health plans within the State of Maine. Such annual adjustments may not be less than the annual percentage change in the Consumer Price Index for medical care services from the later of July 1, 2012 or the effective date of the last adjustment through the date of calculation, unless the Superintendent approves a lower adjustment factor as requested by the Association. Any such adjustments shall be effective as of January 1 of each year, and notice of such adjustments shall be provided to Member Insurers not less than 90 days prior to the effective date of such adjustment.

For the Transition Period, the retention levels set forth in Section 9.6(b) shall be applied only with respect to claims incurred by the Member Insurers on or after July 1, 2012.

(c) Member Insurer Payment Obligation. No Reinsurance Reimbursement shall be provided on any claim until the Member Insurer has made actual payment on each claim in an amount equal to the retention level specified in Section 9.6(b), as adjusted from time to time pursuant thereto.

(d) Termination of Reinsurance. The Association's liability for Reinsurance Reimbursement for a Covered Person ceases upon the earlier of (i) receipt by the Association of the Member Insurer's notice of non-renewal of the reinsurance for such Covered Person pursuant to Section 9.4(b); (ii) the termination of such Covered Person's primary coverage provided by the Member Insurer; and (iii) termination of reinsurance by the Association in accordance with the terms of this Plan. Termination of reinsurance does not terminate Reinsurance Reimbursement for losses incurred during the term of the reinsurance in excess of the retention levels

established pursuant to Section 9.6(b). Reimbursement is subject to the claims submission deadlines set forth in Section 9.9.

9.7 Reinsurance Reimbursement. For the purposes of this Section, "Reinsurance Reimbursement" shall include only such amounts as are actually paid by Member Insurer for benefits provided to Covered Persons reinsured by the Association. Reinsurance Reimbursement shall not include:

(a) Claim expenses or salaries paid to employees of the Member Insurer who are not providers of health care services;

(b) Court costs, attorney's fees or other legal expenses;

(c) Claim expenses incurred as a result of the investigation of any submitted claims prior to payment;

(d) Any amount paid by the Member Insurer for (i) punitive or exemplary damages; (ii) compensatory or other damages awarded to any Covered Person, arising out of the conduct of the Member Insurer in the investigation, trial, or settlement of any claim or failure to pay or delay in payment of any benefits under any policy; or (iii) the operation of any managed care, cost containment, or related programs;

(e) Any statutory penalty imposed upon a Member Insurer, whether on account of any unfair trade practice, any unfair insurance practice, or otherwise; or

(f) Non-medical benefits, such as dental, vision, disability, or other services not covered under any pre-determined base plan of benefits established by the Association.

9.8 Claims Reporting. Within thirty (30) days after the close of each month, each Member Insurer shall furnish to the Association, in a form approved by the Board, the following information with respect to reinsurance-eligible incurred claims and paid claims by such Member Insurer during such month ("Claims Reports"):

(a) the Covered Person's identification number;

(b) the Covered Person's name and, if available, social security number;

(c) the claimant's name and date of birth;

(d) the claim incurred date and paid date;

(e) any claim payment and the reinsurance claim amount;

(f) the claim coding (e.g., CPT and ICD9) as required by the Board; and

(g) such other information as may be required by the Board.

Monthly Claims Reports and Enrollment Reports required under Section 9.5(d)(ii) hereof shall be submitted together as a single consolidated report in such form as may be required by the Association.

9.9 Claim Submission Deadlines. Except as otherwise approved by the Board in writing, reinsurance will be provided only for Reinsurance Reimbursement related to claims incurred during the reinsurance period which are submitted (i) within ninety (90) days from the date the claim was paid, and (ii) no more than twelve (12) months from the date the expenses were incurred, in each case unless the Member Insurer demonstrates that the claimant was not legally capable of submitting the claims within such timeframe. In the event of prolonged subrogation proceedings or other extraordinary circumstances which make compliance with the 12-month deadline infeasible, Member Insurers shall have the right to apply to the Association for an extension of the 12-month deadline, and the Association shall have the right, but not the obligation, to extend such deadline for such period and under such terms and conditions as the Association may deem appropriate under the circumstances. The claims payment submission deadline will be extended to accommodate claims reporting with respect to designation of Covered Persons from the closed block ceded according to the Initial Designation process under Section 9.4(a)(ii).

9.10 Conduct of Member Insurers.

(a) Member Insurers shall promptly investigate, settle, defend and take other appropriate action on all claims arising under the risks reinsured in a manner consistent with the Member Insurer's non-reinsured business. Upon the request of the Association, Member Insurers shall promptly forward to the Association copies of such reports of investigation.

(b) Member Insurers shall adjudicate all claims on reinsured risks in a manner consistent with the Member Insurer's non-reinsured business.

(c) Each Member Insurer shall use its cost containment programs to control costs on reinsured business to the same extent it would use such programs on its non-reinsured business, including but not limited to utilization review, individual case management, preferred provider arrangements, claims processing and other methods of operation on the same basis as the Member Insurer's non-reinsured business, without regard to whether claims are reinsured with the Association.

(d) Failure to satisfy the requirements of Sections 9.10(a), (b) and (c) may result in the denial or reduction of reinsurance claim payments, as determined by the Administrator. Disagreements regarding denial of claims for Reinsurance Reimbursement may be appealed to the Board for a final and binding determination pursuant to the provisions of Section 14.7 hereof.

(e) The Association shall have the right, at its own expense, to participate jointly with a Member Insurer in the investigation, adjustment or defense of any claim. Notwithstanding any such participation, investigation, adjustment and defense of claims shall remain the responsibility of the Member Insurer, and any such participation shall in no way prejudice the Association's rights to deny or reduce claims payments pursuant to Section 9.10(d) above.

(f) The Association shall have the right to inspect the records of the Member Insurer in connection with the risks reinsured by the Association. Member Insurers shall submit to the Association any additional information within their possession or control that the Association may request in connection with claims submitted to the Association for reimbursement. Member Insurers shall be responsible to secure necessary authorization from Covered Person(s) for this purpose.

(g) All information disclosed to the Association by the Member Insurer or to the Member Insurer by the Association in connection with operations pursuant to this Plan shall be considered by both the Member Insurer and the Association to be confidential information.

(h) In the event that the Member Insurer is reimbursed by another party for expenses previously reimbursed by the Association, the Member Insurer shall reimburse the Association for the amount of any duplicate reimbursement. The Member Insurer shall execute and deliver any instruments and otherwise undertake any actions necessary in order to preserve and secure its right to

reimbursement from third parties, including any actions that may be required by the Association.

(i) Member Insurers shall pay claims that are subject to Reinsurance Reimbursement on the same basis as the Member Insurer's non-reinsured claims, and shall not delay payment of otherwise valid claims due to such claims being reinsured with the Association.

9.11 Audit and Inspection Rights. As a condition of each Member Insurer's membership in the Association and as a condition of the Member Insurer's ability to obtain reinsurance of Covered Persons by the Association, the Association shall have the following audit and inspection rights:

(a) At any time and from time to time upon reasonable advance notice to any Member Insurer, audit and inspect all the Member Insurer's books and records relating in any way to the identification of Covered Persons eligible for reinsurance, the ceding or designation of Covered Persons, the issuance and administration of primary coverage underlying the Association's reinsurance, the calculation of reinsurance premium, and the Member Insurer's systems for managing each of the foregoing.

(b) At any time and from time to time upon reasonable advance notice to any Member Insurer, audit and inspect all the Member Insurer's books and records relating to the investigation, adjustment and defense of any claims, including, without limiting the generality of the foregoing, all books and records relating to the Member Insurer's claims administration process and systems and the compliance or non-compliance by the Member Insurer with the requirements of Sections 9.10(a), (b) and (c) hereof.

(c) All references to books and records shall include all data and information storage regardless of the technology or media used to produce, capture and retain such data and information. Member Insurers shall provide access to qualified personnel sufficient in all respects to assist the Association's audit personnel with access to and review and analysis of all books, records, data and other information required in connection with performing complete audits and inspections, in accordance with the foregoing.

9.12 Computation of Time Period. In computing a period of time allowed by this Article IX, the date of the event after which the period of time begins to run is not to be included. The last day of the period so computed is to be included, unless it is a Saturday, a Sunday or a legal holiday in the State of Maine, in which event the period runs until the end of the next day which is neither a Saturday, a Sunday, or a holiday.

9.13 Notices. All notices and other communications required or permitted by this Article IX shall be deemed given when (a) delivered to the appropriate address by hand or by nationally recognized overnight courier service (costs prepaid); (b) sent by facsimile or internet e-mail with confirmation of transmission by the transmitting equipment to a fax number or email address provided by the recipient; or (c) deposited in the U.S. mail properly addressed and with sufficient postage.

ARTICLE X HEALTH STATEMENT; LIST OF SPECIFIED CONDITIONS

10.1 Health Statement. The Board shall develop, and may update from time to time, a Health Statement to be used by each Member Insurer to collect information from individuals for purposes of making reinsurance determinations ("Health Statement"). Information provided in the Health Statement shall be the sole basis for such determinations. A Member Insurer may require a completed Health Statement in order for an application for coverage to be considered complete. Member Insurers may require a Health Statement from Covered Persons on an annual basis to assist in making the determination whether to renew or cancel the designation of the Covered Person for reinsurance hereunder. Designation of an insured to pursuant to this Section is referred to herein as a "Discretionary Cede" or "Discretionary Ceding," as applicable.

10.2 Specified Conditions List. The Board shall develop, and may amend from time to time, a list of medical or health conditions for which a person shall be automatically designated for reinsurance by the Association ("Specified Condition(s)"). The automatic ceding of Covered Persons pursuant to this Section is referred to herein as "Automatic Cede" or "Automatic Ceding," as applicable. A person who demonstrates the existence or history of any such medical or health condition through any reasonably verifiable means other than the Health Statement is not be required to complete the Health Statement. Persons who have not otherwise demonstrated a Specified Condition will be required to complete the Health Statement at the time of applying for Medical Insurance. The completion of a Health Statement is not the exclusive means of identifying a Specified Condition. Member Insurers shall exercise a reasonable level of care and make diligent inquiry in identifying Specified Conditions, and shall cede Covered Persons who demonstrates the existence or history of any Specified Condition whether discovered by the Member Insurer through the completion of the Health Statement or through claims history, risk scores or other appropriate means of determination.

ARTICLE XI ASSESSMENTS

11.1 Organizational Assessment. The Board shall assess each Insurer a one-time initial organizational assessment in an amount of $500 per insurer. This assessment shall be due within 30 days following receipt of a bill therefor from the Association ("Organizational Assessment").

11.2 Regular Assessments. On an annual basis, the Board shall assess each Insurer an amount not to exceed four dollars ($4) per month per Covered Person enrolled in Medical Insurance insured, reinsured or administered by the Insurer ("Regular Assessment"). Except for the Transition Period, beginning calendar year 2013, the Board shall determine the rate of the Regular Assessment on or before March 31 of each year. Notification of Regular Assessments due from Insurers shall be provided on or before March 31 of each year, and Regular Assessments shall be payable on a quarterly basis, due within 30 days after the end of each calendar quarter. The Board shall determine the rate of Regular Assessments for the Transition Period as soon as reasonably possible following the Effective Date of this Plan. The Regular Assessment for the Transition Period shall be assessed beginning with the second calendar quarter of 2012 and shall be due and payable on or before July 31, 2012. Thereafter assessments shall be made on the quarterly schedule described herein.

