STATE OF MAINE
DEPARTMENT OF ADMINISTRATIVE AND FINANCIAL SERVICES
BUREAU OF GENERAL SERVICES

In Re: Health Insurance Services RFP # 200909526	)	**PROPOSED FINDINGS OF FACT AND CONCLUSIONS OF LAW**

NOW COMES Harvard Pilgrim Health Care ("HPHC") and, pursuant to the Hearing Officer's request, hereby submits its Proposed Findings of Fact and Conclusions of Law.

INTRODUCTION

After evaluating the proposals received in response to the above-referenced RFP, the Dirigo Health Agency (the "Agency") awarded the contract to HPHC. The unsuccessful bidder, Celtic Insurance, appealed. Celtic's appeal was limited to the issues raised in its appeal letter. (*February 2, 2010 Order of Hearing Officer and Agency Exhibit 27*) In its appeal letter, Celtic characterized its appeal as involving three distinct issues. However, in essence, Celtic's appeal involves one issue: Celtic contends that it should not have been penalized for providing confusing and inconsistent information in its proposal, which prevented the Agency from understanding Celtic's proposed plan designs and further resulted in the Agency's inability to confirm Celtic's reported actuarial values.

As explained below, Celtic's appeal is without merit. Simply put, Celtic's proposal initially failed to provide basic information requested in the RFP. Then, in an attempt to fix it, Celtic provided inconsistent and inaccurate information to the Agency in response to clarifying questions and was unable to reconcile the conflicting information during finalist interviews. More specifically, Celtic provided plan design information in four different sets of documents, and those four sets of documents conflicted with one another. (*Compare Exhibits C, D, E, and F attached hereto*) It was therefore impossible for the Agency to understand what Celtic was proposing. HPHC, on the other hand, provided accurate, complete, and easy-to-understand plan design information in accordance with the RFP. As a result, the Agency could determine HPHC's proposed plan designs and HPHC won the award.

Faced with an, at best, confusing and, at worst, non-responsive proposal, it was entirely consistent with express provisions of the RFP and well within the discretion of the Agency reviewers to penalize Celtic and, under the applicable standard of review, Celtic has not overcome the presumption that the Agency's award was valid and not arbitrary or capricious. Moreover, the only thing that would be fundamentally unfair would be to give Celtic yet another chance to correct its deficiencies in the competitive bidding process through this appeal process. The RFP and competitive bidding process place a premium on responsiveness and accuracy within certain deadlines and Celtic failed to satisfy these requirements through its own action and inaction, not because of some kind of unfairness in the process.

FINDINGS OF FACT

The RFP Requirements

The Dirigo Health Board directed the Agency to expand the availability of the Dirigo Health insurance product to the uninsured market with existing resources. Thus, on October 5, 2009, the Agency issued an RFP designed to elicit two proposals: (1) a so-called Status Quo ("SQ") plan and (2) an Alternate plan. For the SQ plan, the Agency sought proposals to administer the Dirigo Health insurance product with its current benefit design. With the Alternate plan, however, the Agency sought proposals for six (6) benefit designs that could be priced to expand access with existing resources. To expand access with existing resources, health plans generally must offer lower premiums. To offer lower premiums, plans generally increase patient out-of-pocket expenses or decrease coverage, or a combination of both. Therefore, to make sure it understood what plan designs it was purchasing, i.e., the deliverables, the Agency required bidders to submit six (6) complete benefit plan designs for the Alternate plan.

More specifically, the RFP required bidders to "provide plan designs that meet an aggregate target revenue PMPM of $509.96." (*Agency Exhibit 1*) "Plan design" is a term of art in the health insurance industry and means the basic information necessary to understand the benefit plan; for example, coverage limitations, in and out-of-network coinsurance, co-pays, or deductibles, and out-of-pocket maximums.[1] To make sure bidders provided this basic information, the Agency included Bid Form 2 in the RFP. (*See Exhibit A, attached hereto for*

[1] This is the same basic information anyone would need in order to choose between health plans offered through their employer.

ease of reference) Bid Form 2 required bidders to provide all of the basic plan design information, including deductible and co-pay information, covered services, and any plan limitations. In addition, Bidders were encouraged to provide a Summary of Benefits ("SOB") document, which is a standard document in the industry that describes a plan's benefit design. Finally, the RFP contained Bid Sheets with instructions describing how to complete the sheets and what additional information to include. (*See Exhibit B, attached hereto for ease of reference*) Consistent with the requirement to submit a proposal with six (6) plan designs, the RFP contained six (6) bid sheets for the Alternate plan, and instructed bidders to:

> [P]lease submit a methodology write-up that corresponds to the bid form. The write-up should include sources of data, populations used to develop rates, nature of each adjustment and methodology for calculating them.

Testimony at the hearing established that this is also referred to as an actuarial memorandum.

In addition to the instructions on Bid Form 2 and on the Bid Sheets, the RFP contains the following important provisions quoted in relevant part below:

> **Section 2.1 General Instructions**
>
> Proposals must conform to mandatory requirements, instructions, and conditions of the RFP.
>
> **Section 2.9.1 Submission of Proposals**
>
> Emphasis should be concentrated on conformance to the RFP instructions, responsiveness to requirements, and completeness and clarity of the content. If the Bidder's proposal is presented in a fashion that makes evaluation difficult and overly time-consuming, points will be sacrificed in the evaluation process. (*Emphasis added*)
>
> **Section 3.5.1 Target PMPM**
>
> Bidders must provide plan designs that meet an aggregate target revenue PMPM of $509.96
>
> **Section 4.1 Compliance and Full Disclosure**
>
> Failure to provide required assurances and/or to disclose any of the information required in this RFP may result in disqualification of the Bidder or cancellation of award.
>
> To be considered for award, the Bidder must address all applicable RFP specifications to the Agency's satisfaction. If required by the Agency, the Bidder must provide the Agency with information necessary to validate any statements made in its Proposal. ... If any

requested information is not provided within the timeframe allotted, the associated Proposal may be rejected.

