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ANNUAL REPORT TO JOINT STANDING COMMITTEE ON INSURANCE AND FINANCIAL SERVICES

March 15, 2013

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I. INTRODUCTION

This report is submitted pursuant to 24-A MRS § 3955(5). Pursuant to that statute, the Maine Guaranteed Access Reinsurance Association (the "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 Association's financial solvency and administrative expenses.

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 the Association as a reinsurance program for the higher risk segment of Maine's individual health insurance market. The portion of PL90 establishing the Association was codified at 24-A MRS c. 54-A and, together with a series of technical amendments enacted on April 12, 2012, is referred to herein as the "Enabling Act."

The Board of Directors of the Association (the "Board") was appointed by the Superintendent of Insurance effective December 1, 2011. The Board is comprised of 11 seats, constituting 6 members appointed by the Maine Superintendent of Insurance and 5 members appointed by the member insurers.

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 its reinsurance program. 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.

The Association was formally organized as a Maine non-profit corporation on January 23, 2012 and, following an initial start-up phase, commenced reinsurance operations on July 1, 2012. As discussed in greater detail below, early signs suggest that the program has already demonstrated a significant impact in reducing the cost of health insurance in Maine's individual market.

III. COMPANY DESCRIPTION

Following is a brief overview of the Association's organizational and operations structure.

The Board oversees the Association's operations. It continues to meet on a monthly basis

to review the operational performance of the Association and address strategic and executive matters.

The Association's operations are governed by a Plan of Operation, which was approved by the Superintendent of Insurance on June 11, 2012 in accordance with the requirements of the Enabling Act. A copy of the Plan of Operation is attached hereto as Appendix A and incorporated herein by reference.

The day-to-day administration of the Association's reinsurance program is conducted through a third-party administrator, and the Board receives additional support from several third-party providers as outlined below. The Association has no employees.

- Pierce Atwood LLP serves as the Association's legal counsel and executive support. Pierce Atwood was selected due to its significant experience in the insurance area, and Chris Howard, the partner in charge of the account, has experience serving in a legal/executive capacity in connection with the organization and initial operations of MEMIC. Pierce Atwood provides legal services regarding, among other things, regulatory compliance, governance, third-party contracting, and legislative matters.
- AmeriBen/IEC Group serves as the Association's administrator pursuant to Section 3956 of the Enabling Act. AmeriBen is a nationally recognized TPA and has served, among other things, as administrator for the Idaho high risk reinsurance pool since its inception. Ameriben provides, among others, the following administrative services: administration of the Association's reinsurance program, including all assessments, premiums, claims, and reimbursements; finance and accounting services, together with financial reporting; design, implementation, and maintenance of technology systems (e.g., data reporting systems); and general advice and counsel to the Association regarding operational matters.
- Milliman, Inc. provides actuarial services to the Association. Milliman is one of the world's leading actuarial firms with offices worldwide, and has extensive experience in advising high risk reinsurance pools. In the past year, Milliman has provided services to the Association in the following areas; development of the specified conditions list required for mandatory ceding to the reinsurance program; development of the health assessment form for the Association; reinsurance rate development; projection regarding the effect of the Association's operations on Maine's individual insurance market; and financial projections for the Association and development of a funding model. Milliman continues to provide additional actuarial services to the Association upon request.
- Key Bank holds the Association's deposit accounts and manages its investments. Details regarding the Association's investments are provided under Section VI below.

IV. PROGRAM DESCRIPTION

The reinsurance program operated by the Association reinsures health insurance policies ceded to the Association by primary carriers operating in Maine's individual health insurance market either voluntarily or on a mandatory basis based on the presence of certain specified high-risk conditions. The Association's reinsurance program is 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 Association's reinsurance program provides reinsurance coverage for 90% of reinsured claims between $7,500 and $32,500 and 100% of reinsured claims over $32,500 (without a cap). The costs associated with that reinsurance are spread across the individual, group and self-insurance markets by means of a two-part funding mechanism, including (1) assessments payable by all health insurers and third-party administrators operating in the State of Maine and (2) reinsurance premiums charged to the carriers ceding policies to the Association. (In addition, startup costs were funded in part by an initial Organizational Assessment payable by all health insurers and third-party administrators operating in the state.)

For its initial year of operation, the Association set the assessment at $4 per person per month and premiums at a rate of 90% of the premium charged under the underlying policy. Although the Association's operations are still at a very early stage, early indications are that the program is having a significant impact in reducing the cost of health insurance in Maine's individual market. By way of example, Anthem HealthChoice's most recent rate filing sought an increase of only 1.7%. This rate filing took into account the Association's reinsurance program. Anthem estimated that its participation in the program will reduce total claims for its individual products by about $11 million, resulting in a much smaller rate increase than would otherwise have been needed. Anthem projected that without this program, the premium increase would have been 21.6%. As of December 31, 2012, 3,248 lives had been ceded to the Association for reinsurance coverage.

V. SELECTED FINANCIAL INFORMATION AND DISCUSSION

Chronology. The Association commenced operation of its reinsurance program on July 1, 2012. Prior to that date, in accordance with the provisions of the Enabling Act, the Association collected a one-time organizational assessment from for each insurer (including third party administrators) licensed for medical insurance in the State of Maine, totaling $263,496. The first regular assessment of health insurers based on covered lives in the individual market was collected beginning in July 2012, and has continued on a quarterly basis. MGARA began accepting ceded lives, reinsurance premium, and claims as of July 1, 2012, although prescribed timeframes for ceding and claims submission resulted in limited activity until the third quarter of 2012.

Financial Model. The Association's operating budget was established based on a proprietary financial model (the "Financial Model") developed by Milliman for use by the Association in projecting its operational and financial performance. Based on Milliman's analysis of actual historical data for the Maine individual insurance market, the Financial Model projected, among other metrics, revenue (including revenue derived from both assessments and premiums), claims, and cedes, and provided the actuarial basis for the establishment of the Association's premium rates and list of specified conditions for mandatory ceding. As discussed in greater detail herein, the Association's actual financial performance for the six months ending December 31, 2012, as well as carriers' ceding behavior, has closely tracked the Financial Model, as applied to its first six months of operations and financial results.

Summary of Key Financial Data. Following is a summary of certain key financial data for the Association based on its unaudited December 31, 2012 financial statements. A complete copy of the December 31, 2012 unaudited financial statements is attached hereto as Appendix B. The Association's audit of its 2012 financial statements is currently underway and is expected to be completed on or about April 15, 2013. All financial results reported herein and contained in Appendix B are preliminary and unaudited. Because the Association commenced operation of its reinsurance program in July 2012, it experienced both anticipated and unanticipated lags in systems integration, ceding, and claims submission associated with rapid commencement of operations. As a result, the financial results reflected herein and conclusions contained herein are based on limited and preliminary data, and the Association reserves the right to make any necessary adjustments to this information.