11.3 Assessments to Cover Net Losses. In addition to the organizational and Regular Assessments described in Sections 11.1 and 11.2, the Board may, in accordance with this Section 11.3, assess Insurers at such a time and for such amounts as the Board finds necessary in its discretion to cover any net loss in an amount not to exceed two dollars ($2) per month per Covered Person enrolled in Medical Insurance insured, reinsured or administered by each Insurer ("Deficit Assessment").

11.4 Self-Reporting. Both Regular Assessments and Deficit Assessments shall initially be calculated and paid by each Insurer on a self-reported basis. Insurers will be required to submit to the Association the calculation of their assessment, together with the payments required under Sections 11.2 and 11.3 above. The Insurer's determinations shall be subject to verification by the Association, either through audit or through any other independent means available to the Association for verification of Insurer enrollment.

11.5 Federal or State Employees. An Insurer shall not be subject to assessments pursuant to Sections 11.2 or 11.3 on policies or contracts insuring federal or state employees.

11.6 Determination and Payment of Assessments.

(a) The Regular Assessment payable by each Insurer pursuant to Section 11.2, and the Deficit Assessment payable by each Insurer pursuant to Section 11.3 will each be calculated based upon the rate of assessment determined by the Board and each Insurer's Covered Person enrollment. For purposes of calculating their Regular Assessments, Insurers shall report to the Association their Covered Person enrollment (determined on a basis consistent with Section 11.5(b) below) within 30 days after the close of each calendar quarter ("Quarterly Assessment Report") and shall remit payment of the Regular Assessment due, calculated in accordance with the enrollment reported therein. The most current information shall also be used for calculation of Deficit Assessments payable by Insurers if, as and when Deficit Assessments are declared by the Association. In the event a Quarterly Assessment Report is not timely received from any Insurer, then that Insurer's enrollment will be determined based upon its report as reported to the Bureau of Insurance pursuant to Rule 945 (adjusted to exclude FEHBP enrollment) or such other means as the Association deems appropriate. Quarterly Regular Assessment payments shall be made on a provisional basis, and the Association shall have a right to adjust enrollment reported by Insurers to reflect any additional information obtained or provided to the Association regarding enrollment of Insurers and make appropriate adjustments in the amount of Regular Assessments and/or Deficit Assessments. The Board may verify the amount of each Insurer's assessment based on annual statements and other reports determined to be necessary by the Board. The Board may use any reasonable method of estimating the number of Covered Persons of an Insurer if the specific number is not reported. With respect to self-insured health plans subject to assessment, the Association shall develop and apply a consistent reasonably appropriate methodology to determine the enrollment in those plans based on such information as may from time to time be or become available to the Association. In the event a self insured health plan subject to assessment does not provide a Quarterly Assessment Report or other adequate information to allow for determination of its enrollment, then the Association may interpolate its enrollment based on such other data as the Board may deem appropriate.

(b) In preparing its count of Covered Persons for assessment purposes:

(i) The Board shall make reasonable efforts to ensure that each Covered Person is counted only once with respect to an assessment.

(ii) Each Insurer that obtains excess or stop loss insurance shall include in its count of Covered Persons all persons whose

coverage is insured, in whole or in part, through excess or stop loss coverage; and

(iii) A Reinsurer shall be permitted to exclude from its number of Covered Persons those who have been counted by the primary insurer or by the primary reinsurer or primary excess or stop loss insurer for the purpose of determining its assessment.

11.7 Late Payments. Assessment payments paid after the applicable due date shall be subject to a late payment charge equal to 5% of the amount due, plus interest at the rate of 18% per annum, to be charged on and after the applicable due date.

11.8 Deferral of Assessments. An Insurer may apply to the Superintendent for a deferral of all or part of an assessment imposed by the Association. The Superintendent may defer all or part of the assessment if the Superintendent determines that the payment of the assessment would place the Insurer in a financially impaired condition. If all or part of the assessment is deferred, the amount deferred shall be assessed against other Insurers in a proportionate manner consistent with this Article. The Insurer that receives a deferral remains liable to the Association for the amount deferred and is prohibited from reinsuring any person through the Association until such time as the Insurer pays the assessments.

11.9 Failure to Pay Assessment.

(a) The Association shall report all unpaid assessments to the Superintendent requesting that appropriate action be taken to facilitate collection of such amounts.

(b) The Superintendent may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in Maine of any Insurer that fails to pay an assessment.

(c) As an alternative, the Superintendent may levy a penalty on any Insurer that fails to pay an assessment when due.

(d) In addition, the Superintendent may use any power granted to the Superintendent under Title 24-A to collect any unpaid assessment.

11.10 Excess Funds. If assessments and other receipts by the Association, Board or Administrator exceed the actual losses and administrative expenses of the Association, the Board shall hold the excess in an interest bearing account or otherwise invested in accordance with the Association's Investment Policy and shall use those excess funds to offset future losses or to reduce reinsurance premiums, as determined by the Board in its

discretion. As used in this Section 11.9, "future losses" includes reserves for IBNR.

11.11 Federal Funds to Reduce Assessment. The Board shall comply with § 3957(9) of the Act with respect to unused funds from the federal pre-existing condition insurance plan.

11.12 Disputes Regarding Assessments. The Administrator will act on behalf of the Board in connection with billing, payment and collection of assessments. In the event of any dispute between an Insurer and the Association, the Administrator will act on behalf of the Association in attempting to resolve any dispute; provided, however, in the event such dispute cannot be resolved within 30 days following written notice of the dispute, the Insurer shall be entitled to petition the Board for an appearance before the Board in connection with such dispute, as more particularly described in Section 14.7 hereof.

ARTICLE XII FINANCIAL ADMINISTRATION

12.1 Books and Records. The Association shall maintain books and records to satisfy any applicable requirements of law and/or of the Board, the Superintendent, and outside auditors, and may contract with the Administrator or such other third party as the Board of Directors shall in its discretion select to carry out one or more of the following functions:

(a) The receipt and disbursement of cash by the Association and financial statements shall be prepared on the accrual basis of accounting.

(b) Non-cash transactions shall be recorded when the asset or the liability should be realized by the Association in accordance with generally accepted accounting principles.

(c) Assets and liabilities of the Association, other than cash, shall be accounted for and described in itemized records.

(d) For each Insurer, the net balance due to/from the Association shall be calculated and confirmed with Insurers as deemed appropriate by the Board or when requested by the respective Insurer. Such net balance shall be supported by a record of such Insurer's financial transactions with the Association. For each Insurer, this record shall include:

(i) Assessments, including any late, deferred, or unpaid assessments.

(ii) Any adjustments to the amount due to/from the Insurer resulting from corrections to information submitted by the Insurer.

(iii) Interest charges due from the Insurer for late payments.

(iv) If the Insurer is a Member Insurer, the amount of reinsurance premium due from the Member Insurer to the Association.

(v) If the Insurer is a Member Insurer, the amount of reimbursement due from the Association to the Member Insurer.

(vi) Such other records as may be required by the Board.

(e) The Association shall maintain a general ledger whose balances are used to produce the Association's financial statements in accordance with generally accepted accounting principles.

(f) The Association shall maintain all records as to premium, reimbursement, and administrative expenses with respect to a given calendar year for a period of seven (7) years following the end of such calendar year.

12.2 Handling and Accounting of Assets and Money. Money and marketable securities shall be kept in bank accounts and investment accounts as approved by the Board. The Administrator, or other party selected by the Board of Directors, shall deposit receipts into and make disbursements from these accounts.

12.3 Bank Accounts. All bank accounts/checking accounts shall be established in the name of the Maine Guaranteed Access Reinsurance Association, and shall be approved by the Board. Authorized check signers shall be approved by the Board.

12.4 Lines of Credit. All lines of credit shall be established in the name of the Maine Guaranteed Access Reinsurance Association, and shall be approved by the Board. Lines of credit may be used for any operating expense, including to meet cash shortfalls.

12.5 Investment Policy. There shall be an "Investment Policy" established by the Board with the assistance of professional investment advisors selected by the Board, which shall identify the appropriate types of investments to be held by the Association, together with any applicable limitations on such investments All cash shall be invested in accordance with the Investment Policy.

ARTICLE XIII AUDIT FUNCTION

13. 1 Statutory Reporting. On an annual basis, the Association shall provide the following audits and reports to the parties indicated:

(a) Annual Audit. The Board shall cause an audit of the Association to be conducted annually and shall provide the certified audit report to the Superintendent and the Joint Standing Committee.

(b) Annual Report to the Legislature. The Association shall report to the Joint Standing Committee not later than March 15th of each year, commencing in 2013. The report shall include information on the financial solvency of the Association and the administrative expenses of the Association.

(c) Annual Review for Solvency. The Board shall cause a review of the Association for solvency to be conducted annually and shall submit the results of such review to the Superintendent. Before April 1st of each year, commencing in 2013, the Association shall determine and report to the Superintendent (i) the Association's expected net losses for the previous calendar year, including administrative expenses and incurred losses for the year, taking into account investment income and other appropriate gains and losses, and (ii) an estimate of the assessments needed to cover the losses incurred by the Association in the previous calendar year, including IBNR reserves.

13. 2 Audit Scope. The audit shall review both the Association and the relevant operations of the Administrator. The audit report shall include the auditor's opinion as to whether the financial statements of the Association fairly present in all material respects the financial position of the Association. Auditors of the Association shall also provide the Audit Committee and the Board a report of any reportable conditions or material weaknesses in the internal controls and processes of the Association. Each of the Board or Audit Committee may at its discretion request copies of audit programs and details of audit testing from the auditor.

13. 3 Auditor. The Association's annual audit shall be conducted by a firm of Certified Public Accountants selected by the Board. The audit firm shall be independent and have no conflicting interests with any Member Insurer, the Association, or the Administrator. The Association's annual audit examinations shall be made in accordance with the Generally Accepted Auditing Standards of the American Institute of Certified Public Accountants, and all annual solvency reviews shall be made using generally accepted accounting principles.

13. 4 Additional Testing, Audits and Investigation. The Board may, at its discretion, cause such additional audit procedures to be conducted as it

deems appropriate. Such additional audits may include detailed testing of representative samples of items required in order to inform the Audit Committee regarding the accuracy, completeness and timeliness of the Administrator's performance of all duties and responsibilities specified hereunder and under the Administrator's contract; the compliance by the Administrator and the Association with all applicable laws, rules, regulations and industry standards; and the adequacy of internal financial and operating controls and procedures.

ARTICLE XIV PENALTIES AND DISPUTE RESOLUTION

14.1 Good Faith and Due Diligence Of Insurers. Given the numerous factual determinations and tasks to be performed by Insurers in connection with their participation in the Association, it is expected that all Insurers will exercise the highest degree of good faith and due diligence in all aspects of their relationship with the Association.