The RFP Process

A bidder's conference was held on October 16, 2009, and both Celtic and HPHC participated. There were at least two rounds of formal questions and answers, where bidders were given the opportunity to ask any clarifying questions about the RFP and the DHA data book. Celtic participated in both Q & A's and, among other answers, was provided claims and experience data for Dirigo Health members.[2] (*Agency Exhibits 10 and 11*) The Agency provided bidders with Clarification Questions. (*Agency Exhibit 18*) Finally, bidders were given topics and questions for finalist interviews. (*Id.*) Thus, bidders had multiple opportunities to ask questions to ensure they understood the RFP and to ensure their proposal was responsive to the RFP.

Celtic's Proposal and its Attempts to Provide Missing Information and to Clarify Confusing Information

Celtic's proposal, as submitted, was non-responsive to the RFP in two key respects. First, it did not include out-of-pocket-maximum information for the Alternate plans.[3] Celtic's witness admitted at hearing that Celtic's Bid Form 2 did not include this important limitation information as required by the RFP. (*See Exhibit C, attached hereto for ease of reference*) Thus, while the Agency could determine the deductible and coinsurance amount, it could not determine the maximum amount an insured would pay out-of-pocket in a year. This is basic information anyone evaluating a health plan would need to know and the Agency rightly required it. Secondly, in response to the request for a memorandum explaining the methodology for calculating rates, Celtic only provided a footnote consisting of four short sentences that did not respond to the Agency's questions. (*See Exhibit D, at p. 4, attached hereto for ease of reference*) In addition, Celtic's proposal was confusing because it noted on the rate sheets the same deductible level ($2,500) for three of the six requested Alternate plans, even though the actuarial values for each differed. (*See Exhibit D, at pp. 4-6*) For the Agency (and insurance industry

[2] Celtic claims in its appeal letter and implied at hearing that HPHC had information as the incumbent bidder that Celtic did not have. This is not true. HPHC received requests from the Agency for additional claims and experience data related to Dirigo Health members, and HPHC supplied the requested information. This information was ultimately requested by Celtic. The Agency updated the DHA Databook with the data supplied by HPHC and Celtic therefore had access to the same data as HPHC. (*Agency Exhibits 10 and 11*)

[3] A health insurance policy's out-of-pocket-maximum is the limit on the total coinsurance and deductible an insured would pay in any calendar year.

professionals generally), a different actuarial value would indicate a different benefit design. As such, if the deductibles were the same, some other element of the plan design would need to be different in order for the plan designs to have different actuarial values. However, Celtic's Bid Form 2 indicated that the only variation in the plan designs was the deductible and all other benefits were the same. (*See Exhibit C*)

Rather than reject Celtic's proposal, which the Agency had the authority to do under the RFP,[4] the Agency requested additional information from Celtic through "Clarifying Questions." Specifically, the Agency asked Celtic to "[p]lease provide plan design descriptions for your alternative plan proposals, including: a. Out of pocket structure b. Deductibles c. Coinsurance." Essentially, in terms of plan design the Agency said "do it again." In addition, the Agency asked for an actuarial memorandum because Celtic's four sentence footnote was inadequate to understand Celtic's rate calculation methodology.

Celtic responded to the Clarifying Questions with, among other items, an "Attachment A," which purported to be Summary of Benefits for the "Status Quo and Alternate Plan," and an "Attachment C," which purported to be an Actuarial Memorandum. (*See Exhibits E and F, attached hereto for ease of reference*) Celtic's efforts to clarify its proposal, however, actually had the effect of further confusing the Agency because the SOB's at Attachment A were inconsistent with what Celtic had originally proposed at Bid Form 2. For example, Bid Form 2 describes deductible levels of $1,250, $2,500, and $5,000, whereas the SOB's at Attachment A describes deductible levels at $1,200, $1,750, and $2,500. (*compare Exhibit C to Exhibit E*) In addition, the Actuarial Memorandum made clear to the Agency that Celtic's actuary had not developed six premium rates for six plan designs as instructed by the RFP. Rather, the Celtic actuary had developed twenty premium rates based on twenty plan designs. As a result, the Agency could not determine how Celtic blended twenty separate rate structures into six because Celtic submitted six premium rates for the Alternative option (since only six bid sheets were provided). In short, the Agency asked for six plans, the actuary priced twenty, then somehow shoehorned the twenty rates into the six bid forms, but did not provide details to explain how he

[4] The RFP at Section 4.1 states in relevant part: "Failure to provide required assurances and/or to disclose any of the information required in this RFP may result in disqualification of the Bidder or cancellation of award. ... To be considered for award, the Bidder must address all applicable RFP specifications to the Agency's satisfaction. If required by the Agency, the Bidder must provide the Agency with information necessary to validate any statements made in its Proposal. ... If any requested information is not provided within the timeframe allotted, the associated Proposal may be rejected."

did this, nor did he indicate what six benefit designs were associated with the final six premium rates. In essence, the actuary answered a different question than what was asked by the RFP and the Clarifying Questions.

In yet another attempt to understand Celtic's proposal, the Agency asked Celtic representatives to explain its proposal at the finalist interview. Despite being put on notice to have actuarial resources available, Celtic chose not to have the actuary who developed the memorandum present, and Celtic was unable to otherwise explain what they had proposed in terms of actual plan designs. As such, the Agency was unable to determine what Celtic proposed for the six Alternate plans and, therefore, unable to calculate the actuarial value of the actual plans.

CONCLUSIONS OF LAW

A. Governing Law and Standard of Review

The issue in this case is whether Celtic has met its burden of proof by clear and convincing evidence that the Agency's award of the contract to HPHC (1) was in violation of law; (2) contained irregularities that created a fundamental unfairness; or, (3) was arbitrary and capricious. *See* 18-554 C.M.R. Ch. 120, §§ 3(2), 4(1). The "clear and convincing evidence" standard of proof requires the Panel to be convinced that it is highly probable that the award was illegal, unfair or arbitrary or capricious.[5]

To invalidate the contract award because of irregularities creating a fundamental unfairness, the Appeal Panel must find an irregularity so basic that it would be inequitable to uphold the award decision. *See Id.* Arbitrary and capricious conduct by an agency is defined as "willful and unreasoning action, without consideration of facts or circumstances." *Help-U-Sell, Inc. v. Maine Real Estate Commission*, 611 A.2d 981, 984 (Me. 1992). When applying the arbitrary and capricious standard, the Appeal Panel "must not substitute its judgment for that of the [Agency's bid review] Committee."[6] Moreover, "[t]here is a presumption that the agency's actions were not arbitrary or capricious." *Id., citing Central Maine Power Co. v. Waterville Urban Renewal Auth.*, 281 A.2d 233, 242 (Me. 1971). Thus, the Appeal Panel is required to begin its review of the Agency's contract award with the presumption that the award was valid.