Summary Financial Data
12-Months Ended December 31, 2012
Unaudited

Revenue	
Organizational Assessment	$263,496
Regular Assessment	$14,033,160
Premium	$8,176,047
Total Revenue	$22,472,703
Expenses	
Claims Incurred	$13,010,366
IBNR	$5,000,000
Other Expenses	$577,350
Total Expenses	$18,587,716
Balance Sheet Information	
Total Assets	$20,445,314
Total Liabilities	$16,560,327
Fund Balance	$3,884,987
Ceded Lives	
Mandatory Ceded Lives	1,760
Voluntary Ceded Lives	1,488
Total Ceded Lives	3,248

Consistent with its mission, the Association has, to date, returned 80% of 2012 revenues to pay reinsurance claims generated by the high risk segment of Maine's individual health insurance market. The Association expended only 2.5% of 2012 revenues for startup and administrative expenses, which the Board believes is an extremely favorable expense ratio. Although start up expenses are reflected as expenses in the Association's financial statements, the bulk of these expenses represent start up expenses that could fairly be capitalized.

- *Assets and Liabilities*. As of December 2012, the Association had total assets of

$20,445,314, with $19,135,756 in cash and investments and $1,303,557 in premium receivable. The Association had total liabilities of $16,560,327, including $11,504,619 in claims payable and $5 million in claims incurred but not reported ("IBNR"). IBNR represents an estimate established by Milliman based on the Association's claims experience to date and other relevant data. Claims incurred and IBNR for the period are consistent with the Association's Financial Model.

- *Revenues*. The Association received $22,472,703 in revenues in calendar year 2012, of which $14,033,160 represented funds from regular market assessments and $8,176,047 represented reinsurance premiums. Total revenue for the period is slightly ahead of the Association's Financial Model, reflecting approximately $2,000,000 million in excess of projected regular assessment revenues.

- *Expenditures*. The Association incurred $18,587,716 in expenses for the period, of which $13,010,366 represented reinsurance claims incurred, $5,000,000 represented projected IBNR, and $577,351 represented administrative expenses. The Association's administrative expenses amounted to 2.5% of the Association's 2012 annual revenue and included legal and actuarial fees for Pierce Atwood and Milliman and administration fees for Ameriben, as well as professional liability insurance premiums, bank charges, and miscellaneous other expenses.

- *Fund Balance*. The Association's balance of funds, representing assets over liabilities and revenues in excess of expenditures, was $3,884,986 as of December 31, 2012. This is within $100,000 (and slightly ahead) of the Financial Model.

- *Ceded Lives*. Carriers had ceded a total of 3,248 lives to the Association as of December 31, 2012, of which 1,760 were voluntary cedes and 1,488 were mandatory cedes. The aggregate figure tracked closely to the Financial Model, which projected 3,042 lives for the initial year of operation, although voluntary cedes were higher and mandatory cedes lower than projected.

Solvency. The Financial Model projected a net operating gain of $3,788,472 for its first year of operation, which was determined by the Board as an appropriate buffer against variation in operating results. The Association's financial performance for the period ended December 31, 2012 closely tracks the Financial Model. To date, the Financial Model has proven to be accurate and predictive of the Association's experience over its first six months of program operation. Although the Association's operations are still at an early stage of development, the Association is solvent as of December 31, 2012, reflecting a $3,884,987 fund balance. The Board believes the Association's operational model has sufficient protections in place to assure the Association's continued solvency.

VI. FEDERAL TRANSITIONAL REINSURANCE PROGRAM

The federal Affordable Care Act establishes a temporary uniform national reinsurance program to be operated across all 50 states in the years 2014, 2015, and 2016 (the "Federal Program"). The Federal Program will provide coverage for 80% of claims between $60,000 and

$250,000 across the entire individual insurance market, and will be funded through assessments payable by all health insurers and TPAs (including those operating in Maine) at a rate of approximately $5.25 per person per month. As a result, Maine's individual market would be subject to double assessments for overlapping reinsurance coverage if both the Association and the Federal Program operate coterminously. Accordingly, it is the Board's conclusion that Maine should only be serviced by one of these programs.

Because the Federal Program does not contain an exemption for states, such as Maine, that operate their own reinsurance program, the Board has concluded that the only reasonable alternative is to suspend operation of the Association's reinsurance program during the pendency of the Federal Program in order to avoid the cost burden associated with multiple programs and multiple assessments. The Board further believes that there is a strong likelihood that there will still be a continued need for subsidization of the individual health market in Maine following the conclusion of the Federal Program.

In light of the foregoing, the Board believes that the public interest in the State of Maine would be best served by suspending the Association's reinsurance operations during the pendency of the Federal Program. Accordingly, the Board has recommended the temporary suspension of the Association's operations effective as of the date the Federal Program commences operation in Maine (currently contemplated to be January 1, 2014) through the date the Federal Program ceases operation in Maine (currently contemplated to be December 31, 2016); provided that the Association shall retain its existing statutory authority to wind down its operations, including (i) paying reinsurance claims incurred prior to the effective date of its suspension of operations; and (ii) imposing any additional assessment necessary to fund any net losses for the period of the Association's operation pursuant to 24-A M.R.S. §3957(5).

VII. APPENDICES

A. Plan of Operation
B. Unaudited 2012 Financial Report

MAINE GUARANTEED ACCESS REINSURANCE ASSOCIATION

PLAN OF OPERATION

Effective June 12, 2012

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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 Titles 13-B and 24-A, Chapter 54-A of the Maine Revised Statutes.

ARTICLE II ASSOCIATION MEMBERS

2.1 The members of the Association (each, a "Member Insurer") 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", 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 Association pursuant to the applicable provisions of the Enabling Act.

"Association" is defined in Section 1.1.

"Board" is defined in Section 7.2.

"Board Petition" is defined in Section 14.7(d).

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

"Business Day" means any day other than Saturday, Sunday or any other day on which banks in the State of Maine are permitted or required to be closed.

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

"Ceding Records" is defined in Section 9.4(f).

"Ceding Term" is defined in Section 9.4(h).

"Claims Reports" is defined in Section 9.8.

"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.

"Dispute Notice" is defined in Section 14.7(b).

"Eligible Claims" is defined in Section 9.7.

"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).

"Executive Dispute Process" is defined in Section 14.7(b).

"Freeze Out Period" is defined in Section 9.4(h)(iii).

"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(a)(i).

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

"In-Force Book" means all medical insurance policies, as defined by 24-A M.R.S. 3952(7), that a Member Insurer has in force covering residents (as

defined by 24-A M.R.S. 2736-C(1)(C-2)) of the State of Maine, as of June 30, 2012.

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

"Insurance Code" means the Maine Insurance Code, M.R.S. Title 24-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 Chapter 83 of the Insurance Code that insures the health coverage risks of its members, the Dirigo Health Program established in Chapter 87 of the Insurance Code, 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.

"Legal Committee Hearing" is defined in Section 14.7(c).

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

"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.

"New Business Book" means all medical insurance policies, as defined by 24-A M.R.S. 3952(7), a Member Insurer sells to any Covered Person with an initial effective date on or after July 1, 2012.

"Nonprofit Act" means M.R.S. Title 13-B.

"Organizational Assessment" is defined in Section 11.1.