14.2 Common Administrative Errors. There are certain common administrative errors that, notwithstanding the exercise of good faith and due diligence can be expected to occur. The following provisions govern the corrective actions to be taken in connection with certain anticipated administrative errors. The following provisions do not, and are not intended to, limit the Association's right to exercise any rights or remedies to which it may be entitled under this Plan, the Enabling Act or to request the Superintendent exercise enforcement or supervisory authority in connection with any of the following circumstances.

(a) *Reinsuring an ineligible individual (initial placement or failure to remove an individual becoming ineligible)*: Coverage for the individual shall be terminated as of the first date of ineligibility, unless the Member Insurer was not notified of the ineligibility in a timely manner and/or the termination occurs on a prospective basis. Reimbursements paid by the Association in excess of premiums received are to be promptly returned to the Association. Premiums paid in excess of reimbursements paid by the Association will be promptly refunded by the Association, subject to the limitation on premium refunds.

(b) *Reinsuring an eligible individual at the incorrect premium rate (failure to use correct rates or to apply correct rates to persons reinsured)*: Reinsurance premiums for the persons involved shall be recalculated and any additional premiums shall be promptly paid. Excess premium payments will be promptly refunded, subject to the limitation on premium refunds.

(c) *Incorrect claim payments or submissions*: The claim will be recalculated and any amount due to the Association will be repaid immediately.

14.3 Errors Related to Assessments. All Insurer errors related to assessments shall require the immediate payment of any additional amounts due plus interest calculated from the date such sum should have been paid and an administrative charge. Nothing set forth in this Section shall limit the Association's right to take any action or exercise any remedies provided in this Plan, the Enabling Act or other applicable law.

14.4 Other Errors. All additional sums due to the Association as a result of errors made by Insurers (including Member Insurers) other than those listed above shall be paid immediately. Nothing set forth in this Section shall limit the Association's right to take any action or exercise any remedies provided in this Plan, the Enabling Act or other applicable law.

14.5 Interest and Administrative Charges. Usual and ordinary errors and corrections shall not result in interest or administrative charges. In the event the Association determines that errors are the result of intentional, negligent or habitual behavior, then interest and administrative charges may be imposed in the Association's discretion. Any such charges shall require Board approval. All interest payments required under this Article shall be calculated from the date the incorrect payment occurred or correct payment should have been made through the date of payment, and shall bear interest at 18% per annum. Any applicable administrative charge shall be established by the Board, in its discretion.

14.6 Limitation on Premium Refunds. All premium refunds due under this Article XIV shall be limited to a period of twelve (12) months from the date the error was corrected, except as otherwise agreed by the Board. This determination is subject to the dispute resolution provisions set forth in Section 14.7.

14.7 Disputes Resolution. In the event of any dispute between the Association and a Member Insurer, the following provisions shall govern resolution of the dispute. In the event of a dispute with an Insurer (other than a Member Insurer), the Association shall make dispute resolution available based on the following provisions, to the extent the Insurer agrees to follow such provisions.

(a) In the event of a dispute between the Administrator and any Member Insurer regarding the implementation of this Plan or the operation of the Reinsurance Program, the Administrator and the Member Insurer shall exercise good faith efforts to resolve such dispute in the normal course of business.

(b) In the event a dispute is not resolved in the ordinary course of business, then a Member Insurer may give the Association written notice of such dispute ("Dispute Notice"). The executive of the Administrator and counsel for the Association shall meet with authorized representatives of the Member Insurer within 30 days following the receipt of a Dispute Notice in an attempt in good faith to resolve any such dispute through informal communication accompanied by such documentation, presentation or other materials as the parties may mutually find helpful in facilitating an informal, amicable resolution ("Executive Dispute Process").

(c) In the event the dispute has not been resolved within 30 days after the Executive Dispute Process, the Member Insurer shall have the right to submit a petition to the Legal Committee of the Board for an appearance before the Legal Committee in connection with the dispute ("Petition"). The Petition shall include with reasonable particularity (i) the name and title of the executive who will represent that party and of any other person who will accompany the executive, (ii) a statement of each party's position and a summary of arguments supporting that position, (iii) any supporting documentation the Member Insurer deems relevant or appropriate. At the next regularly scheduled meeting of the Legal Committee following receipt of a Petition, the Legal Committee shall provide the Member Insurer an opportunity to meet with the Legal Committee and make a presentation regarding the dispute ("Legal Committee Hearing"). The Legal Committee shall provide the Member Insurer with notice of the time and place of the meeting.

(d) In the event the dispute has not been resolved within 30 days after the Legal Committee Hearing, the Member Insurer shall have the right to submit a petition to the full Board for an appearance before the Board in connection with the dispute ("Board Petition"). The Board Petition shall include with reasonable particularity (i) the name and title of the executive who will represent that party and of any other person who will accompany the executive, (ii) a statement of each party's position and a summary of arguments supporting that position, (iii) any supporting documentation the Member Insurer deems relevant or appropriate and for the clear and concise statement of the Member Insurer's objection to the determination by the Legal Committee. Within 45 days following receipt of a Board Petition, the Board shall schedule a special meeting at which the Member Insurer shall have the opportunity to make a presentation regarding the dispute. The Board shall provide the Member Insurer with notice of the time and place of

the meeting. The Member Insurer shall provide such further information, documentation and other data as the Board may reasonably request, in advance of hearing.

(e) All offers, promises, conduct and statements, whether oral or written, made in the course of the negotiation by any of the parties, their agents, employees, experts and attorneys are confidential, privileged and inadmissible for any purpose, including impeachment, in arbitration or other proceeding involving the parties, provided that evidence that is otherwise admissible or discoverable shall not be rendered inadmissible or non-discoverable as a result of its use in the negotiation. All applicable statutes of limitation and defenses based upon the passage of time shall be tolled while the procedures specified in subsections (a)-(d) above are pending and for 15 calendar days thereafter. The parties will take such action, if any, required to effectuate such tolling.

ARTICLE XV INDEMNIFICATION AND LIABILITY

15.1 Indemnification. The Association shall indemnify directors and officers of the Association, and may indemnify employees and agents of the Association, pursuant to and as provided in the Bylaws of the Association.

15.2 Liability. Liability of directors and employees of the Association and others is limited as set forth in the Enabling Act.

ARTICLE XVI AMENDMENT

16.1 Amendments to this Plan of Operation may be adopted by the Board at any time, subject to the approval of the Superintendent.

ARTICLE XVII REPORTING REQUIREMENTS

17.1 General. This Plan sets forth certain reports and reporting requirements for Insurers summarized in Section 17.2 below. The Association reserves the right to adopt additional reporting requirements and require submission of additional reports, or require additional information in the existing reports, as the Board, in its discretion, deem appropriate. The identification of reports and the information contained therein in this Plan shall not limit the Association's ability to establish additional reporting requirements, as determined necessary to effectively implement this Plan.

17.2 Summary of Reporting Requirements. The following summarizes the reports required by this Plan. This section is included for reference and

organizational purposes, and does not alter the reports or reporting requirements set forth in other sections of the Plan.

(a) Ceding Notice. Described in Sections 9.4(a)(i) and (ii) is the notice provided by Member Insurers upon initial ceding of a Covered Person to the Reinsurance Program.

(b) Enrollment Report. Described in Section 9.5(d)(ii) is the monthly report provided by Member Insurers listing all Covered Persons reinsured with the Association by the Member Insurer.

(c) Renewal/Cancellation Notice. Described in Section 9.4(e)(ii) is the annual notification by a Member Insurer of the Covered Persons ceded to the Reinsurance Program for the applicable year, and termination of reinsurance for any formerly ceded Covered Persons withdrawn from the Reinsurance Program for that year.

(d) Claims Report. Described in Section 9.8 is the monthly report by each Member Insurer describing reinsurance-eligible losses incurred by the Member Insurer for the preceding month.

(e) Quarterly Assessment Report. Described in Section 11.5(a) is the quarterly report of each Insurer's Covered Person enrollment utilized to calculate the Insurer's Regular Assessment payment, and any Deficit Assessment.

ARTICLE XVIII TERMINATION

18.1 The Association shall continue in existence perpetually, subject to termination in accordance with the requirements of any law or laws enacted by the State of Maine or the United States of America. In case of enactment of a law or laws which, in the determination of the Board and the Superintendent, shall result in, or require, the termination of the Association, the Association shall terminate and conclude its affairs in a manner to be determined by the Board and set forth in a Plan of Termination, which shall be subject to approval by the Superintendent. Any funds or assets of any nature held by the Association at the time of adoption of the Plan of Termination shall be applied and distributed in the following order of priority:

(a) To the payment of the expenses of liquidation and the debts and liabilities of the Association, including all claims for reimbursement by the Member Insurers;

(b) To the setting up of any reserves which the Board may deem necessary or desirable for any contingent or unforeseen liabilities

or obligations of the Association, which reserves shall be held for such period as the Plan of Termination may specify for the purpose of payment of the aforesaid liabilities and obligations, at the expiration of which period the balance of such reserves shall be distributed in accordance with the following subparagraph;

(c) After satisfaction of all liabilities and obligations for which reserves have been established pursuant to subparagraph (b) above, all remaining property and assets of the Association shall be transferred to a trust, non-profit corporation or other fund established pursuant to the Plan Termination to be used and applied for the general purposes for which the Association was originally organized, and provided that no part of the remaining assets or net earnings of the Association shall inure to the benefit of any private entity or individual.

EXHIBIT A

ARTICLES OF INCORPORATION

DOMESTIC
NONPROFIT CORPORATION

STATE OF MAINE

ARTICLES OF INCORPORATION

File No. 20120270ND Pages 7
Fee Paid $ 40
DCN 2120231800012 ARTI
----FILED----------
01/23/2012

Julie L Flynn
Deputy Secretary of State

A True Copy When Attested By Signature

Julie L Flynn
Deputy Secretary of State

Pursuant to 13-B MRSA §403, the undersigned incorporator(s) execute(s) and deliver(s) the following Articles of Incorporation

FIRST: The name of the corporation is Maine Guaranteed Access Reinsurance Association

SECOND: ("X" one box only. Attach additional page(s) if necessary.)

☐ The corporation is organized as a public benefit corporation for the following purpose or purposes

☑ The corporation is organized as a mutual benefit corporation for all purposes permitted under Title 13-B or, if not for all such purposes, then for the following purpose or purposes

SEE EXHIBIT A ATTACHED

THIRD: The Registered Agent is a: (select either a Commercial or Noncommercial Registered Agent)

☑ Commercial Registered Agent CRA Public Number: P10026

Christopher E. Howard
(name of commercial registered agent)

☐ Noncommercial Registered Agent

(name of noncommercial registered agent)

(physical location, not P O Box – street, city, state and zip code)

(mailing address if different from above)

FOURTH: Pursuant to 5 MRSA §108.3, the registered agent as listed above has consented to serve as the registered agent for this nonprofit corporation.

FIFTH: The number of directors (not less than 3) constituting the initial board of directors of the corporation, if the number has been designated or if the initial directors have been chosen, is 11.

The minimum number of directors (not less than 3) shall be 11 and the maximum number of directors shall be 11

SIXTH: Members ("X" one box only)

☐ There shall be no members
☑ There shall be one or more classes of members and the information required by 13-B MRSA §402 is attached.