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[5] *See* Decision of Bid Appeal Panel, Conley's Garden Center Appeal of Award: Marine Resources—Landscaping, February 28, 2007 (*citing Dubois v. Madison Paper Co.*, 2002 ME 1 ¶¶ 10, 11, 795 A.2d 696, 699.).

[6] *See* Decision of Bid Appeal Panel, In re: Air and Water Quality, Inc., August 25, 2006, *citing International Paper Co. v. Board of Envt'l Protection*, 1999 ME 135, ¶ 29, 737 A.2d 1047, 1054.

B. Celtic Initially Failed to Provide Basic Information Required by the RFP and Subsequently Provided Inconsistent and Confusing Information that was Appropriately and Fairly Scored by the Agency Reviewers

The RFP provisions quoted above require bidders to submit proposals that conform to the RFP in a complete and clear manner. Bidders were required to submit complete benefit plan designs. Further, bidders were required to submit any additional information requested by the Agency to verify the proposals in the same complete and clear manner. Failure to submit a proposal in a complete and clear manner can result in rejection of the proposal at worst, and, at best, a loss of points. This is not surprising in a competitive bidding process—mistakes cost you.

1. Celtic's Proposal was Fairly and Appropriately Scored by the Agency Reviewers in Light of the Requirements of the RFP

Celtic's proposal fares poorly when considered in light of the provisions in the RFP. Its original submission failed to provide basic information required by the RFP. Specifically, Celtic failed to provide the out-of-pocket maximum required by the RFP at Section 3.5.1 and Bid Form 2, and also failed to provide an explanation of the rate methodology as required by the Bid Sheet instructions. This, in itself, would have been grounds for rejection of its proposal. The Agency determined, however, to give Celtic another bite at the apple through clarifying questions. Rather than clarify the proposed plan designs, Celtic's response made matters worse. As the Agency's actuary, Ms. Bela Gorman, testified, she "was left to guess" what Celtic proposed for plan designs because the newly provided Summary of Benefit documents were inconsistent with the originally provided Bid Form 2. (*Compare Exhibit C to Exhibit E*) The Agency's Executive Director, Ms. Karynlee Harrington, testified that, with over thirteen years (13) of experience in health insurance, she also could not understand what Celtic had proposed. At a very basic level, the deductibles did not match. What is more, the Actuarial Memorandum was inconsistent with the Summary of Benefits[7] provided by Celtic in its response to clarification questions. Again, the deductibles did not match. (*Compare Exhibit E to Exhibit F*) Thus, Celtic's response to clarifying questions was inconsistent with what Celtic had originally proposed and also internally inconsistent.

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[7] The label on these Summary of Benefit forms, "Status Quo and Alternative Plan", is confusing and problematic in itself. The Agency asked for two overall proposals: (1) a status quo and (2) an alternate plan that would expand coverage by offering a less rich benefit at a lower price. Celtic's response is inconsistent with this RFP construct because it appears to combine plan designs for status quo and alternate. (*See Exhibit E*)

Tellingly, at hearing Celtic did not offer a single witness to explain the discrepancy between the Summary of Benefit documents provided, as compared to the original Bid Form 2 and the Actuarial Memorandum. When asked, the Milliman Actuary, Mr. Keizur, stated that he did not prepare the Summary of Benefits forms attached hereto as Exhibit E. He also stated that he did not really review them in performing his work. The only other Celtic witness, Mr. Jones, testified that he looked at the documents "at a high level," and did not attempt to reconcile the original Bid Form 2 with the supplemental Summary of Benefit forms and Actuarial Memorandum. This was Celtic's fatal error. Apparently no one at Celtic was charged with ensuring that all of the information provided tied together so that the Agency could determine what plan designs it would be purchasing. At the end of the day, the Agency had to understand what exactly it would be buying and it could not determine this from Celtic's initial or subsequent information.

Faced with this problem, Celtic concentrated substantially all of its testimony and cross examination at hearing on attempting to reconcile Bid Form 2 with the Actuarial Memorandum. Celtic's basic argument seems to be that, if you ignore the SOB documents we submitted, and just refer to the original Bid Form 2 and the supplemental Actuarial Memorandum, then you should be able to figure out what we proposed for plan designs and then calculate the Actuarial Value. Putting aside for a moment that this argument does not speak to whether the award (1) was in violation of law; (2) contained irregularities that created a fundamental unfairness; or, (3) was arbitrary and capricious, the problem with that argument, of course, is that it is not up to the Agency to pick and choose between conflicting information submitted by a bidder. Rather, the burden is on the bidder to provide all information responsive to the bid in a clear and complete manner. Indeed, as provided in the RFP at Section 2.9.1, "[i]f the Bidder's proposal is presented in a fashion that makes evaluation difficult and overly time-consuming, points will be sacrificed in the evaluation process." In accordance with Section 2.9.1 and their inherent discretion with scoring, the Agency reviewers penalized Celtic for not providing information in a clear manner, and it was not a violation of law, fundamentally unfair, or arbitrary or capricious for the Agency to adhere to Section 2.9.1 when it scored Celtic's proposal.

Accordingly, Celtic has not met its burden, and the award to HPHC should be upheld.

2. The Agency Cannot Infer from a Bidder's Conflicting Information and Celtic Cannot Complain After Multiple Bites at the Apple

In addition to its attempt to have the Panel ignore the SOB's it provided, Celtic elicited a lot of complex testimony at the hearing about Actuarial Value. Again, Celtic apparently takes the position that, although there were problems with their proposal, if you ignore certain parts and use other parts, then you can calculate Actuarial Value. This argument misses the mark and makes this case out to be more complex than it is. The problem with Celtic's proposal is more fundamental. That is, the inability of the Agency to calculate and confirm reported Actuarial Value is the manifestation of the problem, not the problem in itself. The real problem is that Celtic was not clear in what it was proposing for plan designs. Thus, the Agency could not determine what the actuarial values provided by Celtic ultimately were for, and the Agency reviewers cannot infer what a bidder means by choosing to ignore some plan design information while using other plan design information provided by the bidder. On the contrary, this would be fundamentally unfair to all other bidders who provided clear and accurate plan design information.