"Petition" is defined in Section 14.7(c).

"Quarterly Assessment Report" is defined in Section 11.6(b).

"Rating Methodology" is defined in Section 9.5(c).

"Regular Assessment" is defined in Section 11.2.

"Reinsurance Effective Date" is defined in Section 9.6(a).

"Reinsurance Program" is defined in Section 9.1.

"Reinsurance Reimbursement" is defined in Section 9.6(b) 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(h)(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 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) References to "assessment" shall refer to Organizational Assessments, Regular Assessments and Deficit Assessments, as the context requires.

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

(k) Generally, a Covered Person is "designated" for reinsurance, while a policy is "ceded," although the terms are occasionally used interchangeably in this Plan. A Covered Person designated pursuant to the provisions of Section 9.4 and those other individuals covered under the same policy may collectively be referred to as "reinsured by the Association."

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 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 under 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 assures 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 with subsections (i) and (iii) above, and any other audit-related matters the Board deems necessary.

(d) Legal Committee – The duties of the Legal Committee are to:

i. Coordinate with legal counsel, as needed, on routine legal matters relating to the Association's operations, including proposed contracts and operational practices;

ii. Be familiar with, and provide assistance to the Board concerning, litigation and other disputes involving the Association and its operations;

iii. Participate in the dispute resolution procedures set forth in Section 14.7 hereof; and

iv. Assist the Board in other legal-related matters as appropriate.

7.4 Policies. The Board 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 Member Insurers.

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 the Association.

(e) Review and duly consider 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 to the Administrator. The Administrator is responsible, together with the Board, 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 shall 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 shall 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 shall 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:

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

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

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

(iv) Assisting the Board in developing rules, protocols and other requirements associated with designation of Covered

Persons for ceding 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 such reinsurance.

(b) Management Services. The Administrator shall 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 shall 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, and 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 pursuant to policies 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 shall 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 Insurers, Member Insurers, assessments, designated lives, ceded policies, premium calculation, billing and collection and such other information as is relevant to the Association's operations.

(e) Planning and Compliance. The Administrator shall 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; and

(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 shall be responsible for assisting the Board with government and public relations. 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 maintain the confidentiality of all information pertaining to Insurers and/or Covered Persons in accordance with Section 10.1(a)(iii) herein and 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 Enabling 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, cede to the Association each insurance policy covering a designated Covered Person, and pay premiums for reinsurance of each Covered Person covered under each ceded policy, and the Association shall provide reinsurance coverage to Member Insurers for such persons, in accordance with the provisions set forth herein (the "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 in the State of Maine (each, an "Eligible Health Plan"). A copy of each new Eligible Health Plan, and each amendment, change or revision to any existing plan, shall be provided at least ninety (90) days prior to the implementation of such plan, amendment, change or revision.

9.3 Basis for Ceding.

(a) Mandatory or Discretionary. Covered Persons shall be designated for reinsurance either (i) at the discretion of the applicable Member Insurer, as more fully described in Section 10.1; or (ii) automatically and mandatorily on the basis of a Specified Condition (as defined herein), as more fully described in Section 10.2.

(b) Policy Basis. Member Insurers shall cede coverage of 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 policy covering such Covered Person are automatically, and without further action on the part of the Member Insurer (whether as a Discretionary Cede or a Mandatory Cede), included for reinsurance by the Association.

(c) Association Coverage. To the extent that any policy available to members of an association or a professional or trade group, or offered on any similar master policy basis, is eligible for reinsurance by the Association, Member Insurers shall cede such coverage on a family basis, and each covered family shall be treated as a separate policy for purposes of this Plan.

9.4 Designation for Ceding.

(a) Initial Designation.

(i) *New Business Book.* For each Covered Person insured through an Eligible Health Plan in a Member Insurer's New Business Book who is initially designated for reinsurance by a Member Insurer (whether a Mandatory 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 (a "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 (A) a completed Health Statement, to the extent available, and (B) for Mandatory Ceding, a statement from 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) *In-Force Book.*

(1) Ceding Notice for In-Force Book. For each Covered Person insured through an In-Force Book who is initially designated for reinsurance by a Member Insurer (whether pursuant to Mandatory or Discretionary Ceding), 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, and describing in such detail as the Association may require the basis for the Member Insurer's ceding decision.

(2) Mandatory Ceding. On or before October 1, 2012, each Member Insurer shall identify and designate for Mandatory Ceding each Covered Person insured through its In-Force Book who demonstrates the existence or history of a Specified Condition. In order to obtain uniformity among Member Insurers' respective procedures for identifying Covered Persons insured through an In-Force Book for Mandatory Ceding, each Member Insurer shall review each policy within its In-Force Book for, and base its Mandatory Ceding determinations on, the diagnosis code(s) associated with each Specified Condition, as provided by the Administrator. Where multiple diagnosis codes are used, this review shall include all diagnosis code fields (and not, for example, only the first one or two fields populated for a given Covered Person).

(iii) Each Ceding Notice shall list, and include any other information as the Association may request regarding, each other individual covered under the ceded policy.

(b) <u>Adding a Covered Person to an Existing Policy; Change Between Member Insurer's Plans</u>.

(i) If a Covered Person is added to an Eligible Health Plan, including as the result of such Covered Person's change from one plan offered by a Member Insurer to another plan offered by the same Member Insurer, a Member Insurer shall have the ability to designate (or redesignate, in the case of a plan change) such Covered Person for Discretionary Ceding 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. The effective date of reinsurance of such Covered Person is governed by Section 9.6(a)(6) of this Plan.

(ii) A Covered Person's change from one plan offered by the Member Insurer to another plan offered by such Member Insurer constitutes a termination of primary coverage under clause (ii) of Section 9.6(d). As such, the Member Insurer must give notice of the redesignation of such Covered Person within sixty (60) days of the effective date of primary coverage under the new plan in order to effectively designate such Covered Person for Discretionary Ceding under the new plan.

(c) Transfer from In-Force Book to New Business Book. Notwithstanding the application of the Freeze Out Period, if a Covered Person enrolls for primary coverage in an Eligible Health Plan that results in transfer of a Covered Person from a Member Insured's In-Force Book to the Member Insurer's New Business Book, 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. Mandatory Ceding under Section 10.2 shall apply to transfer of a Covered Person who demonstrates the existence or history of a Specified Condition.

(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 to a Member Insurer, a Member Insurer may designate that person for reinsurance within sixty (60) days after the date on which the Member Insurer becomes, or reasonably should have become, aware that the person should have been designated.

(e) Mandatory Cede Corrections. If at any time within 24 months following the effective date of a Covered Person's primary coverage the Association or the applicable Member Insurer determines that such Covered Person should previously have been designated for Mandatory Ceding pursuant to Section 10.2 hereof but was either (i) not designated for ceding or (ii) erroneously classified as a Discretionary Cede, then the Association may require that the Member Insurer designate such Covered Person as a Mandatory Cede and such designation shall be effective as of the effective date of the primary coverage. In such event, (x) premium for reinsurance shall accrue as of the effective date of the designation (and any accrued and unpaid premium shall be due promptly upon the corrected designation), and (y) the renewal and cancellation provisions applicable to Discretionary Cedes pursuant to Section 9.4(h) will not apply.