SEVENTH: **(Optional)** ☑ (Check if this article is to apply)

No substantial part of the activities of the Corporation shall be the carrying on of propaganda, or otherwise attempting to influence legislation, and the Corporation shall not participate in or intervene in (including the publication or distribution of statements) any political campaign on behalf of any candidate for public office

EIGHTH: **(Optional)** ☑ (Check if this article is to apply)

Other provisions of these articles including provisions for the regulation of the internal affairs of the corporation, distribution of assets on dissolution or final liquidation and the requirements of the Internal Revenue Code section 501(c) are set out in Exhibit A attached hereto and made a part hereof

Incorporators* **Dated** January 20, 2012

(signature)

Street 89 Whites Point Road
(residence address)

Christopher E. Howard
(type or print name)

Standish, ME 04084
(city, state and zip code)

(signature)

Street
(residence address)

(type or print name)

(city, state and zip code)

(signature)

Street
(residence address)

(type or print name)

(city, state and zip code)

For Corporate Incorporators*

Name of Corporate Incorporator _____

By _____ (signature of officer)

Street _____ (principal business location)

_____ (type or print name and capacity)

_____ (city, state and zip code)

Name of Corporate Incorporator _____

By _____ (signature of officer)

Street _____ (principal business location)

_____ (type or print name and capacity)

_____ (city, state and zip code)

***Articles are to be executed as follows:**

If a corporation is an incorporator (13-B MRSA §401), the name of the corporation should be typed or printed and signed on its behalf by an officer of the corporation. The articles of incorporation must be accompanied by a certificate of an appropriate officer of the corporation, not the person signing the articles, certifying that the person executing the articles on behalf of the corporation was duly authorized to do so.

Please remit your payment made payable to the Maine Secretary of State

Submit completed form to: **Secretary of State**
Division of Corporations, UCC and Commissions
101 State House Station
Augusta, ME 04333-0101
Telephone Inquiries: **(207) 624-7752** Email Inquiries: CEC.Corporations@Maine.gov

EXHIBIT A

TO

ARTICLES OF INCORPORATION

OF

MAINE GUARANTEED ACCESS REINSURANCE ASSOCIATION

Capitalized terms used in this Exhibit A and not otherwise defined herein shall have the meanings assigned to them in Section 3952 of the Maine Guaranteed Access Reinsurance Association Act, Chapter 54-A of Title 24-A of the Maine Revised Statutes (the "Act")

EIGHTH: **Purposes**

Section 1. The Corporation is organized and operated exclusively for the provision of reinsurance coverage for medical care on a not-for-profit basis to individuals, subject to and pursuant to the provisions of the Act and the provisions of Section 501(c) (26) of the Internal Revenue Code of 1986, as amended (the "Code").

Section 2. All activities and functions of the Corporation shall be conducted in a manner which is consistent with the requirements of Section 501(c)(26) of the Code, and solely in furtherance of its purposes, the Corporation is authorized to do everything necessary, suitable, or proper for the accomplishment, attainment, or furtherance of, to do every other act or thing incidental to , appurtenant to, growing out of, or connected with, the purposes, objects, or powers set forth in these Articles of Agreement, whether alone or in association with others; to possess all the rights, powers, and privileges now, or hereafter conferred by the laws of the State of Maine upon a nonprofit corporation organized as a mutual benefit corporation under Title 13-B of the Maine Revised Statutes, as amended, and, in general, to carry on any of the activities and to do any of the things herein set forth to the same extent and as fully as a natural person might or could do; provided that nothing herein set forth shall be construed as authorizing the Corporation to possess any purpose, object, or power, or to do any act or thing forbidden of any organization exempt from federal income tax pursuant to Section 501(c)(26) of the Code, or any successor provision, which would threaten the Corporation's tax exempt status.

NINTH: **Membership**

Section 1. Membership. Each Member Insurer of the Corporation, as defined in Section 3953(9) of the Act, is a member of the Corporation with all rights and obligations of such membership provided by these Articles of Incorporation, the Bylaws of the Corporation, and by law.

Section 2. Authority of the Board of Directors. The Board of Directors shall have the authority to determine whether any insurer is a duly qualified Member Insurer, in accordance with applicable provisions of law.

Section 3. Voting Rights. Members shall have no right to vote except as provided in Article TENTH with respect to the election of Member Directors, for which each member shall have one vote.

TENTH: **Board of Directors**

Section 1. Composition of Board.

(a) General. The Board of Directors shall consist of 11 members, comprised of 5 Member Directors and 6 Public Interest Directors.

(b) Member Directors. "Member Directors" mean natural persons who are designated by Member Insurers, at least one of whom shall be an officer, employee, director, manager, shareholder, partner, member or designee of a domestic insurer (as defined in the Act) and at least one of whom a shall be an officer, employee, director, manager, shareholder, partner, member or designee of a third party administrator (as defined in the Act). Member Directors shall be elected by the Member Insurers at the Annual Meeting of the Corporation

(c) Public Interest Directors. "Public Interest Directors" mean natural persons serving as members of the Board of Directors appointed by the Superintendent of Insurance ("Superintendent"). The Public Interest Directors shall consist of:

(i) 2 individuals chosen from the general public who are not associated with the medical profession, a hospital or an insurer;

(ii) 2 individuals who represent medical providers;

(iii) 1 individual who represents a statewide organization that represents small businesses; and

(iv) 1 individual who represents producers, as defined in Section 3952(10) of the Act.

Section 2. Elections; Appointments.

Subject to any requirements contained in the Bylaws, Member Directors shall be elected by the Member Insurers. The Public Interest Directors shall be appointed by the Superintendent as provided in Section 3953(2)(A) of the Act.

Section 3. Terms.

The Directors shall be divided into three classes, as nearly equal in number as practicable. The terms of office of each class shall expire at staggered annual intervals over three years. A full term on the Board of Directors is three years. An individual may not serve more than three consecutive full terms as a director. At each Annual Meeting of the Corporation, the Member Directors elected to succeed those Member Directors whose terms expire shall be elected for a term of office to expire at the third succeeding Annual Meeting of the Corporation after their election. All Directors shall serve for the terms provided and until their successors are duly appointed or elected and qualified.

Section 4. Vacancies; Action by Board of Directors when Vacancies Exist. Any vacancy in the Member Directors may be filled by a majority of the remaining Directors. Any Director so elected to fill any vacancy shall be elected for the unexpired term of his predecessor. Except as provided in the following sentence, a majority of the total number of Directors then in office shall constitute a quorum for the transaction of business. If at any time there are fewer Directors in office than one-half of the total number of Directors fixed in these Articles of Incorporation, *i.e.*, fewer in office than six, the Directors then in office may transact no other business than the filling of vacancies on the Board of Directors, until sufficient vacancies have been filled so that there are in office at least one-half of the number of Directors fixed in these Articles of Incorporation.

Section 5. Initial Directors. The names, addresses and initial term of the initial members of the Board of Directors, are as follows:

Name	Initial Term (in years)	Address
Jennifer Juke	1	585 Winthrop Road, Deep River, CT 06417
Edward J. Kane	2	1 Market Street, 3rd Floor Portland, ME 04101
Katherine Pelletreau	1	250 Greely Road, Cumberland, ME, 04021
Christopher T. Roach	3	254 Commercial Street

		Portland, ME 04101
William M. Whitmore	3	2 Gannett Drive Portland, ME 04106
Jolan F. Ippolito	3	442 Ellis River Road Rumford Point, ME 04276
Dr. David Howes, M D	1	331 Veranda Street Portland, ME 04104
Dana C. Kempton	3	98 Malbons Mills Road Skowhegan, ME 04976
Scott Davis	1	155 Highland Avenue Winthrop, ME 04364
Joel Allumbaugh	2	30 Deane Street Gardiner, ME 04345
Charles Gaunce	2	420 Kennedy Memorial Dr. Waterville, ME 04901

ELEVENTH: **Assessments**

For the purpose of providing funds necessary to carry out the powers and duties of the Corporation under applicable law, including without limitation Section 3955 of the Act, the Board of Directors shall assess insurers, as defined in Section 3952(6) of the Act ("Insurers"), at such time or times and for such amounts as the Board finds necessary, as more fully provided in Section 3957 of the Act. Any assessment levied against Insurers is for the benefit of the Corporation and shall be utilized to carry out the powers and duties of the Corporation under Section 3955 of the Act. Assessments shall be on such other terms and conditions, not inconsistent with the Act, as the Board shall determine in its discretion.

TWELFTH: **Amendments**

The Board of Directors shall have the exclusive power to alter, amend or repeal these Articles of Incorporation, subject to approval of the Superintendent, provided that the notice of any regular or special meeting at which such action is to be taken shall either set out the text of the proposed new provision or amendment, or any provision to be repealed, or shall summarize the changes to be effected by such adoption, amendment or repeal.

EXHIBIT B

BYLAWS

BYLAWS

OF

MAINE GUARANTEED ACCESS REINSURANCE ASSOCIATION

These Bylaws have been adopted this 6th day of January, 2012, by the persons constituting all of the members of the first Board of Directors of the Maine Guaranteed Access Reinsurance Association, a Maine nonprofit corporation formed under Title 13-B, Maine Revised Statutes (the "Corporation").

ARTICLE I

GENERAL

Section 1. Definitions. Capitalized terms used herein without definition shall have the same definitions as such terms have in the Corporation's Articles of Incorporation and in Chapter 54-A of the Maine Revised Statutes, the Maine Guaranteed Access Reinsurance Association Act (the "Enabling Act").

Section 2. Compliance. Every Member Insurer and every Insurer shall comply with these Bylaws.

Section 3. Office. The office of the Corporation and the Board of Directors shall be located at such place as may be designated from time to time by the Board of Directors.

Section 4. Prohibited Activities. No part of the net earnings of the Corporation shall insure to the benefit of, or be distributable to the Members, the Board, its officers, its employees, or other private person, except (i) reasonable compensation for services rendered and payments and distributions in furtherance of the purposes set forth herein, and (ii) as provided for in the Articles in the event of dissolution of the Corporation. No substantial part of the activities of the corporation shall be the carrying on of propaganda, or otherwise attempting to influence legislation, and the corporation shall not participate in, or intervene in (including the publishing or distribution of statements) any political campaign on behalf of or in opposition to any candidate for public office. Notwithstanding any other provision of these Bylaws, for so long as the Corporation is or seeks to remain exempt from federal income tax under Section 501(c)(26) of the Internal Revenue Code of 1986, as now in force or hereafter amended and in effect from time to time (the "Code"), the Corporation shall not carry on any other activities not permitted to be carried on by a corporation exempt from federal income tax under Section 501(c)(26) of the Code, or the corresponding section of any future federal tax code.

ARTICLE II

THE CORPORATION

Section 1. Membership. The Corporation is a Maine mutual benefit nonprofit corporation, all the members of which are Insured Members, as defined in the Enabling Act. A person shall automatically become a Member of the Corporation at the time it becomes an Insured Member within the meaning of the Enabling Act, and shall continue to be a Member so long as it continues to be an Insured Member within the meaning of the Enabling Act.

Section 2. Meetings. Meetings of Members of the Corporation shall be conducted in accordance with the following:

(a) Annual Meetings.