Furthermore, after a second bite at the apple through clarifying questions, Celtic received a third bite at the apple during the finalist interview. Inexplicably, however, Celtic decided not to have the actuary who prepared the memorandum speak at the finalist interview. At the hearing, he testified that he was standing by on the phone, but Celtic did not call him to participate. Regardless, there is nothing fundamentally unfair about losing points for submitting confusing and inconsistent information after neglecting to submit it as required in the first place. In addition, it cannot be said that the Agency acted with willful and unreasoning action, without consideration of facts or circumstances.

Again, the Agency cannot be expected to ignore information and infer what Celtic is really proposing for the deliverables requested by this RFP. This is a competitive bidding process and bidders lose points for making mistakes.[8] Ultimately, Celtic's appeal is an attempt to get a fourth bite at the apple before this Panel, and it should be rejected and the Agency award to HPHC upheld.

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[8] In fact, HPHC believes that Celtic should not have received 14.94 points for adherence to principles because one principal is "Provide an actuarial value of at least 65%," and the Agency was unable to determine actuarial value. This type of scoring decision is similarly within the discretion of the Agency and generally not subject to review by the Appeal Panel.

CONCLUSION

Celtic has failed to meet its burden of proving by clear and convincing evidence that the award to HPHC (1) was in violation of law; (2) contained irregularities that created a fundamental unfairness; or, (3) was arbitrary and capricious. Celtic has cited no law in its appeal letter or at hearing that was allegedly violated in the award to HPHC. Thus, Celtic is apparently relying on alleged irregularities or an arbitrary or capricious award. The facts before this Panel, however, do not support such a finding.

In this case, we have one bidder, HPHC, who was responsive to the RFP and another bidder, Celtic, who initially provided incomplete information and then provided conflicting and inconsistent information concerning the primary deliverable of the RFP—the Alternate plan designs. As the bidder who provided incomplete, inconsistent and conflicting information, Celtic sacrificed points and lost the competitive bid. There is nothing fundamentally unfair or arbitrary about this result in a competitive bid process. The Agency's informed decision should not be overturned now simply because of Celtic's attempt to explain again at the appeal what it could not explain, despite multiple opportunities to do so, during the RFP process. Indeed, far from being unfair, this process gave Celtic far more opportunity than bidders would normally get, and it is remarkable that they are now asking for yet another bite at the apple.

Based on the foregoing, HPHC respectfully requests that the Panel uphold the Agency's contract award to HPHC.

Dated: February 18, 2010

Respectfully submitted,

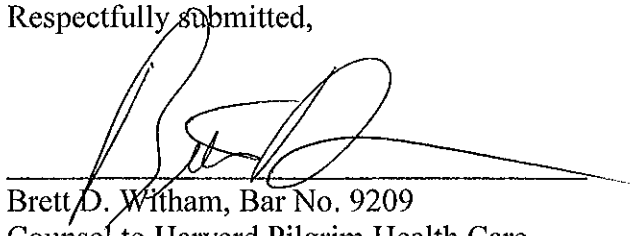

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EXHIBIT A

Bid Form 2 – Benefit Checklist

EXHIBIT A

'ructions:

1) Please provide deductible information as described in the form.
2) Please indicate services included in your proposed plan(s).
3) Please describe the service and any limitations that you apply to the service.
4) Please indicate whether a co-pay applies to the service and the amount of the co-pay.
5) Please indicate whether the service applies to the plan deductible or whether the service applies to a separate deductible.

Bidders may provide a copy of their Summary of Benefits, but must also complete this form.

Deductible

Please describe how a member with family coverage satisfies the family deductible.
Is the deductible accumulated on a plan year or calendar year basis?
Do you include a roll-over in the deductible?

Service	Included Y / N	Description and Limitations	C
Hospital Services			
Inpatient			
Outpatient			
Emergency Room Services			
`reening Mammograms			
ofessional Services			
Inpatient			
Outpatient			
Diagnostic tests, x-rays, and surgery			
Endoscopic Procedures (including Colonoscopies)			
Maternity			
Pre- & Post-natal			
Delivery			
Physician Office Visits			
Sick Care			
Specialists			
Well Child visits, immunizations, and annual routine physical exams, including any lab, x-rays, or other diagnostic procedures such as colonoscopies and mammograms ordered as part of this physicals and any subsequent procedure undertaken during the diagnostic procedure visit. This service corresponds with the Agency's principle 1, to include robust preventative benefits.			
Hearing aids			
Occupational Therapy			
Speech Therapy			
Physical Therapy			
Chiropractic Care			
Skilled Nursing Facility			
`spice			
ome Health Care			

Ambulance
Cardiac Rehabilitation
rable Medical Equipment
utine Eye Exams
glasses
ental
Prostheses (excluding limbs)
Prostheses for limb replacement
Smoking Cessation:
Smoking Cessation Program
Smoking Cessation Medications
Biologically Based Mental Illnesses including Substance Abuse services

These services correspond with the Agency's principle 2, include mental health parity.

Inpatient
Day treatment
Outpatient
Office Visits
Home Health Care Services
Non-Biologically Based Mental Illnesses:
Inpatient
Outpatient
Home Health Care Services
Prescription Drugs
Generic
Brand Name Preferred
Brand Name Non-Preferred
man Organ and Tissue Transplants
rge Case Management
Disease Management

These services correspond with the Agency's principle 1, to include disease management benefits.