(f) Designation Records. Member Insurers shall establish, and maintain for seven (7) years following the date of termination of reinsurance of a Covered Person, the records governing such Covered Person's eligibility for reinsurance and the Member Insurer's determination to designate the Covered Person for reinsurance, including the Health Statements or similar questionnaires utilized by the Member Insurer, claims history, risk scores, diagnosis code analysis or any other information utilized or relied upon in making its ceding decisions (collectively, "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: Mandatory Ceding. Each Covered Person who is designated pursuant to Mandatory Ceding, and each individual covered under the same policy as such Covered Person, shall be reinsured by the Association for a period commencing on the effective date of the designation (determined pursuant to Section 9.6(a)) through the date of termination of such Covered Person's primary coverage provided by the Member Insurer, unless

such reinsurance is earlier terminated in accordance with clause (iii) of Section 9.6(d) hereof.

(h) Term of Designation; Renewal and Cancellation: Discretionary Ceding.

(i) *Term of Designation.* Each Covered Person designated for reinsurance pursuant to Discretionary Ceding shall be reinsured by the Association for a "Ceding Term," as follows:

(1) the initial Ceding Term shall consist of (x) the time from the effective date of the initial designation (determined pursuant to Section 9.6(a)) through the end of the calendar year in which the Covered Person is initially designated (*i.e.*, through December 31st of the year in which such designation is made), plus (y) one calendar year thereafter, unless such reinsurance is earlier terminated in accordance with Section 9.6(d) hereof; and

(2) each subsequent Ceding Term shall consist of one calendar year, unless such reinsurance is earlier terminated in accordance with Section 9.6(d) hereof.

(ii) *Renewal and Cancellation.* For each Covered Person designated for Discretionary Ceding, a Member Insurer shall, at the conclusion of each Ceding Term, 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 designation decision shall be binding for one calendar year (also referred to as the "Ceding Term"). For the avoidance of doubt, the provisions of this Section 9.4(h), including the renewal and cancellation

provisions of this subsection (ii), apply only to Discretionary Ceding and not to Mandatory Ceding. In the event that a Member Insurer fails to provide the required Renewal/Cancellation Notice, or omits one or more of its currently designated Covered Persons from the Notice, then the applicable designation or designations shall be deemed renewed for the ensuing calendar year.

(iii) *Re-designation; Freeze Out.* A Member Insurer shall be prohibited from designating (or re-designating, as the case may be) a Covered Person for reinsurance pursuant to Discretionary Ceding for a period of three calendar years after (x) such Member Insurer's initial determination not to designate such Covered Person for reinsurance, measured from December 31st of the year in which such determination is made; or (y) the cancellation of designation of a previously designated Covered Person pursuant to subsection (ii) above, measured from the date of the Renewal/Cancellation Notice deadline applicable to such Covered Person (in either such case, the "Freeze Out Period").

By way of illustration:

- if a Covered Person becomes covered by a Member Insurer effective September 1, 2012, and no Ceding Notice is delivered to the Association within 60 days of such date, then the last day of the Freeze Out Period applicable to such Covered Person would be December 31, 2015 (i.e., the end of the third calendar year following December 31st of 2012, the year in which the Member Insurer made the non-designation determination); and

- if a Member Insurer cancels the designation of a previously designated Covered Person in December 2013, effective January 1, 2014, then the last day of the Freeze Out Period applicable to such Covered Person would be December 31, 2016 (i.e., the end of the third calendar year following the Renewal/Cancellation Notice deadline applicable to the Member Insurer's cancellation of such Covered Person's designation).

The Freeze Out Period shall apply to the following specific circumstances as set forth below:

(1) *Non-designation determination.* Covered Person X is insured through a Member Insurer A's In-Force Book and is not required to be designated pursuant to Mandatory Ceding. Member Insurer A has until October 1, 2012 to give notice to the Administrator of a Discretionary Ceding designation of X. Member Insurer A determines not to designate X for Discretionary Ceding and, accordingly, submits no Ceding Notice with respect to X on or before the Ceding Notice deadline of October 1, 2012. Member Insurer A will be precluded from subsequently designating X pursuant to Discretionary Ceding for the duration of the Freeze Out Period, which will remain in place through December 31, 2015 (i.e., the end of the third calendar year following A's determination not to designate X, measured from December 31 of the year of non-designation). If X were insured through a New Business Book, the same analysis would apply.

(2) *Enrollment in new plan.* Member Insurer A cancels the Discretionary Ceding designation of Covered Person X on December 1, 2013, effective January 1, 2014. The applicable Freeze Out Period is scheduled to remain in place through December 31, 2016. X enrolls in a new plan offered by Member Insurer A, effective January 1, 2015. The Freeze Out Period continues to apply to preclude A's Discretionary Ceding designation of X through December 31, 2016, after which A is free to redesignate X for Discretionary Ceding on a going-forward basis.

(3) *Change in carrier.* Member Insurer A cancels the Discretionary Ceding designation of Covered Person X on December 1, 2013, effective January 1, 2014. The applicable Freeze Out Period is scheduled to remain in place through December 31, 2016. One year into the Freeze Out Period, Covered Person X changes insurance carriers to Member Insurer

B, effective January 1, 2015. No Freeze Out Period applies with respect to B's ability to designate X upon X's enrollment in B's plan.

(4) *Return following change in carrier.* In the scenario described in (3) above, X subsequently cancels X's enrollment in B's plan and re-enrolls for insurance coverage with Member Insurer A, effective January 1, 2016. No Freeze Out Period applies with respect to A's ability to designate X upon X's re-enrollment in A's plan (notwithstanding that the original Freeze Out Period applicable to A's ability to designate X would otherwise have continued through December 31, 2016).

(5) *Addition as Dependent under non-Freeze Out policy.* Member Insurer A cancels the Discretionary Ceding designation of Covered Person X on December 1, 2013, effective January 1, 2014. The applicable Freeze Out Period is scheduled to remain in place through December 31, 2016. X then marries Covered Person Y, who is insured under a policy offered by Member Insurer A that has been Discretionarily Ceded. X is added as a Dependent under that policy, effective January 1, 2015. The Freeze Out Period does not affect A's ability to reinsure X upon X's addition as a Dependent under the ceded policy covering Y.

(6) *Addition of qualifying Dependent.* Member Insurer A cancels the Discretionary Ceding designation of Covered Person X on December 1, 2013, effective January 1, 2014. The applicable Freeze Out Period is scheduled to remain in place through December 31, 2016. X then experiences a life event that adds as a Dependent on X's policy, effective January 1, 2015, Covered Person Z. The Freeze Out Period does not prohibit A from re-ceding X's policy (and thus reinsuring X) based on Z's profile, whether Z is a Mandatory Cede or a Discretionary Cede.