(1) Members shall hold an Annual Meeting of Members for the purposes stated in Section 2(a)(2) hereof (the "Annual Meeting"). The Annual Meeting shall be held on the second Tuesday of April of each year unless such date shall be a legal or religious holiday, in which event the meeting shall be held on the next following Tuesday.

(2) The purpose of the Annual Meeting shall be to elect the Member Directors of the Board of Directors, and to conduct such other business as may properly come before the meeting. The Treasurer shall present at each Annual Meeting a financial report, which shall included audited financial statements of the Corporation as contemplated by Section 3955(6) of the Enabling Act.

(b) Special Meetings.

(1) The President shall call a special meeting of the Corporation, if so directed by resolution of the Board of Directors or upon petition signed and presented to the Secretary by Member Insurers entitled to cast at least twenty-five percent (25%) of the votes in elections Corporation, for any lawful. The notice of any special meeting shall state the time, place and purpose thereof. Such meetings shall be held within forty-five (45) days after receipt by the President of said resolution or petition. No business shall be transacted at a special meeting except business that is lawfully brought before the meeting and is stated in the notice.

(c) Notice. Notices to Member Insurers of meetings of the Corporation shall be delivered either by hand or by prepaid mail to the mailing address of each Member Insurer or to another mailing address designated in writing by the Member Insurer to the Board of Directors. All such notices shall be delivered to all Member Insurers not less than ten (10) nor more than fifty (50) days in advance of the date of the meeting to which the notice relates and shall state the date, time and place of the meeting and the items on the agenda. The Secretary shall cause all such notices to be delivered as aforesaid. Notice sent by mail shall be deemed to have been delivered on the second day after the date of mailing, in the case of mailed notices or the date of deposit in the Member Insurer's mailbox in the case of hand delivery. No subject may be dealt with at any Annual Meeting or Special Meeting of the Corporation unless the notice for such meeting stated that such subject would be discussed at such meeting.

(d) Quorum. Except as set forth below, the presence in person or by proxy of 2 or more of the Member Insurers at the commencement of a meeting shall constitute a quorum at all meetings of the Corporation. If a quorum is not present, Member Insurers entitled to cast a majority of the votes represented at such meeting may adjourn the meeting to a time not less than forty-eight (48) hours after the time for which the original meeting was called. If a meeting is adjourned, a quorum at the reconvened meeting, and throughout such reconvened meeting, shall be deemed present if 2 or more of the Member Insurers are present in person or by proxy at the beginning of the meeting.

(e) Voting. Voting by Members at all meetings of Members of the Corporation shall be only as provided in Articles Ninth and Tenth of the Articles of Incorporation of the Corporation.

(f) Proxies. A vote may be cast in person or by proxy. Such proxy may be granted by any Member Insurer only in favor of another Member Insurer or an officer or director of the Corporation. Proxies shall be duly executed in writing, shall be valid only for the particular meeting designated therein and must be filed with the Secretary of the Corporation at least twenty (20) days before the appointed time of the meeting. Such proxy shall be deemed revoked only by actual receipt by the person presiding over the meeting of written notice of revocation from the grantor of the proxy. No proxy shall be valid for a period in excess of one year after the execution thereof.

A Proxy Committee of the Board may be designated by the Board of Directors. The Proxy Committee may utilize the facilities of the Corporation for the purpose of soliciting proxies. The expense of the Committee incurred in the solicitation of proxies shall be defrayed from the funds of the Corporation. No person, other than the Proxy Committee, shall be authorized to employ Corporation facilities or funds for the purposes of soliciting proxies from Members.

(g) Actions of Corporation without a Meeting. Any action required or permitted to be taken by a vote of the Corporation may be taken without a meeting if all Member Insurers shall individually or collectively consent in writing to such action. Any such written consent shall be filed with the proceedings of the Corporation.

(h) Conduct of Meetings. The Chair of the Board shall preside over all meetings of Members of the Corporation, and the Secretary shall keep the minutes of all such meeting, and record in a Minute Book all resolutions adopted at any such meeting as well as keep a record of all transactions occurring at any such meeting.

(i) Proper Business at Meetings. At any annual or special meeting of Members of the Corporation, only such business shall be conducted as shall have been properly brought before such meeting. To be properly brought before a special meeting, business must be specified in the notice of meeting given by or at the direction of the Board of Directors. To be properly brought before an annual meeting, business must be specified in the notice of meeting given by or at the direction of the Board of Directors, or otherwise properly brought before the

meeting by or at the direction of the Board of Directors or otherwise properly brought before the meeting by a Member.

For business to be properly brought before an annual meeting by a Member, the Member must have given timely notice thereof in writing to the Secretary of the Corporation. To be timely, a Member's notice must be delivered to, or mailed and received at, the principal executive offices of the Corporation not less than 120 days nor more than 180 days prior to the annual meeting; provided, however, that in the event that written notice is given, and such written notice is less than 135 days' prior to the date of such meeting, notice by the member to be timely must be so received not later than the close of business on the 15th day following the day on which such notice of the date of the meeting was mailed. In no event shall an adjournment of an annual or special meeting commence a new time period for the giving of a Member's notice as described above. A Member's notice to the Secretary shall set forth as to each matter the Member proposes to bring before the meeting (i) a brief description of the business desired to be brought before the meeting and the basis on which it is a proper action to be taken by Members at such meeting, (ii) the name and record address of the Member proposing such business, and (iii) any material interest of such Member in such business. The Chair of the meeting shall, if the facts warrant, determine and declare to the meeting that such business is not properly brought before the meeting in accordance with these provisions, and if he or she should so determine, he or she shall so declare to the meeting and any such business not properly brought before the meeting shall not be transacted.

(j) Nominations to Board by the Governance and Nominating Committee. The Governance and Nominating Committee of the Board shall nominate persons who are or will become Member Directors (as defined in the Corporation's Articles of Incorporation) for election as directors to serve for terms commencing at the next succeeding Annual Meeting. Nominations shall be made by the Committee at least sixty days before the date of the Annual Meeting at which the persons nominated are to be voted upon, except that a vacancy in the list of nominees caused by the death, resignation or removal of a nominee may be filled at any time.

(k) Nominations to Board by Members. Other nominations for election to the Board for terms commencing at an Annual Meeting of the Corporation may be made by petition of any Member containing the signatures of not less than three Member Insurers entitled to vote at such election. Each such nominee shall be an individual qualified to serve as a Member Director under the Corporation's Articles of Incorporation. Such petition shall be filed with the Secretary of the Corporation at its principal office not later than one hundred twenty days before the date of the Annual Meeting at which the persons therein nominated are to be voted upon. Each petition shall be accompanied by a statement giving all information relating to each such proposed nominee that would be required to be disclosed in solicitations of proxies for election of directors in an election contest, or that otherwise would be required, if the Corporation were subject to the proxy rules promulgated under the Exchange Act, in each case pursuant to Regulation 14A under the Securities Exchange Act of 1934, as amended (the "Exchange Act"), and Rule 14a-11 thereunder (including such proposed nominee's written consent to serve as a Member Director if elected).

(l) Record Date. For the purpose of determining the Members entitled to notice of or to vote at any meeting of the Members or any adjournment thereof, or to make a determination of Members for any other proper purpose, the Board of Directors shall fix in advance a record date for any such determination. Such record date shall not in any case be more than sixty (60) days nor less than thirty (30) days prior to the date designated for the particular action. If a meeting of the Members is adjourned for less than thirty (30) days, a determination of the Members entitled to vote at the original meeting, made as provided in this section, shall apply to the adjourned meeting unless the Board of Directors shall fix a new record date for such adjourned meeting in accordance with this section and cause new notice of the adjourned meeting to be given as for an original meeting. If a meeting of the Corporation is adjourned for thirty (30) days or more, a new record date shall be fixed for the adjourned meeting in accordance with this section.

ARTICLE III

BOARD OF DIRECTORS

Section 1. Management of the Corporation; Composition. The business and affairs of the Corporation shall be managed by or under the direction of the Board of Directors, which may exercise all of the powers granted the Corporation in its Articles of Incorporation and by the Enabling Act, and do all lawful acts and things as are not by statute, the Articles of Incorporation or the Bylaws required to be exercised or done by the Members.

The Board of Directors shall consist of individuals elected or appointed by the Superintendent of Insurance of the State of Maine and by the Member Insurers, as provided in the Corporation's Articles of Incorporation.

Section 2. Election and Term of Office.

The Public Interest Directors shall be appointed by the Superintendent as provided in Section 3953(2)(A) of the Act.

The election of Member Directors shall be held at the Annual Meeting of Members of the Corporation, in accordance with the Articles of Incorporation and these Bylaws. The term of office of any member of the Board of Directors shall be three years. The members of the Board of Directors shall hold office until the earlier to occur of the election of their respective successors or their death, adjudication of incompetency, removal or resignation. A member of the Board of Directors may serve up to three (3) consecutive terms, and may succeed himself.

Vacancies on the Board may be filled as provided in the Articles of Incorporation.

Section 3. Meetings of the Board of Directors. Meetings of the Board of Directors shall be conducted in accordance with the following:

(a) Regular Meetings. Regular meetings of the Board of Directors may be held at such time and place, either within or without the State of Maine, as shall from time to time be fixed by the Board. Unless otherwise specified by the Board, once the schedule of regular meetings is established no additional notice of regular meetings shall be necessary.

(b) Special Meetings. Special meetings of the Board of Directors may be called by the Chairman of the Board of Directors (if any), the President, the Secretary, or a majority of the Directors. The person or persons calling the special meeting shall fix the time and place thereof.

(c) Notice; Generally. Notice of each special meeting of the Board of Directors shall be given to each Director who has not signed a waiver of notice before or after the meeting. Notices of meetings of the Board of Directors shall be given by the Registered Agent or the Secretary, or the person or persons calling the meeting. Neither the business to be transacted at nor the purpose of the meeting need be specified in the notice unless the Act shall otherwise require. The giving of notice of a special meeting of the Board of Directors by or at the direction of the person or persons authorized to call the same shall constitute the call thereof.

(d) Notice; When and How Given. Notice of meetings of the Board of Directors may be given by any of the following methods within the time period specified for that method:

(i) by depositing a copy of the notice in the United States mail, first class postage prepaid, addressed to the Director at his usual or last known business or residence address, at least 3 business days before the meeting;

(ii) by delivering a copy of the notice to a recognized overnight delivery or express service addressed to the Director at his usual or last known business or residence address, including street or the like in the address, at least 2 business days before the meeting;

(iii) by delivering a copy of the notice in hand to the Director at least 24 hours before the meeting;

(iv) by reading or causing to be read the notice over the telephone to the Director at least 24 hours before the meeting;

(v) by sending a telegram containing the contents of the notice addressed to the Director at his usual or last known business or residence address at least 2 business days before the meeting;

(vi) by electronic transmission, including email or fax, as provided in, and subject to, the provisions of this Section relating to electronic transmissions and set forth below; or

(vii) by sending a copy of the notice by any usual means of communication addressed to the Director at his usual or last known business or residence address, including street or the like in the address, at least 3 business days before the meeting.

Notice to any Director actually received by him at least 24 hours before the meeting shall be deemed sufficient, notwithstanding the method or means of communication selected or the time when sent. For the purposes of this Section, a "business day" is any day other than a Saturday, Sunday or legal holiday in Maine.