Asthma
Autism
Cholesterol
Cancer
Congestive Heart Failure (CHF)
Coronary Artery Disease (CAD)
Chronic Obstructive Pulmonary Disease (COPD)
Depression
Diabetes
Eating Disorders
High-Risk Pregnancy
Hypertension
Low Back Pain
Migraines
Obesity
Cardiovascular Disease
Others (Please list)
24-Hour Nurse Line
Centers of Excellence (Describe any services that are exclusive to se Centers)

Web Tools for Member Services and Lifestyle Management
Other Utilization/Medical Management Services (Describe)
- Discharge Planning
- Retrospective Reviews
- Hospital Precertification
- Concurrent Review
- Outpatient Pre-authorization
- Prior Approval (list services that require)

Other (Describe)

EXHIBIT B

DIRIGOCHOICE RFP
Premium Rate Bid Sheets
Fiscal Year 11
Alternative Option
Instructions for Bid Sheets

Please follow the instructions below, which provide step by step guidance for filling out each row of the bid sheet. In addition, please submit a methodology write-up that corresponds to the bid form. The write-up should include sources of data, populations used to develop rates, nature of each adjustment and methodology for calculating them. Also, please fill out the worksheet titled "Additional Tables".

Steps 1-6 Descriptive Information

1	Please enter name of bidding health plan
2	Prefilled - either Individual/Sole Prop or Small Group
3	Prefilled. There are 6 bid sheets. For Individual/Sole Prop, please quote 3 options, one for income category B, one for income category C, and one for income categories D, E, and F. For Small Group please quote 3 options: a Value, Basic and a HSA compatible High Deductible Health Plan. Please ensure that the Value plan has lower cost sharing than the Basic Plan. Current plan designs for populations are found in the summary of benefits description in the RFP. Membership enrollment is located in the worksheet titled "Additional Tables".
4	Prefilled
5	Prefilled
6	Please enter Actuarial Value of Option. Actuarial Value should be in relation to a health benefit plan with no cost sharing.

Steps 7-16 Medical Claims Projection

7	Please enter Base Medical Claims. Please refer to the worksheet titled "Data Book". Also please include which population data represents in your write-up section.
8	Please enter Base Member Months. Please refer to the worksheet titled "Data Book".
9	Step 9 is a calculation.
10	Please enter benefit adjustment factor which brings the experience period to the projection period
11	Please enter your medical trend adjustment factor which brings the experience period to the projection period. Please also fill out the Trend Table, located in the worksheet titled "Additional Tables". The Trend Table should correspond to this medical trend adjustment factor.
12-15	Please enter other adjustments to your medical claims pmpm to bring to projected time period. Please outline description of all adjustments and methodology of calculation in the methodology write-up.
16	Projected Medical Claims PMPM is a calculation.

DIRIGOCHOICE RFP
Premium Rate Bid Sheets
Fiscal Year 11
Alternative Option
Instructions for Bid Sheets

Steps 17-26 Pharmacy Claims Projection

17	Please enter Base Pharmacy Claims. Please refer to the worksheet titled "Data Book". Also please include which population data represents in your write-up section.
18	Please enter Base Member Months. Please refer to the worksheet titled "Data Book".
19	Step 19 is a calculation.
20	Please enter benefit adjustment factor which brings the experience period to the projection period.
21	Please enter your pharmacy trend adjustment factor which brings the experience period to the projection period. Please also fill out the Trend Table, located in the worksheet titled "Additional Tables". The Trend Table should correspond to this pharmacy trend adjustment factor.
22-25	Please enter other adjustments to your pharmacy claims pmpm to bring to projected time period. Please outline description of all adjustments and methodology of calculation in the methodology write-up.
26	Projected Pharmacy Claims PMPM is a calculation.

Steps 27-30 Target Revenue PMPM

27	Projected Medical Claims PMPM is a calculation.
28	Please enter your target Medical Loss Ratio (MLR). Please fill out "Table 2 - Retention Table" that corresponds to this MLR, located in the worksheet titled "Additional Tables".
29	Admin+Contribution PMPM is a calculation
30	Target Revenue PMPM is a calculation

Steps 31 - 35 Translating PMPM Revenue Requirements to Rates

31	Please enter your conversion factor to bring a revenue pmpm to Individual Rate
32-34	Please enter rate ratios from the worksheet titled "Data Book"
35	Calculation of Rates for 1Q FY 11

EXHIBIT C

Bid Form 2 – Benefit Checklist

Instructions:

1) Please provide deductible information as described in the form.
2) Please indicate services included in your proposed plan(s).
3) Please describe the service and any limitations that you apply to the service.
4) Please indicate whether a co-pay applies to the service and the amount of the co-pay.
5) Please indicate whether the service applies to the plan deductible or whether the service applies to a separate deductible.

Bidders may provide a copy of their Summary of Benefits, but must also complete this form.

Deductible

Please describe how a member with family coverage satisfies the family deductible.

If a member of a covered family meets an individual Deductible, then services for that member that are subject to that deductible are covered by the plan for the remainder of the calendar year.

If any number of members in a covered family collectively meets a family deductible, then all services that are subject to that deductible are covered by the plan for the remainder of the calendar year.

Is the deductible accumulated on a plan year or calendar year basis?
Calendar year

Do you include a roll-over in the deductible? yes

Service	Included Y / N	Description and Limitations	Co-Pay	Deductible
Plan Deductible(s)		$1,250, $2,500 or $5,000 Annual Deductible		
Hospital Services				
Inpatient	Yes	70% after deductible		Plan Ded.
Outpatient	Yes	70% after deductible		Plan Ded.
Emergency Room Services	Yes	$300 Copay if not admitted to the hospital (no	$300	