(7) *Development of Specified Condition.* Member Insurer A cancels the Discretionary Ceding designation of Covered Person X on December 1, 2013, effective January 1, 2014. The applicable Freeze Out Period is scheduled to remain in place through December 31, 2016. During the Freeze Out Period, X develops a health condition that is a Specified Condition for which Mandatory Ceding is required. The Freeze Out Period does not apply to the Mandatory Ceding designation of X.

(iv) *Carrier Ceding Responsibilities.* Each carrier designating a Covered Person for reinsurance by the Association is responsible for ascertaining and certifying to the Association that:

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

(2) 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. 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 applicable reinsurance effective date for each Covered Person.

(b) Rate Changes. The initial 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 Reinsurance Program. Thereafter, the Association shall provide at least a ninety (90) day advance notice in the event of a change in its reinsurance 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.

(c) Methodology for Determining Rates. This section describes the methodology for determining reinsurance premium rates (the "Rating Methodology"). Reinsurance premium rates shall be determined as a fixed percentage of the gross premiums charged for individual health plans offered by Member Insurers, to be set at levels that, together with other funds available to the Association, will be sufficient to meet the Association's anticipated costs. As an alternative to a single applicable percentage of underlying premiums, the Association may, in its discretion, (1) develop differential rates for policies within In-Force Books versus New Business Books and/or (2) develop a variable range of applicable percentage rates to be applied based on the structure and benefit levels of the primary Eligible Health Plans. The applicable percentage or range of percentages shall be subject to approval of the Superintendent.

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 recommendations to the Board regarding the Rating Methodology. The Board shall be required to approve any changes in the 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 may include provisions for trend which shall adjust ceding premium rates for reinsurance periods with varying effective dates.

(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 a Mandatory Cede, a Discretionary Cede, or 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 all of 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; (3) such other information as may be required by the Association; and (4) payment of the applicable premium as provided therein (collectively, an "Enrollment Report"). Because Member Insurers have 60 days after the effective date of coverage to designate a Covered Person for reinsurance, 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. 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, but not the obligation, to terminate reinsurance of any Covered Person in its sole discretion in the event premium is not paid on or before thirty (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 designated for reinsurance shall be automatically designated again without a lapse in reinsurance in the event of reinstatement. If a Covered Person terminates coverage with a Member Insurer by active lapse, the Member Insurer will notify the Administrator within sixty (60) days of the cancellation. For Covered Persons that fail to pay premiums, the Member Insurer will notify the Administrator within ninety (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 designated for reinsurance, and for each individual covered under the same policy as such Covered Person, shall be effective on the following dates ("Reinsurance Effective Date"):

(i) For a Covered Person in a New Business Book designated for reinsurance during the Transition Period, the effective date shall be the effective date of such person's coverage under the primary coverage provided by the Member Insurer for such Covered Person, but in no event earlier than July 1, 2012.

(ii) For a Covered Person in a New Business Book with a primary coverage effective date on or after January 1, 2013, the effective date shall be the same as the effective date of the primary coverage provided by the Member Insurer for such Covered Person.

(iii) For a Covered Person in an In-Force Book designated for reinsurance 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 either an In-Force Book or a New Business Book redesignated in the Renewal/Cancellation

Notice described in Section 9.4(h)(ii), the effective date shall be January 1 of each year.

(v) For a Covered Person in either an In-Force Book or a New Business Book designated for reinsurance after being added to an Eligible Health Plan providing primary coverage as described in Section 9.4(b), the effective date shall be the effective date of such Covered Person's coverage under such Eligible Health Plan.

(vi) For a Covered Person designated for reinsurance after being added to an Eligible Health Plan, which addition results in the transfer of such Covered Person from an In-Force Book to the New Business Book as described in Section 9.4(c), the effective date shall be the same date as the primary coverage in a New Business Book provided by the Member Insurer for such Covered Person.

(vii) For a Covered Person designated for reinsurance 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 Eligible Claims paid under an Eligible Health Plan with respect to a Covered Person reinsured by the Association after the Member Insurer has incurred Eligible Claims for that Covered Person under the Eligible Health Plan during the applicable calendar year in excess of $7,500, at the following rates of reimbursement (the "Reinsurance 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.

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, reimbursement shall be available only for Eligible Claims incurred by a Member Insurer on or after July 1, 2012, and only Eligible Claims incurred by a Member Insurer on or after July 1, 2012 shall be considered in calculating the claims incurred in calendar year 2012 for purposes of the retention levels set forth in Section 9.6(b).

(c) Member Insurer Payment Obligation. No Reinsurance Reimbursement shall be provided on any Eligible Claim until the Member Insurer has made actual payments on Eligible Claims in an aggregate 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 ceded policy ceases upon the earliest of (i) the first day of the next Ceding Term following the Member Insurer's non-renewal of a Discretionary Ceding designation pursuant to Section 9.4(h)(ii); (ii) the termination of such policy 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), provided, however, that reimbursement is subject to the claims submission deadlines set forth in Section 9.9.

9.7 Eligible Claims. "Eligible Claims" include only such amounts as are actually paid by a Member Insurer for benefits provided to Covered Persons reinsured by the Association with respect to claims incurred after the Reinsurance Effective Date. Eligible Claims do 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 non-medical benefits or services.

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 (i) Eligible Claims incurred, and (ii) Eligible Claims paid, by such Member Insurer during such month ("Claims Reports"):

(a) the Covered Person's name;

(b) the Covered Person's identification 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.

9.9 Claim Submission Deadlines. Except as otherwise approved by the Board in writing, reimbursement will be provided only for Reinsurance Reimbursement related to Eligible Claims incurred during the period of reinsurance coverage 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 covering the period from July 1, 2012 through October 1, 2012 with respect to Covered Persons from an In-Force Book designated for ceding 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, the 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 (1) to inspect the records of the Member Insurer in connection with the risks reinsured by the Association and (2) to request Member Insurers to provide to the Association records, data, or other information relevant to the operation of 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 or otherwise in connection with the operation of the Association. 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 designation of Covered Persons and ceding of policies, 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 day that is not a Business Day, in which event the period runs until the end of the next day which is a Business Day.

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 Discretionary Ceding: Health Statement; Other Basis. Designation of a Covered Person pursuant to this Section 10.1 is referred to herein as a "Discretionary Cede" or "Discretionary Ceding," as applicable. Discretionary Ceding determinations may be made by Member Insurers on the basis of any reasonable means of determination, including, but not limited to, information contained in a Health Statement submitted by a Covered Person, the Covered Person's claims history or any risk scoring methodology.

10.2 Mandatory Ceding: Specified Conditions List.

(a) Mandatory Ceding. 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 and mandatorily designated for reinsurance by the Association ("Specified Condition(s)"). Member Insurers shall exercise a reasonable level of care and make diligent inquiry in identifying Specified Conditions, and shall designate any Covered Person who demonstrates the existence or history of any Specified Condition, whether discovered by the Member Insurer through the completion of the Health Statement, through claims history or risk scores or through review of diagnosis codes associated with each Covered Person to identify any diagnosis codes associated with Specified Conditions, as provided by the Administrator. The designation of Covered Persons pursuant to this Section is referred to herein as "Mandatory Cede" or "Mandatory Ceding," as applicable.