Written notice of an meeting of directors includes any notice delivered by electronic transmission, as defined below, provided that the Corporation shall have sent an electronic transmission to such Director at a specific e-mail address selected and confirmed by the Director, and that such electronic transmission shall contain the full text of the notice of the meeting. For purposes of these Bylaws, an "electronic transmission" means any form or process of communication, not directly involving the physical transfer of paper or another tangible medium, which (a) is suitable for the retention, retrieval, and reproduction of information by the recipient, and (b) is retrievable in paper form by the recipient through an automated process used in conventional commercial practice. Electronic transmission includes, without limitation, communications by e-mail and by fax. An electronic transmission is received by the recipient when (1) it enters an information processing system that the recipient has designated or uses for the purpose of receiving electronic transmissions or information of the type sent, and from which the recipient is able to retrieve the electronic transmission, and (2) it is in a form capable of being processed by that system. An electronic transmission is received even if no individual is aware of its receipt.

(e) Telephone Meetings. Members of the Board of Directors or of any committee designated thereby may hold a regular or special meeting by means of conference telephone or similar communications equipment by means of which all persons participating in the meeting can hear each other. The provisions of this Article relating to notice shall apply to such meetings.

(f) Attendance as Waiver of Notice. Attendance of a Director at any meeting, including participation in any telephone meeting, shall constitute a waiver of notice of such meeting, except where a Director attends for the express purpose, stated at the commencement of the meeting, of objecting to the transaction of any business because the meeting is not lawfully called, noticed or convened. Neither the business to be transacted at, nor the purpose of, any regular or special meeting of the Board of Directors need be specified in the notice or waiver of notice of such meeting.

(g) Quorum and Vote Required. At any meeting of the Directors, a majority of the Directors then in office shall constitute a quorum for the transaction of business. The Directors present at a duly called or held meeting at which a quorum was once present may continue to do business notwithstanding the withdrawal of enough Directors to leave less than a quorum; provided, however, that a quorum must be present in order for the Board to take action, and any action of the Board shall be subject to the voting requirements set forth below. Any meeting may be adjourned from time to time by a majority of the votes cast upon the question, whether or not a quorum is present, and the meeting may be held as adjourned without further notice if the time and place to which it is adjourned is fixed and announced at such meeting. The vote of a majority of the directors present at a meeting at which a quorum is present shall be the act of the

Board of Directors unless the vote of a greater number is required by these Bylaws, the Articles of Incorporation, or statute; provided, however, that all matters submitted for a vote of the Directors must receive at least six (6) affirmative votes in order to be approved.

(h) Action by Unanimous Consent. Any action required or permitted to be taken at a meeting of the Directors, or of a committee of the Directors, may be taken without a meeting if written consents setting forth the action so taken are signed by all the Directors or members of such committee and are filed with the minutes of Directors' meetings or committee meetings, as the case may be. Any such action shall have the same effect as if taken at a meeting duly called and held.

ARTICLE IV

COMMITTEES OF THE BOARD OF DIRECTORS

Section 1. Executive Committee. The Board of Directors by resolution adopted by a majority of the full Board of Directors then in office may create and appoint an Executive Committee consisting of three or more Directors and may delegate to it some or all of the Board's authority in the management of the corporation's business and affairs except as limited by Section 709 of the Maine Nonprofit Corporations Act, the resolution establishing such executive authority or any other resolutions thereafter adopted by the Board of Directors. The Executive Committee shall keep regular minutes of its proceedings and report the same to the Board of Directors. Members of the Executive Committee may be removed, with or without cause, and vacancies may be filled by resolution adopted by a majority of the full Board of Directors then in office.

Section 2. Other Committees. Other committees may be designated by a resolution adopted by a majority of the Directors present at a meeting at which a quorum is present. Members of each such committee shall be Directors of the Corporation, and shall include the following:

(a) Executive Committee.

(b) Governance and Nominating Committee.

(c) Actuarial Committee.

(d) Audit Committee.

(e) Investment Committee.

(f) Legal Committee.

(g) Finance Committee.

Any member of a committee may be removed by a majority of the Directors whenever in their judgment the best interest of the Corporation shall be served by such removal.

Section 3. Term of Office. Each member of a committee shall continue as such until the next annual meeting of the Members of the Corporation and until his or her successor is appointed, unless the committee shall be sooner terminated, or unless such member shall be removed from such committee, or unless such member shall cease to qualify as a member of the Board of Directors as provided in Article Tenth of the Articles of Incorporation.

Section 4. Chairperson. One (1) member of each committee shall be appointed chairperson by the person or persons authorized to appoint the members thereof.

Section 5. Vacancies. Vacancies in the membership of any committee may be filled by appointments made in the same manner as provided in the case of the original appointments.

Section 6. Quorum. Unless otherwise provided in the resolution of the Board of Directors designating a committee, a majority of the whole committee shall constitute a quorum, and the act of a majority of the members present at a meeting at which a quorum is present shall be the act of the committee.

ARTICLE V

OFFICERS

Section 1. Election. At the first meeting of the Board of Directors, and at every annual meeting of the Board of Directors thereafter, the members of the Board of Directors, if a quorum is present, shall elect officers of the Corporation for the following year, such officers to serve for a one year term and until their respective successors are elected. The officers to be elected are: Chair of the Board, President, Secretary, and Treasurer. Each officer may serve an unlimited number of terms so long as such member or officer continues to be re-elected to the Board of Directors. Any member may hold two offices simultaneously, except that the President shall not hold any other office.

Section 2. Duties. The duties of the officers shall be as follows:

(a) Chair. The Chair shall be the chairperson of the Board and shall preside over all meetings of the Board of Directors. If the Chair is absent from any meetings of Board of Directors, the President of the Corporation shall preside, and in his or her absence the senior officer of the Corporation present at such meeting shall preside, and in the absence of any officer, the Board shall elect a person to preside.

(b) President. The President shall be the chief executive officer of the Corporation. The President shall be responsible for implementing the decisions of the Board of Directors and in that capacity shall direct, supervise, coordinate and have general control over the affairs of the Corporation and the Board of Directors, subject to the limitations of the laws of the State of Maine, the Enabling Act, these Bylaws and the actions of the Board of Directors. The President shall have the power to sign checks and other documents on behalf of the Corporation with or without the signatures of any other officers, as may be determined by the Board of Directors.

The President shall be a member of all committees. If the Board of Directors so provides, the President also shall have any or all of the powers and duties ordinarily attributable to the chief executive officer of a corporation domiciled in Maine.

(c) Secretary. Unless otherwise determined by the Board of Directors, the Secretary shall keep or cause to be kept all records (or copies thereof if the original documents are not available to the Corporation) of the Corporation and the Board of Directors and shall have the authority to affix the seal of the Corporation to any documents requiring such seal. The Secretary shall give or cause to be given all notices as required by law, the Enabling Act or these Bylaws, shall take and keep or cause to be taken and kept minutes of all meetings of the Corporation, the Board of Directors and all committees, and shall take and keep or cause to be taken and kept at the Corporation's office a record of the names and addresses of all Member Insurers as well as copies of the Enabling Act, the Articles of Incorporation and these Bylaws, all of which shall be available at the office of the Corporation for inspection by Member Insurers during normal business hours of the Corporation and for distribution to them at such reasonable charges (if any) as may be set from time to time by the Board of Directors. The Secretary shall also perform all duties and have such other powers as are ordinarily attributable to the secretary of a corporation domiciled in Maine.

(d) Treasurer. Unless otherwise determined by the Board of Directors, the Treasurer shall have the charge and custody of, and be responsible for, all funds and securities of the Corporation, shall deposit or cause to be deposited all such funds in such depositories as the Board of Directors may direct, shall keep or cause to be kept correct and complete accounts and records of all financial transactions of the Corporation and the Board of Directors and shall submit or cause to be submitted to the Board of Directors and the Corporation such reports thereof as the Declaration, the Board of Directors or these Bylaws may from time to time require. The foregoing financial records shall be kept at the Corporation's office and shall be available there for inspection by Member Insurers during normal business hours of the Corporation. The Treasurer shall also perform such duties and have such powers as are ordinarily attributable to the treasurer of a corporation domiciled in Maine.

Section 3. Compensation. The officers of the Corporation shall serve without compensation for their services in such capacity unless such compensation is expressly authorized or approved by a vote of more than fifty percent (50%) of the votes of all Member Insurers, at any Annual or Special Meeting of the Corporation; provided that no such compensation shall be permitted in violation of the restrictions set forth in Article I, Section 4 hereof.

Section 4. Resignation and Removal. Any officer may resign at any time by written notice to the Board of Directors, such resignation to become effective at the next meeting of the Board of Directors. Any officer may be removed from his office at any time by vote of Board of Directors, with or without cause.

Section 5. Vacancies. Vacancies caused by resignation or removal of officers or the creation of new offices may be filled by a majority vote of the Board of Directors.

ARTICLE VI

Indemnification

Section 1. Mandatory Indemnification and Advances for Directors and Officers.

(a) Indemnification. The Corporation shall in all cases indemnify, to the fullest extent permitted by law, any individual who is a party or threatened to be made a party to any threatened, pending or completed action, suit or proceeding, whether civil, criminal, administrative, arbitrative, or investigative and whether formal or informal (a "proceeding") because that person (i) is or was a director or officer of the Corporation, or (ii) is or was serving at the request of the Corporation as a director, officer, trustee, partner, manager, member, fiduciary, employee or agent of another corporation, partnership, limited liability company, limited liability partnership, joint venture, trust, pension, or other employee benefit plan, or other enterprise, against liability incurred in the proceeding.

(b) Advances. The Corporation shall in all cases, before final disposition of a proceeding, advance funds to pay for or reimburse the reasonable expenses incurred by a director or officer who is a party or threatened to be made a party to a proceeding because that individual (i) is or was a director or officer of the Corporation, or (ii) is or was serving at the request of the Corporation as a director, officer, trustee, partner, manager, member, fiduciary, employee or agent of another corporation, partnership, limited liability company, limited liability partnership, joint venture, trust, pension, or other employee benefit plan, or other enterprise, against liability incurred in the proceeding, if the director or officer delivers to the Corporation:

(1) a written affirmation of the director's or officer's good faith belief that the director or officer acted in good faith in the reasonable belief that his action was in the best interests of the Corporation or, with respect to any criminal action or proceeding, had reasonable cause to believe that his conduct was lawful, or that the proceeding involves conduct for which liability has been eliminated under the Enabling Act; and

(2) the director's or officer's written undertaking to repay any funds advanced if the director or officer is not entitled to mandatory indemnification under Section 714 of the Act and it is ultimately determined that the director or officer has not met the relevant standard of conduct described in Section 714(1) of the Act.

The undertaking required by paragraph (2) shall be an unlimited general obligation of the director or officer seeking the advance, but need not be secured and may be accepted without reference to the financial ability of the director or officer to make repayment.

(c) Indemnification and Advances Regardless of Capacity. Indemnification and advances for directors and officers of the Corporation under this Section 1 shall be required in all cases, regardless of the capacity in which such director and officer is or was made a party or threatened to be made a party to the proceeding.