EXHIBIT C

		deductible or coinsurance)		
Screening Mammograms	Yes	100%, no copayment or deductible		
Professional Services				
Inpatient	Yes	70% after deductible		Plan Ded.
Outpatient	Yes	70% after deductible		Plan Ded.
Diagnostic tests, x-rays, and surgery	Yes	70% after deductible		Plan Ded.
Endoscopic Procedures (including Colonoscopies)	Yes	70% after deductible		Plan Ded.
Maternity				
Pre- & Post-natal	Yes	$0 copay for prenatal visits, 100%		
Delivery	Yes	60% after deductible		Plan Ded.
Physician Office Visits				
Sick Care	Yes	100%,after $30 copayment	$30	
Specialists	Yes	100%,after $50 copayment	$50	
Community Health Center	Yes	100%, no copayment or deductible		
Well Child visits, immunizations, and annual routine physical exams, including any lab, x-rays, or other diagnostic procedures such as colonoscopies and mammograms ordered as part of this physicals and any subsequent procedure undertaken during the diagnostic procedure visit. This service corresponds with the Agency's principle 1, to include robust preventative benefits.	Yes	100%, no copayment or deductible		
Hearing aids	Yes	70% after deductible (For members through the age limit required by Maine Law. Limited to one hearing aid every 36 months, per hearing impaired ear, up to a limit of $1,400		Plan Ded.
Occupational Therapy	Yes	70% after deductible (Combined limit of $3,000 per calendar year, Occupational, Speech, and Physical Therapy)		Plan Ded.
Speech Therapy	Yes	70% after deductible (Combined limit of $3,000 per calendar year, Occupational, Speech, and Physical Therapy)		Plan Ded.
Physical Therapy	Yes	70% after deductible (Combined limit of $3,000 per calendar year, Occupational, Speech, and Physical Therapy)		Plan Ded.
Chiropractic Care	Yes	70% after deductible (12 visits per calendar year)		Plan Ded.
Skilled Nursing Facility	Yes	70% after deductible (up to 100 days per member per calendar year)		Plan Ded.
Hospice	Yes	100%,after $30 copayment, per day	$30	

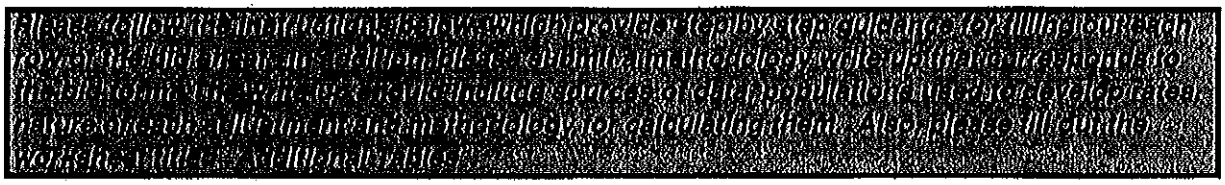
Home Health Care	Yes	70% after deductible (30 visits per calendar year)		Plan Ded.
Ambulance	Yes	70% after deductible ($10,000 limit per calendar year)		Plan Ded.
Cardiac Rehabilitation	Yes	70% after deductible (up to 24 visits per member per calendar year)		Plan Ded.
Durable Medical Equipment	Yes	70% after deductible (up to $3,500 per member per calendar year)		Plan Ded.
Routine Eye Exams	Yes	100%, no copayment or deductible (One vision exam per calendar year)		
Eye glasses	Yes	(Up to $125 per year)		
Dental	No			
Prostheses (excluding limbs)	Yes	70% after deductible		Plan Ded.
Prostheses for limb replacement	Yes	70% after deductible		Plan Ded.
Smoking Cessation:				
Smoking Cessation Program	Yes	100%, no copayment or deductible (Up to $35 per program/$70 per lifetime)		
Smoking Cessation Medications	Yes			
Biologically Based Mental Illnesses including Substance Abuse services				
These services correspond with the Agency's principle 2, include mental health parity.				
Inpatient	Yes	70% after deductible		Plan Ded.
Day treatment	Yes	70% after deductible		Plan Ded.
Outpatient	Yes	70% after deductible		Plan Ded.
Office Visits	Yes	100%,after $30 copayment	$30	
Home Health Care Services	Yes	70% after deductible		Plan Ded.
Non-Biologically Based Mental Illnesses:				
Inpatient	Yes	$150 deductible, 70% after deductible (combined in and out of network Combined limit of 30 days per calendar year. Two days of day treatment equal one day of inpatient treatment		Separate Ded.
Outpatient	Yes	$150 deductible, 70% after deductible (combined in and out of network Combined limit of 40 visits per member per calendar year. Two days of day treatment equal one day of inpatient treatment		Separate Ded.
Home Health Care Services	Yes	$150 deductible, 70% after deductible		Separate

			Ded.
Prescription Drugs			
The first $2,500 of charges:			
Tier 1: Generic	Yes	$0 copay, up to 30-day supply	
Tier 2: Brand Name Preferred	Yes	$50 copay, up to 30-day supply	$50
Tier 3: Brand Name Non-Preferred	Yes	$75 copay, up to 30-day supply	$75
The next $2,500 of charges:			
Tier 1: Generic	Yes	$0 copay, up to 30-day supply	
Tier 2: Brand Name Preferred	No	Not covered	
Tier 3: Brand Name Non-Preferred	No	Not covered	
After $5,000 of charges:			
Tier 1: Generic	Yes	$0 copay, up to 30-day supply	
Tier 2: Brand Name Preferred	Yes	$50 copay, up to 30-day supply	$50
Tier 3: Brand Name Non-Preferred	Yes	$75 copay, up to 30-day supply	$75
Large Case Management	Yes		
Disease Management			
These services correspond with the Agency's principle 1, to include disease management benefits.			
Asthma	Yes		
Autism	No		
Cholesterol	Yes		
Cancer	No	As appropriate, Cancer cases will be enrolled into Celtic case management	
Congestive Heart Failure (CHF)	Yes		
Coronary Artery Disease (CAD)	Yes		
Chronic Obstructive Pulmonary Disease (COPD)	Yes		
Depression	Yes		
Diabetes	Yes		
Eating Disorders	No	As appropriate, would be enrolled in Cenpatico behavioral health case management	
High-Risk Pregnancy	Yes		
Hypertension	Yes		
Low Back Pain	Yes		
Migraines	No		
Obesity	Yes		
Cardiovascular Disease	Yes		

Others (Please list)	Yes	Smoking Cessation
24-Hour Nurse Line	Yes	
Centers of Excellence (Describe any services that are exclusive to these Centers)	Yes	
Web Tools for Member Services and Lifestyle Management	Yes	Provided via Nurtur's Balance Program
Other Utilization/Medical Management Services (Describe)		
Discharge Planning	Yes	
Retrospective Reviews	Yes	
Hospital Precertification	Yes	
Concurrent Review	Yes	
Outpatient Pre-authorization	Yes	
Prior Approval (list services that require)	Yes	
Healthy Rewards Program	Yes	Members can earn up to a $100

EXHIBIT D

DIRIGOCHOICE RFP
Premium Rate Bid Sheets
Fiscal Year 11
Alternative Option
Instructions for Bid Sheets



Steps 1-6 Descriptive Information

1	Please enter name of bidding health plan
2	Prefilled - either Individual/Sole Prop or Small Group
3	Prefilled. There are 6 bid sheets. For Individual/Sole Prop, please quote 3 options, one for income category B, one for income category C, and one for income categories D, E, and F. For Small Group please quote 3 options: a Value, Basic and a HSA compatible High Deductible Health Plan. Please ensure that the Value plan has lower cost sharing than the Basic Plan. Current plan designs for populations are found in the summary of benefits description in the RFP. Membership enrollment is located in the worksheet titled "Additional Tables".
4	Prefilled
5	Prefilled
6	Please enter Actuarial Value of Option. Actuarial Value should be in relation to a health benefit plan with no cost sharing.