(b) Development of Specified Conditions. In the event that a Covered Person, who is either (i) not designated or (ii) classified as a Discretionary Cede, demonstrates the existence or history of a Specified Condition that was not previously in evidence, such Covered Person shall be designated for Mandatory Ceding effective upon the commencement of the next Ceding Term following the appearance of such Specified Condition. Any such Mandatory Ceding designation of a Covered Person due to a newly-developed (or newly-demonstrated) Specified Condition shall be communicated to the Association not later than the applicable deadline for receipt of a Renewal/Cancellation Notice for the next Ceding Term.

10.3 Health Statement. A Member Insurer is permitted, but not required, to use a Health Statement (as described herein) for guidance in making Discretionary Ceding determinations. The Health Statement will also serve as a means, but not the exclusive means, of identifying Specified Conditions for purposes of Mandatory Ceding.

(a) Development and Use. The Board shall develop, and may at its discretion 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"). A Member Insurer shall require a completed Health Statement in order for an application for coverage to be considered complete. Member Insurers may require an updated 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 pursuant to Section 9.4(h)(ii) hereunder. Notwithstanding anything contained herein to the contrary, a Member Insurer is not required to use a Health Statement as the basis, or as the sole basis, for Discretionary Ceding determinations.

(b) Prohibition on Denial of Coverage. A Member Insurer may not deny coverage or refuse to renew or cancel an Eligible Health Plan on the basis of a Covered Person's complete or incomplete Health Statement, claims history or risk scores or on the basis of any omission of material information from a Health Statement or misrepresentation of such Covered Person's health status. The rejection of an application for coverage as incomplete because a Covered Person has not submitted a completed Health Statement is not a denial of coverage for purposes of this prohibition.

(c) Confidentiality of Information. Protected health information included in a Health Statement submitted to the Association that is covered by the federal Health Insurance Portability and Accountability Act of 1996 or covered by Chapter 24 of the Insurance Code, remains confidential and is not open to public inspection. In addition to the foregoing, all information (whether protected health information or otherwise, and whether or not included in a Health Statement) that is required to be maintained as confidential, protected, or otherwise subject to statutory safeguards pursuant to Chapter 24 of the Insurance Code shall be so maintained.

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 resident in the State of Maine 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, Regular 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. When such an assessment payment is due, each Insurer shall submit to the Association (i) the calculation of the assessment applicable to such Insurer, together with (ii) the payment required under Sections 11.2 or 11.3 above, as applicable, and (iii) a certification by an authorized officer of the Insurer that all self-reported enrollment data, if any, has been prepared consistent with the basis, reporting methodology, and sources used by such Insurer to calculate enrollment data for purposes of reporting to the Superintendent pursuant to the provisions of the Insurance Code. 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. Notwithstanding the self-reporting process described herein, the Association reserves the right to undertake such billing and collection measures or activities as the Board may deem appropriate and nothing set forth herein shall be construed as limiting that authority.

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, except with respect to coverage of Maine state legislators and their dependents.

11.6 Determination and Payment of Assessments.

(a) Basis. 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.

(b) Calculation of Assessments. For purposes of calculating their Regular Assessments, Insurers shall report to the Association their Covered Person enrollment (determined on a basis consistent with Section 11.6(f) below) within thirty (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

enrollment information shall also be used for calculation of Deficit Assessments payable by Insurers if, as and when Deficit Assessments are declared by the Association.

(c) Third Party Administrator Enrollment and Assessment Determination. In the event a Third Party Administrator demonstrates to the Administrator's satisfaction that it is unable to determine the actual number of Covered Persons enrolled in a self-insurance program or plan administered by the Third Party Administrator with reasonable effort, then the Administrator may, in its discretion, calculate, and allow the Third Party Administrator to calculate, its enrollment and the resulting assessment based on an estimated average number of covered persons per employee enrolled in the plan or program, based on such actuarial analysis as the Administrator deems necessary or appropriate to make such determination.

(d) Assessment Payments. Regular and Deficit 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 an Insurer's enrollment and make appropriate adjustments in the amount of Regular Assessments and/or Deficit Assessments.

(e) Verifying Enrollment. 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 enrolled with an Insurer if a specific number is not reported, including, without limitation, the Insurer's enrollment as reported to the Bureau of Insurance pursuant to Rule 945. 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 extrapolate its enrollment based on such other data as the Board may deem appropriate.

(f) Determining Enrollment: Special Provisions. 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 a given 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.

(g) Responsibility for Paying Assessments. As between an insurance carrier that insures a Covered Person and a Third Party Administrator that administers such insurance (or provides any related service) with respect to such Covered Person on behalf of such insurance carrier, the payment of Regular Assessments and Deficit Assessments based on the coverage of such Covered Person shall be the responsibility of the insurance carrier, unless the insurance carrier and the Third Party Administrator agree otherwise (and provided that the assessment is paid on a timely basis). The carrier and the Third Party Administrator shall be responsible to coordinate their respective responsibilities with respect to payment and self-reporting to assure timely reporting and payment in accordance with this Plan.

11.7 Late Payment of Assessments. 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 XI. 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 the Insurance Code 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 11.10, "future losses" includes reserves for IBNR.

11.11 Federal Funds to Reduce Assessment. The Board shall comply with § 3957(9) of the Enabling 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 thirty (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 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, 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 XIV 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 eighteen percent (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 below.

14.7 Dispute 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 (a "Dispute Notice"). The executive of the Administrator and counsel for the Association shall meet with authorized representatives of the Member Insurer within thirty (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 thirty (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. The Legal Committee shall provide notice of its determination regarding the dispute within fifteen (15) days after the Legal Committee Hearing.

(d) In the event the dispute has not been resolved within thirty (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 forty-five (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 the hearing. The Board shall provide notice of its determination regarding the dispute within thirty (30) days after the hearing, which determination shall be final and binding.

(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) of this Section 14.7 are pending and for fifteen (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(h)(ii) is the annual notification by a Member Insurer of the Covered Persons designated for ceding for the applicable year, and termination of reinsurance for any formerly designated Covered Persons withdrawn from the Reinsurance Program for that year, pursuant to Discretionary Ceding.

(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 11.6(b) 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; and

(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

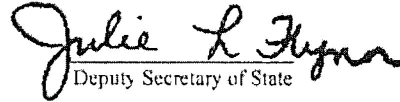
ARTICLES OF INCORPORATION

DOMESTIC
NONPROFIT CORPORATION

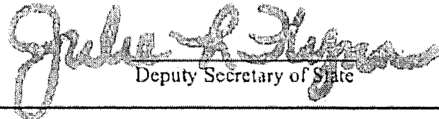
STATE OF MAINE

ARTICLES OF INCORPORATION

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


Deputy Secretary of State

A True Copy When Attested By Signature


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

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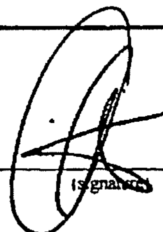
Incorporators*



(signature)

Christopher E. Howard
(type or print name)

Dated January 20, 2012

Street 89 Whites Point Road
(residence address)

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

(signature)

(type or print name)

Street
(residence address)

(city, state and zip code)

(signature)

(type or print name)

Street
(residence address)

(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. <u>Permissive Indemnification of Employees and Agents</u>. 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. <u>Permissive Advances for Employees and Agents</u>. 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.