Section 2. Permissive Indemnification of Employees and Agents. The Corporation may, in its discretion, indemnify any individual who is not a director or officer of the Corporation, but who is a party or threatened to be made a party to a proceeding because that person is an employee or agent of the Corporation, against liability incurred in the proceeding, only as authorized for a specific proceeding upon a determination, based solely on the facts then known to those making the determination and authorization but without further investigation, that (a) the individual's conduct was in good faith, and (b) the individual reasonably believed:

(a) in the case of conduct in the individual's capacity as an employee or agent of the corporation, that the individual's conduct was in the best interests of the Corporation;

(b) in the case of any criminal proceeding, that the individual had no reasonable cause to believe that the individual's conduct was unlawful; and

(c) in the case of an employee benefit plan, that the individual's conduct was in the interests of the participants in, and the beneficiaries of, the plan.

The termination of a proceeding by judgment, order, settlement or conviction or upon a plea of *nolo contendere* or its equivalent is not of itself determinative of the employee or agent did not meet the relevant standard of conduct described in this Section.

A specific determination as provided above shall be made by the board of directors, based solely on the facts then known to those making the determination and authorization but without further investigation, by a majority vote of a quorum consisting of directors who were not parties to such action, suit or proceeding, or if such a quorum is not obtainable, or even if obtainable, if a quorum of disinterested directors so directs, by independent legal counsel in a written opinion.

Once such a determination has been made, a specific authorization of indemnification must also be made for any such indemnification of employees or agents, in the same manner as the foregoing determination except that if there are fewer than two disinterested directors or if the determination is made by special legal counsel, then authorization of indemnification must be made by those persons entitled above to select special legal counsel.

Such a determination and authorization, once made, may not be revoked and, upon the making of that determination and authorization, the employee or agent may enforce the indemnification against the Corporation by a separate action notwithstanding any attempted or actual subsequent action by the Corporation.

Section 3. Permissive Advances for Employees and Agents. The Corporation may, in its discretion, advance funds before final disposition of a proceeding to pay for or reimburse the reasonable expenses incurred by an employee or agent of the Corporation who is a party or threatened to be made a party to a proceeding because that individual is an employee or agent of the Corporation, upon (1) a determination and authorization made in accordance with the procedures established in Section 3 hereof, based solely on the facts then known to those making

the determination and authorization but without further investigation, and (2) the delivery by the employee or agent to the Corporation of:

(a) a written affirmation of the employee or agent (i) that such individual's conduct was in good faith, and (ii) that such individual reasonably believed:

(1) in the case of conduct in the individual's capacity as an employee or agent of the corporation, that the individual's conduct was in the best interests of the corporation;

(2) in the case of any criminal proceeding, that the individual had no reasonable cause to believe that the individual's conduct was unlawful; and

(3) in the case of an employee benefit plan, that the individual's conduct was in the interests of the participants in, and the beneficiaries of, the plan; and

(b) a written undertaking of the employee or agent to repay any funds advanced unless it shall ultimately be determined that the individual is entitled to be indemnified by the Corporation as authorized in this Article.

Section 4. Mandatory Indemnification on Successful Defense. Any provisions of this Article VII hereof to the contrary notwithstanding, the Corporation shall indemnify a director, officer, employee or agent of the Corporation, to the extent that individual has been successful, on the merits or otherwise, in the defense of any action, suit or proceeding to which the individual was a party or threatened to be made a party because the individual was a director, officer, employee or agent of the Corporation, or is or was serving at the request of the Corporation as a director, officer, trustee, partner, manager, member, fiduciary, employee or agent of another corporation, partnership, limited liability company, limited liability partnership, joint venture, trust, pension, or other employee benefit plan, or other enterprise, against reasonable expenses incurred by the individual in connection with the proceeding.

Section 6. Enforceable by Separate Action. A right to indemnification or to advances of expenses required by, or established pursuant the provisions of, this Article may be enforced by a separate action against the Corporation pursuant to Section 714 of the Maine Nonprofit Corporations Act.

Section 7. Miscellaneous. The Corporation shall be deemed to have requested a person to serve an employee benefit plan whenever the performance by him or her of his or her duties to the Corporation also imposes duties on, or otherwise involves services by, him or her to the plan or participants or beneficiaries of the plan.

Section 8. Indemnification Not Exclusive; Limits. The indemnification and entitlement to advances of expenses provided by this Article shall not be deemed exclusive of any other rights to which an individual may be entitled under any agreement, vote of Members or disinterested directors or otherwise, both as to action in the individual's official capacity and as to action in another capacity while a director, officer, employee or agent of this Corporation, and shall continue as to an individual who has ceased to be a director, officer, employee, agent,

trustee, partner, or fiduciary, and shall inure to the benefit of the heirs, personal representatives, executors and administrators of such a person; provided, however, that no indemnification or advances of expenses under this Article VI shall be permitted in violation of the restrictions set forth in Article I, Section 4 hereof.

Section 9. Insurance. The Corporation may purchase and maintain insurance on behalf of an individual who is a director or officer of the Corporation or who, while a director or officer of the Corporation, serves at the Corporation's request as a director, officer, partner, trustee, employee or agent of another domestic or foreign corporation, partnership, joint venture, trust, employee benefit plan or other entity against liability asserted against or incurred by that individual in that capacity or arising from the individual's status as a director or officer, whether or not the Corporation would have power to indemnify or advance expenses to the individual against the same liability under Section 714 of the Maine Nonprofit Corporations Act.

Section 10. Amendment. No amendment, modification or repeal of this Article, in whole or in part, shall deny, diminish or otherwise limit the rights of any individual to indemnification or advances hereunder with respect to any action, suit or proceeding arising out of any conduct, act or omission occurring or allegedly occurring at any time prior to the date of such amendment, modification or repeal.

ARTICLE VII

GENERAL PROVISIONS

Section 1. Severability. The provisions of these Bylaws shall be deemed independent and severable and the invalidity, partial invalidity or unenforceability of any provision or portion hereof shall not affect the validity or enforceability of any other provision or portion thereof.

Section 2. Conflicts. The Enabling Act shall control in the event of any conflict between the provisions thereof and the provisions of these Bylaws. The Articles of Incorporation shall control in the event of any conflict between the provisions thereof and the provisions of these Bylaws.

Section 3. Amendments. The Board of Directors shall have the exclusive power to alter, amend or repeal these Bylaws, and to adopt new Bylaws provided that the notice, unless notice shall be duly waived, of any regular or special meeting at which such action is to be taken shall either set out the text of the proposed new Bylaw, amendment or Bylaw to be repealed, or shall summarize the changes to be effected by such adoption, amendment or repeal.

APPENDIX B

Maine Guaranteed Access Reinsurance Association
Merrill's Wharf
254 Commercial Street, Fifth Floor
Portland, ME 04101

February 10, 2012

Dear Sir/Madam:

I am writing to you as the Chairman of the Board of the Maine Guaranteed Access Reinsurance Association ("MGARA" or "Association"). My purpose in writing is to advise you of the organization of the Association, familiarize you with its mission and provide advance notice of certain assessments you will be receiving shortly in connection with the organization and initial operations of the Association.

As you may be aware, in May 2011, the Maine State Legislature passed Public Law Chapter 90, "An Act to Modify Rating Practices for Individual and Small Group Health Plans and to Encourage Value-based Purchasing of Health Care Services" (PL90). Included among the many components of PL90 was the establishment of MGARA as a reinsurance program for the higher risk segment of Maine's individual health insurance market. MGARA is a key component of the PL90 reforms, intended to reduce insurance costs in Maine's individual health insurance market by providing reinsurance for a significant portion of the coverage provided through individual health insurance policies. The costs associated with that reinsurance are spread across the individual, group and self-insurance markets by means of a four-part funding mechanism provided under PL90, which provides for the funding described in the following table.

Funding Mechanism	**Description**
Organizational Assessment	One-time nominal $500 fee for each insurer (including TPAs) licensed for medical insurance, whether or not active in that market
Base Market Assessment	Assessment to health insurers based on the number of insured lives covered by each at a rate of up to $4 per covered person per month ("PMPM") for all insureds in the Individual, Small Group, Large Group and Self-insured Markets (excluding State and Federal employees)
Reinsurance Premium	Insurers ceding Covered Persons to Association pay a premium set by the Board
Deficit Assessment	Optional Assessments to cover any Net Losses -- up to a maximum of $2 PMPM assessed to

	health insurers based on the number of insured lives covered by each

The portion of MGARA's funding provided through assessments is estimated to subsidize the individual market at a 1%-2% increase in market premiums outside the individual market.*

The Board of MGARA was appointed December 1, 2011. The Board consists of 11 members, with 6 members appointed by the Maine Superintendent of Insurance and 5 members appointed by insurers who offer individual health plans in Maine. MGARA is required to be fully operational as of July 1, 2012. The Board is in the process of developing a Plan of Operation for the Association and attending to the myriad details associated with its organization and initial operations.

As a private non-profit company, MGARA is entirely dependent upon the funding mechanism provided under PL90. As noted above, that law provides for a one-time organizational assessment in the amount of $500, payable by all insurers authorized to write medical insurance, or that provide medical insurance, in the State of Maine. The definition of "insurer" includes any insurance company, nonprofit hospital and medical service organization, fraternal benefit society, health maintenance organization, self-insured employer subject to state regulation as described in 24-A MRS § 2848-A, third-party administrators, multiple employer welfare arrangements, health reinsurers, health insurance captives, Dirigo Health, and any other State-sponsored health benefit program, whether fully insured or self-funded. By this definition, the organizational assessment will be paid by approximately 600 entities or organizations, resulting in initial working capital for MGARA of approximately $300,000.

We are writing to each of you so that you will be fully apprised of the Association's organization and its purpose in collecting its Organizational Assessment. We are hopeful that this advance communication will expedite the payment of invoices for the Organizational Assessment, once received. We expect to be sending out invoices for the Organizational Assessment within the next several weeks. This Organizational Assessment is a one-time assessment. The Association will be making ongoing assessments to fund its operations; however, those ongoing assessments are applicable only to insurers that write or otherwise provide medical insurance, as it is based on enrolled persons covered by that provider's insurance or health program.

Included with this letter is an FAQ for your reference. Should you have any questions regarding MGARA or its initial Organizational Assessment, please feel free to contact me or Chris Howard of Pierce Atwood LLP, who has been engaged to assist with the organization of the Association. Our contact information is provided below.

As you know, ensuring the availability of affordable health coverage for Maine's citizens is a critically important challenge facing our state, both immediately and over the longer term. MGARA's mission, and your participation in its success, represent a commitment to step forward together in the direction of a sound future for the community of Maine.

* Source: "The Impact of PL 90 on Maine's Health Insurance Markets" Actuarial Report Prepared for the Maine Bureau of Insurance by Gorman Actuarial, LLC dated December 2011.

Thank you very much for your cooperation in this important endeavor.

Very truly yours,

Jolan Ippolito
Chair

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Maine Guaranteed Access Reinsurance Association

Frequently Asked Questions

January __, 2012

What is the Maine Guaranteed Access Reinsurance Association?