Steps 7-16 Medical Claims Projection

7	Please enter Base Medical Claims. Please refer to the worksheet titled "Data Book". Also please include which population data represents in your write-up section.
8	Please enter Base Member Months. Please refer to the worksheet titled "Data Book".
9	Step 9 is a calculation.
10	Please enter benefit adjustment factor which brings the experience period to the projection period
11	Please enter your medical trend adjustment factor which brings the experience period to the projection period. Please also fill out the Trend Table, located in the worksheet titled "Additional Tables". The Trend Table should correspond to this medical trend adjustment factor.
12-15	Please enter other adjustments to your medical claims pmpm to bring to projected time period. Please outline description of all adjustments and methodology of calculation in the methodology write-up.
16	Projected Medical Claims PMPM is a calculation.

DIRIGOCHOICE RFP
Premium Rate Bid Sheets
Fiscal Year 11
Alternative Option
Instructions for Bid Sheets

Steps 17-26 Pharmacy Claims Projection

17	Please enter Base Pharmacy Claims. Please refer to the worksheet titled "Data Book". Also please include which population data represents in your write-up section.
18	Please enter Base Member Months. Please refer to the worksheet titled "Data Book".
19	Step 19 is a calculation.
20	Please enter benefit adjustment factor which brings the experience period to the projection period.
21	Please enter your pharmacy trend adjustment factor which brings the experience period to the projection period. Please also fill out the Trend Table, located in the worksheet titled "Additional Tables". The Trend Table should correspond to this pharmacy trend adjustment factor.
22-25	Please enter other adjustments to your pharmacy claims pmpm to bring to projected time period. Please outline description of all adjustments and methodology of calculation in the methodology write-up.
26	Projected Pharmacy Claims PMPM is a calculation.

Steps 27-30 Target Revenue PMPM

27	Projected Medical Claims PMPM is a calculation.
28	Please enter your target Medical Loss Ratio (MLR). Please fill out "Table 2 - Retention Table" that corresponds to this MLR, located in the worksheet titled "Additional Tables".
29	Admin+Contribution PMPM is a calculation
30	Target Revenue PMPM is a calculation

Steps 31 - 35 Translating PMPM Revenue Requirements to Rates

31	Please enter your conversion factor to bring a revenue pmpm to Individual Rate
32-34	Please enter rate ratios from the worksheet titled "Data Book"
35	Calculation of Rates for 1Q FY 11

DIRIGOCHOICE RFP
Premium Rate Bid Sheets
Fiscal Year 11
Alternative Option
Summary of Bid

Health Plan Name Centene

Option Number	Population	Income Category (ies)	FY 11 MM Distribution	Revenue PMPM
1	Individual/Sole Prop	B	43.5%	581.892422
2	Individual/Sole Prop	C	15.8%	555.928333
3	Individual/Sole Prop	D,E,F	13.0%	510.268664
4 - Value	Small Group	B,C,D,E,F	10.0%	374.343792
5 - Basic	Small Group	B,C,D,E,F	14.1%	358.326977
6 - HDHP	Small Group	B,C,D,E,F	3.5%	364.57772
Total				**508.51665**

Target Revenue PMPM for Alternative Option **$509.96**

Variance From Target 0%

DIRIGOCHOICE RFP
Premium Rate Bid Sheets
Fiscal Year 11
Alternative Option

1	Health Plan	Centene	
2	Population	Individual/Sole Prop	
3	Option Number	1	2500 Deductible Plan
4	Income Category (ies)	B	
5	FY 11 Member Distribution	44%	
6	Actuarial Value of Option	0.8779006	

7	Base Medical Claims	$25,693,467	
8	Base Member Months	59746	
9	Base Medical Claims PMPM	430.044965	
10	Medical Benefit Adjustment Factor	1	
11	Medical Trend Adjustment Factor	1.18429377	
12	Adjustment Factor 1	1.01	
13	Adjustment Factor 2	0.85	
14	Adjustment Factor 3		
15	Adjustment Factor 4		
16	Projected Medical Claims PMPM	436.711375	*Projected Period: FY 11*

17	Base Pharmacy Claims	$5,164,767
18	Base Member Months	59746
19	Base Pharmacy Claims PMPM	86.4453953
20	Pharmacy Benefit Adjustment Factor	1
21	Pharmacy Trend Adjustment Factor	1.18429377
22	Adjustment Factor 1	1.01
23	Adjustment Factor 2	0.84
24	Adjustment Factor 3	
25	Adjustment Factor 4	
26	Projected Pharmacy Claims PMPM	86.991805

27	Total Projected Claims PMPM	523.70318
28	Target Medical Loss Ratio	0.9
29	Admin+Contribution PMPM	58.1892422
30	**FY11 Revenue PMPM**	**581.89242**

31	Conversion Factor	1.07240434
32	Employee+Spouse Rate Ratio	2.0
33	Employee Children Rate Ratio	1.8
34	Family Rate Ratio	3.0

35		**Jul 2010 - Sept 2010**	
	Individual Rate	624.02	624.02
	Employee+Spouse Rate	1248.04	1248.04
	Employee Children Rate	2496.08	1123.24
	Family Rate	4992.16	1872.06

Rates will not increase more than 4 % each quarter

For all Bid Sheets:
The "Base Medical Claims" and "Base Pharmacy Claims" are based on the CY 2008 supplemental databook.
Our pricing was based on manual pricing, relying on the Milliman Health Cost Guidelines, consistent with trended claims experience for both CY 2008 and YTD 2009 claims (from the databook), and other industry research.
However, since the bid form required a starting "experience" base, we input the CY 2008 claims and made an adjustment (Adjustment 2) to get back to our manual pricing.
Adjustment 1 represents the adjustment for re-sloping the premium rates by income group.