Monthly Operations Report

December-12

MGARA
Balance Sheet
as of 12/31/2012

	2012
Assets	
Cash/Investments (Note 1)	$19,135,756
Assessment Receivable	0
Accrued Investment Interest Receivable	0
Allowance for Bad Debts	0
Premium Receivable	1,303,557
Grant Receivable	0
Claims Receivable	0
Prepaid Expenses	6,000
Total Assets	$20,445,314
Liabilities	
Accounts Payable (Note 2)	55,708
Claims Payable	11,504,619
IBNR Liability	5,000,000
Deferred Assessment Liability	0
Line of Credit	0
Total Liabilities	16,560,327
Fund Balance	$3,884,986

Statement of Revenues and Expenditures
For the 12 Months Ending December 31, 2012

	Current Month	YTD 2012
Revenues		
Organizational Assessment	$0	$263,496
Regular Assessment	$8,968	$14,033,160
Additional Assessment	$0	
Premiums	1,542,901	8,176,047
Grant Income	0	0
Gain on Investments	0	0
Penalty Income	0	0
Interest Income	0	0
Misc Income	0	0
Total Income	1,551,869	22,472,703
Total Income excluding Assessments and Grants		8,176,047
Expenditures		
Claims Incurred	9,325,297	13,010,366
Change in IBNR	5,000,000	5,000,000
Administration Fees	28,984	181,040
Interest Expense	0	0
Professional Fees (Note 3)	2,050	376,441
Insurance Expense	0	11,430
Bank Charges	0	3,260
Other Expenses	1,874	5,180
Total Expenses	14,358,205	18,587,716
Revenues excluding Assessments and Grants in Excess of Expenditures	-12,815,304	-10,411,670
Revenues in Excess of Expenditures/ (Expenditures in Excess of Revenues)	$-12,806,336	3,884,986
Fund Balance - Beginning		0
Fund Balance - Ending		$3,884,986

MGARA
Statement of Changes in Fund Balance
as of 12/31/2012

Notes to Financial Statement

Note 1: Schedule of Cash/Investments

Key Bank	$ 1,635,756.12
Key Bank Investments	$ 17,500,000.00
	$ 19,135,756.12

Note 2: Schedule of Accounts Payable

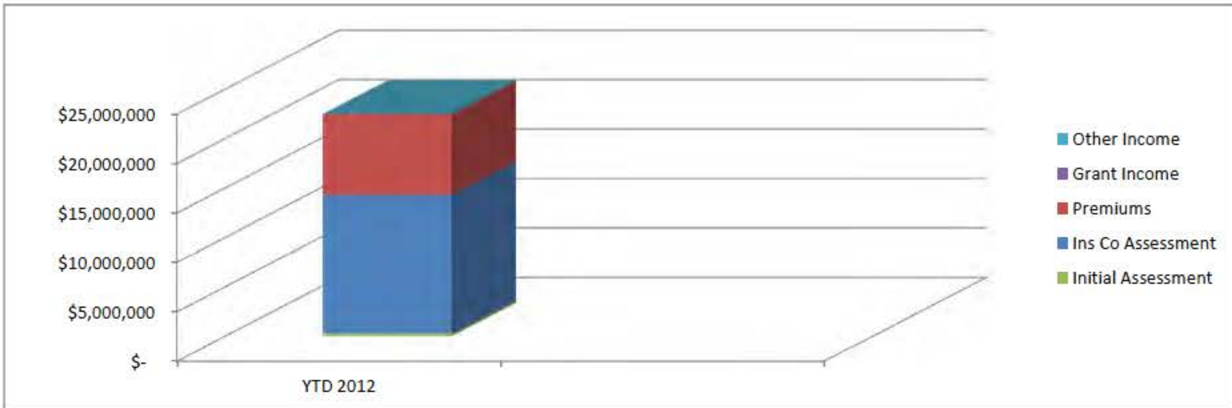
Administrative fees	$ 51,784.00
Professional Fees	$ 2,049.90
Insurance Expense	$ -
Investment Fees	$ -
Interest	$ -
Other Expenses	$ 1,874.30
Total Accounts Payable	$ 55,708.20

Note 3: Professional Fees Expense

	Current Month	Year to Date
Actuarial	$ 1,325.00	$ 134,279.98
Legal	$ 724.90	$ 242,160.37
Accounting	$ -	$ -
Investment	$ -	$ -
Miscellaneous Expense	$ -	$ -
	$ 2,049.90	$ 376,440.35

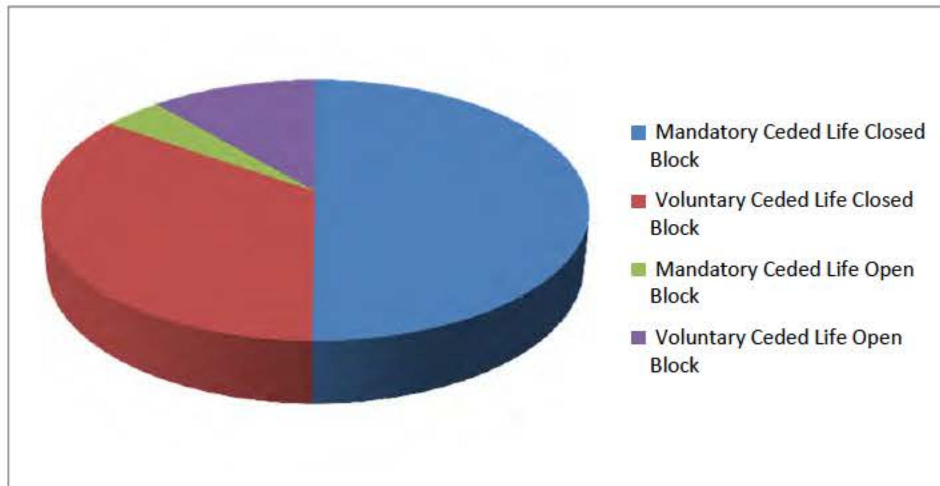
MGARA
Supplemental Information
12/31/2012

	Initial Assessment	Ins Co Assessment	Additional Assessment	Premiums	Grant Income	Other Income	Total funding
YTD 2012	$ 263,496	$ 14,033,160	$ -	$ 8,176,047	$ -	$ -	$22,472,703



MGARA
Supplemental Information
Ceded Risks by Plan
Information provided through December 31, 2012