The Maine Guaranteed Access Reinsurance Association ("MGARA") is a Maine nonprofit corporation organized pursuant to Public Law Chapter 90 "An Act to Modify Rating Practices for Individual and Small Group Health Plans and to Encourage Value-based Purchasing of Health Care Services" (PL90), codified at 24-A MRS c 54-A.

Why was MGARA Established?

MGARA was established as a reinsurance program for the higher risk segment of Maine's individual health insurance market. MGARA is a key component of the PL90 reforms intended to reduce insurance costs in Maine's individual health insurance market by providing reinsurance for a significant portion of the coverage provided through individual health insurance policies.

Who is Responsible for MGARA Operations?

MGARA is governed by an 11-member Board of Directors consisting of 6 members appointed by the Maine Superintendent of Insurance and 5 members appointed by insurers who offer individual health plans in Maine. The Board of MGARA was appointed December 1, 2011. The Board is currently developing the Plan of Operation for the Association, which is subject to approval by the Superintendent of Insurance.

Who are the Members of MGARA?

MGARA's members are insurers that offer individual health plans and are actively marketing individual health plans in the State of Maine.

When Will MGARA be Operational?

MGARA is required to be fully operational as of July 1, 2012.

How is MGARA Funded?

MGARA will be funded through four funding mechanisms: (1) a one-time organizational assessment; (2) assessments on insurers and providers in Maine's health insurance markets; (3) premiums paid by insurers that reinsure their insureds with MGARA; and (4) potential deficit assessments designed to cover net losses should those occur. There is also a one-time organizational assessment. These funding mechanisms function essentially as follows:

Funding Mechanism	Description
Organizational Assessment	One-time nominal $500 fee for each insurer (including TPAs) licensed for medical insurance, whether or not active in that market
Base Market Assessment	Assessment to health insurers based on the number of insured lives covered by each at a rate of up to $4 per covered person per month ("PMPM") for all insureds in the Individual, Small Group, Large Group and Self-insured Markets (excluding State and Federal employees)
Reinsurance Premium	Insurers ceding Covered Persons to Association pay a premium set by the Board
Deficit Assessment	Optional Assessments to cover any Net Losses -- up to a maximum of $2 PMPM assessed to health insurers based on the number of insured lives covered by each

What Organizations are Subject to the $500 Organizational Assessment?

There are approximately 600 entities subject to the initial organizational assessment. These entities, referred to as "insurers," are defined as any

> "... entity that is authorized to write medical insurance or that provides medical insurance in this State. For the purposes of this chapter, "insurer" includes an insurance company, a nonprofit hospital and medical service organization, a fraternal benefit society, a health maintenance organization, a self-insured employer subject to state regulation as described in section 2848-A, a 3rd-party administrator, a multiple-employer welfare arrangement, a reinsurer that reinsures health insurance in this State, a captive insurance company established pursuant to chapter 83 that insures the health coverage risks of its members, the Dirigo Health Program established in chapter 87 or any other state-sponsored health benefit program whether fully insured or self-funded."

What Constitutes Medical Insurance, for Purposes of the Foregoing Definition?

"Medical insurance" means a hospital and medical expense-incurred policy, nonprofit hospital and medical service plan, health maintenance organization subscriber contract or other health care plan or arrangement that pays for or furnishes medical or health care services whether by insurance or otherwise, whether sold as an individual or group policy. "Medical insurance" does not include accidental injury, specified disease, hospital indemnity, dental, vision, disability income, Medicare supplement, long-term care or

other limited benefit health insurance or credit insurance; coverage issued as a supplement to liability insurance; insurance arising out of workers' compensation or similar law; automobile medical payment insurance; or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

What Organizations are Subject to Ongoing, Regular Assessments?

Regular assessments are made against each "insurer" that has covered persons enrolled in medical insurance insured, reinsured or administered by the insurer; provided, however, that an insurer may not be assessed on policies or contracts insuring federal or state employees.

Who Determines the Amount of Regular Assessments?

The Board of MGARA is authorized to assess insurers at such time and for such amounts as the Board finds necessary. The maximum regular assessment is $4 per month, per covered person enrolled in medical insured insured, reinsured or administered by the insurer. The Board intends to make a determination regarding its first regular assessment based upon the advice and guidance from the actuarial firm and administrator currently being engaged by the Board.

How are Reinsurance Premiums Determined?

The Board is charged with responsibility for establishing premium rates to be charged member insurers to reinsure persons eligible for coverage.

What Happens if MGARA Experiences Losses?

MGARA is authorized to make so-called "deficit assessments" to cover any net losses. These assessments are made against insurers subject to regular assessments. This assessment is limited to $2 per month, per covered person.

What Happens if MGARA Collects Excess Funds?

In the event assessments, reinsurance premiums and other receipts exceed actual losses and administrative expenses, the Board is required to apply excess funds to offset future losses or to reduce reinsurance premiums.

What is the Product MGARA is Offering?

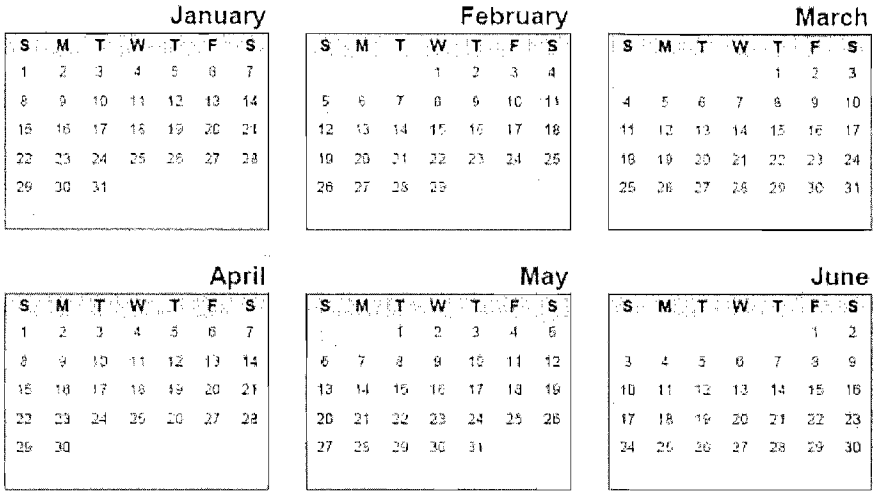
The reinsurance to be offered by MGARA is a prospective program, meaning that insurers cede persons for reinsurance based on (a) information provided in a health statement or (b) the existence of certain health conditions. Thus, insureds that suffer from specified conditions will automatically be ceded to the MGARA reinsurance pool, while other insureds will be ceded on a discretionary basis by the member insurers based on their evaluation of health statements submitted by insureds.

Each member insurer is responsible for the first $7,500 of annual paid claims and 10% of the next $25,000. The MGARA reinsurance program is responsible for 90% of annual paid claims between $7,500 and $32,500 and 100% of claims above $32,500.

APPENDIX C

MAINE GUARANTEED ACCESS REINSURANCE ASSOCIATION

Organizational Timeline



Task	**Deadline**	**Comments**
Company formation	1/18/12	Done
Administrator RFP Distribution	1/18/12	Done
Actuarial Services RFP distribution	1/25/12	Done
Administrator RFP response	2/3/12	Done
Actuarial services RFP response	2/3/12	Done
Actuary selection	2/6/12	Done
Insurance broker selection	2/6/12	Done
Insurance broker RFP response	2/3/12	Done
Organizational Assessment	2/15/12	• Introductory letter out w/o 2/13/12 • Assessment invoices out w/o 3/12/12 • Assessment due 4/30/12
LD 1670/1702 Public Hearing	2/15/12	Done
Milliman contract signing	2/17/12	Done
Administrator selection	2/17/12	Done

Task	Deadline	Comments
LD 1702 Workshop	2/22/12	Done
Milliman engagement signed	2/24/12	Done
Plan of Operation Submission Deadline	2/29/12	Done
Preliminary assessment amount determination	3/5/12	Done
Milliman provides first draft of health assessment form and specified conditions	3/9/12	Done
Administrator contract signed	3/14/12	Final draft sent to Ameriben 3/13/12
MGARA report to Legislature	3/15/12	Done
Milliman provides structure of model to evaluate automatic ceding conditions, rate levels, size of pool, solvency of pool, ceding from inforce, etc.	3/15/12	Board reviews plan to ensure that results will give Board information needed to make decisions about automatic ceding conditions, rate levels, etc.
Milliman proposes methodology and structure for setting premium rates	3/19/12	Board, insurers, and administrator review needed to ensure methodology is appropriate, practical to implement, and covers key rating variables
Carriers provide experience and enrollment data to Milliman	3/19/12	Required in order to meet deadlines below for completing and sharing model results with Board
Liability and D&O insurance bound	3/31/12	
Line of credit closing	3/31/12	Cash flow required by KeyBank to be prepared
Specified conditions and health statement finalized	3/31/12	Initial draft specified conditions provided by Milliman at 3/12/12 meeting; to be refined and finalized
Milliman demonstrates model that allows Board to evaluate and decide on automatic ceding conditions, rate levels, and related items. Model produces Financial projections and funding requirements	4/1/12	Initial projections and funding requirements by April 1; subject to revisions and updates based on Board direction and other analyses NOTE: DELIVERABLE PREDICATED ON RECEIVING DATA FROM CARRIERS BY MARCH 20
Annual meeting	4/10/12	
Ameriben/insurer work	4/11/12	Ameriben to utilize time surrounding the

Task	Deadline	Comments
session		annual meeting to work in person with insurers regarding implementation of reinsurance program
Milliman provides "final" model results showing financial projections for MGARA pool based on automatic ceding conditions, health assessment form, rate levels, marketplace assessments, etc. including effect on individual insurance market rates.	4/15/11	Board adopts automatic ceding conditions, health assessment form, rate levels to be established, etc.
Initial regular assessment notice transmitted to carriers	4/15/12	Subject to finalization of assessment and implementation of Ameriben system sufficient to enable transmission of notices
Financial projections and funding requirements	4/15/12	Initial projections and funding requirements by April 1; subject to revisions and updates based on Board direction and other analyses
Finalize Plan of Operation	4/15/12	Rough target date for finalizing Plan of Operation. Dependent upon Superintendent comments and interaction with Bureau staff, working their comments into the Plan.
Milliman provides complete rate tables and factors to be effective 7/1/12	4/29/12	Board reviews and provides comments. Milliman revises as necessary for final approval
Organizational assessments due	4/30/12	
Assessment workshops	5/1/12	Ameriben and other providers to conduct open workshop for insurers regarding the process for assessment billing and payment.
MGARA catastrophic loss reinsurance determination	5/15/12	Currently unclear whether any catastrophic loss reinsurance will be available to back stop the MGARA program. This is a loose target date for making this determination. This will likely be an ongoing process.
Reinsurance program workshops for member insurers	5/15/12	Ameriben and other providers to conduct open workshop for member insurers regarding implementation of the reinsurance program and Ameriben systems.
Systems initial test	5/15/12	

Task	**Deadline**	**Comments**
Milliman issues formal report to Board presenting results and documentation of its work related to organization and implementation of MGARA	6/1/12	Board reviews report, provides comments. Milliman makes changes as needed based on Board input and re-issues report.
Systems final test	6/15/12	
Fully operational	6/30/12	
Initial regular assessments due	7/30/12	