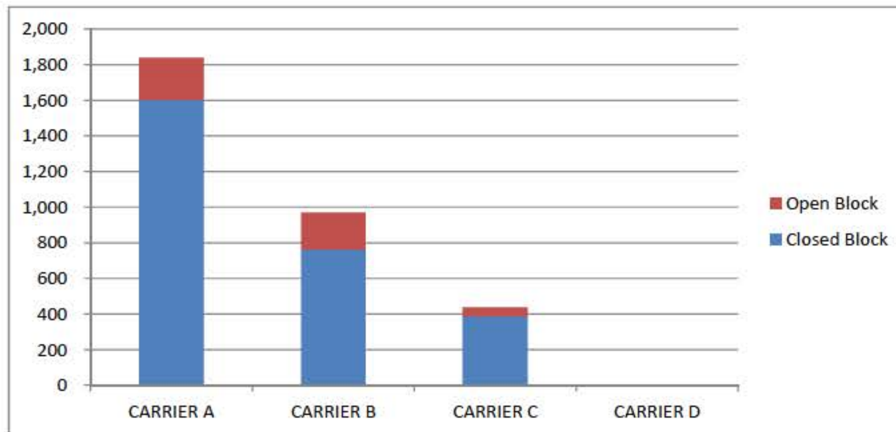
	POOL	PRIOR REPORT TOTAL LIVES	ADDS CUR MONTH	TERMS CUR MONTH	TOTAL LIVES
M-IN	Mandatory Ceded Life Closed Block	1,654	28	52	1,630
V-IN	Voluntary Ceded Life Closed Block	1,138	7	23	1,122
M-NEW	Mandatory Ceded Life Open Block	226	27	123	130
V-NEW	Voluntary Ceded Life Open Block	207	176	17	366
	TOTAL CEDED RISKS	3,225	238	215	3,248



MGARA
Supplemental Information
Ceded Risks by Carrier
Information provided through December 31, 2012

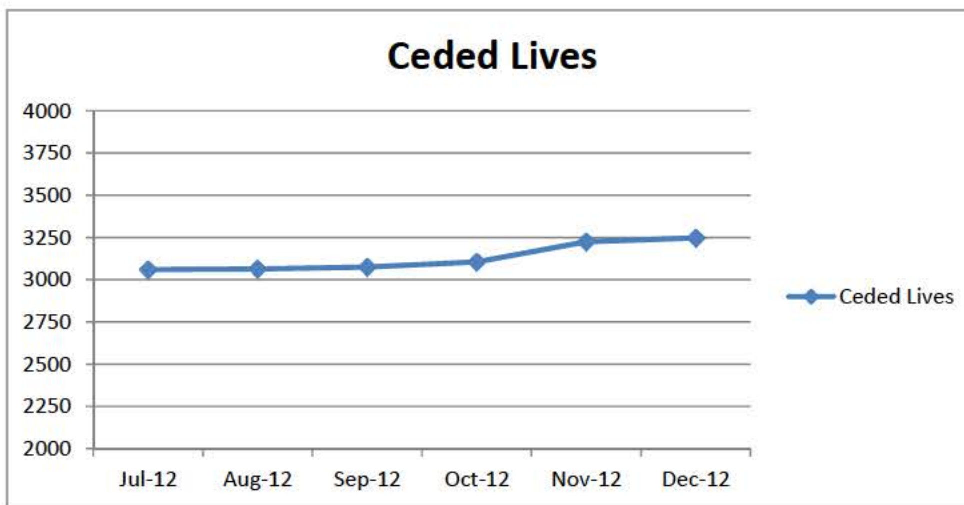
MGARA

POOL	CARRIER A -001 TOTAL LIVES	CARRIER B -002 TOTAL LIVES	CARRIER C -003 TOTAL LIVES	CARRIER D -004 TOTAL LIVES	TOTAL LIVES
Closed Block	1,602	761	387	2	2,752
Open Block	236	209	51	0	496
TOTAL CEDED RISKS	1,838	970	438	2	3,248



MGARA
Supplemental Information
Ceded Lives

Month	Ceded	Terminated	Net	Inforce
Jul-12	3060	0	3060	3060
Aug-12	76	72	4	3064
Sep-12	109	98	11	3075
Oct-12	231	200	31	3106
Nov-12	335	216	119	3225
Dec-12	238	215	23	3248



Claims over
$ 100,000.00

MGARA
Large Claims Report

CERT	Carrier	Enrollment Date	Insured Age	Insured Gender	Prior Month Claim Amount	Net Change	Current Month Claims Amt	Diagnosis	Plan	Currently Ceded
2012										
3-1	D-IN	7/1/2012	58	M	0.00	120,841.74	120,841.74	LIPIDOSES	V	Y
24-1	B-IN	7/1/2012	24	M	0.00	123,072.63	123,072.63	CONGENITAL FACTOR VIII DIS	V	N
407-2	B-IN	7/1/2012	62	F	0.00	119,758.66	119,758.66	MALIG NEOPLASM BRONCH/LUNG OTH	M	Y
616-1	A-IN	7/1/2012	67	F	0.00	101,186.67	101,186.67	MYELOID LEUKEMIA ACUTE	M	N
620-1	A-IN	7/1/2012	51	M	0.00	170,338.37	170,338.37	CONGENITAL FACTOR VIII DIS	V	Y
656-1	A-IN	7/1/2012	45	F	0.00	150,898.50	150,898.50	KIDNEY REPLACED BY TRANSPLANT	M	Y
771-1	A-IN	7/1/2012	56	F	0.00	334,790.43	334,790.43	MALIG NEOPLASM BREAST UNSP	M	Y
813-1	A-IN	7/1/2012	62	M	0.00	145,999.50	145,999.50	LYMPH LEUKEMIA CHRONIC W/O REM	M	Y
868-1	A-IN	7/1/2012	64	F	0.00	102,525.53	102,525.53	INFANTILE CEREBRAL PALSY	M	N
878-1	A-IN	7/1/2012	65	M	0.00	153,097.00	153,097.00	OTH FORMS CHRONIC ISCHEMIC HEA	M	Y
918-4	A-IN	7/1/2012	8	F	0.00	171,192.34	171,192.34	CONGENITAL ATRESIA LARGE INTES	M	Y
936-2	A-IN	7/1/2012	62	F	0.00	113,248.84	113,248.84	MALIG NEOPLASM BREAST UNSP	M	Y
1129-1	A-IN	7/1/2012	61	F	0.00	105,241.09	105,241.09	MALIG NEOPLASM BLADDER UNSP	M	Y
1427-1	A-IN	7/1/2012	65	M	0.00	175,377.43	175,377.43	METHICILLIN SUSCEPT STAPH SEPT	M	Y
1437-2	A-IN	7/1/2012	55	M	0.00	102,783.10	102,783.10	MALIG NEOPLASM UPPER LOBE LUNG	M	Y
1514-1	A-IN	7/1/2012	63	F	103,116.74	120,813.84	223,930.58	MALIG NEOPLASM COLON	V	Y
1620-2	C-IN	7/1/2012	55	M	0.00	114,223.96	114,223.96	SUBARACHNOID HEMORRHAGE	M	Y
1631-1	C-IN	7/1/2012	58	F	0.00	134,036.27	134,036.27	MALIG NEOPLASM BREAST CENTRAL	M	Y