DIRIGOCHOICE RFP
Premium Rate Bid Sheets
Fiscal Year 11
Alternative Option

1	Health Plan	Centene	
2	Population	Individual/Sole Prop	
3	Option Number	2	2500 Deductible Plan
4	Income Category (ies)	C	
5	FY 11 Member Distribution	15.8%	
6	Actuarial Value of Option	0.847111588	

7	Base Medical Claims	$4,916,104	
8	Base Member Months	16630.5	
9	Base Medical Claims PMPM	295.607711	
10	Medical Benefit Adjustment Factor	1	
11	Medical Trend Adjustment Factor	1.18429377	
12	Adjustment Factor 1	1.00	
13	Adjustment Factor 2	1.18	
14	Adjustment Factor 3		
15	Adjustment Factor 4		
16	Projected Medical Claims PMPM	414.205	*Projected Period: FY 11*

17	Base Pharmacy Claims	$789,011
18	Base Member Months	16630.5
19	Base Pharmacy Claims PMPM	47.4436286
20	Pharmacy Benefit Adjustment Factor	1
21	Pharmacy Trend Adjustment Factor	1.18429377
22	Adjustment Factor 1	1
23	Adjustment Factor 2	1.63
24	Adjustment Factor 3	
25	Adjustment Factor 4	
26	Projected Pharmacy Claims PMPM	86.1305

27	Total Projected Claims PMPM	500.3355
28	Target Medical Loss Ratio	0.9
29	Admin+Contribution PMPM	55.5928333
30	**FY11 Revenue PMPM**	**555.92833**

31	Conversion Factor	1.07240434
32	Employee+Spouse Rate Ratio	2.0
33	Employee Children Rate Ratio	1.8
34	Family Rate Ratio	3.0

35		**Jul 2010 - Sept 2010**	
	Individual Rate	596.18	596.18
	Employee+Spouse Rate	1192.36	1192.36
	Employee Children Rate	2384.72	1073.12
	Family Rate	4769.44	1788.54

Rates will not increase more than 4 % each quarter

DIRIGOCHOICE RFP
Premium Rate Bid Sheets
Fiscal Year 11
Alternative Option

1	Health Plan	Centene	
2	Population	Individual/Sole Prop	
3	Option Number	3	2500 Deductible Plan
4	Income Category (ies)	D,E,F	
5	FY 11 Member Distribution	13.0%	
6	Actuarial Value of Option	0.80185673	

7	Base Medical Claims	$7,389,264	
8	Base Member Months	25740	
9	Base Medical Claims PMPM	287.073206	
10	Medical Benefit Adjustment Factor	1	
11	Medical Trend Adjustment Factor	1.18429377	
12	Adjustment Factor 1	0.97	
13	Adjustment Factor 2	1.14	
14	Adjustment Factor 3		
15	Adjustment Factor 4		
16	Projected Medical Claims PMPM	375.726112	*Projected Period: FY 11*

17	Base Pharmacy Claims	$2,501,623
18	Base Member Months	25740
19	Base Pharmacy Claims PMPM	97.1881406
20	Pharmacy Benefit Adjustment Factor	1
21	Pharmacy Trend Adjustment Factor	1.18429377
22	Adjustment Factor 1	0.96964126
23	Adjustment Factor 2	0.75
24	Adjustment Factor 3	
25	Adjustment Factor 4	
26	Projected Pharmacy Claims PMPM	83.5156862

27	Total Projected Claims PMPM	459.241798
28	Target Medical Loss Ratio	0.9
29	Admin+Contribution PMPM	51.0268664
30	**FY11 Revenue PMPM**	**510.26866**

31	Conversion Factor	1.07240434
32	Employee+Spouse Rate Ratio	2.0
33	Employee Children Rate Ratio	1.8
34	Family Rate Ratio	3.0

35		**Jul 2010 - Sept 2010**	
	Individual Rate	547.21	547.21
	Employee+Spouse Rate	1094.42	1094.42
	Employee Children Rate	2188.84	984.98
	Family Rate	4377.68	1641.63

Rates will not increase more than 4 % each quarter

DIRIGOCHOICE RFP
Premium Rate Bid Sheets
Fiscal Year 11
Alternative Option

1	Health Plan	Centene	
2	Population	Small Group	
3	Option Number	4 - Value	1250 Deductible Plan
4	Income Category (ies)	B,C,D,E,F	
5	FY 11 Member Distribution	10.0%	
6	Actuarial Value of Option	0.81054765	

7	Base Medical Claims	$8,525,269	
8	Base Member Months	35202	
9	Base Medical Claims PMPM	242.181394	
10	Medical Benefit Adjustment Factor	1	
11	Medical Trend Adjustment Factor	1.18429377	
12	Adjustment Factor 1	0.99	
13	Adjustment Factor 2	1.00	
14	Adjustment Factor 3		
15	Adjustment Factor 4		
16	Projected Medical Claims PMPM	283.771743	*Projected Period: FY 11*

17	Base Pharmacy Claims	$1,972,865
18	Base Member Months	35202
19	Base Pharmacy Claims PMPM	56.0441069
20	Pharmacy Benefit Adjustment Factor	1
21	Pharmacy Trend Adjustment Factor	1.18429377
22	Adjustment Factor 1	0.98685658
23	Adjustment Factor 2	0.81
24	Adjustment Factor 3	
25	Adjustment Factor 4	
26	Projected Pharmacy Claims PMPM	53.1376699

27	Total Projected Claims PMPM	336.909413
28	Target Medical Loss Ratio	0.9
29	Admin+Contribution PMPM	37.4343792
30	**FY11 Revenue PMPM**	**374.34379**

31	Conversion Factor	1.12428372
32	Employee+Spouse Rate Ratio	2.3
33	Employee Children Rate Ratio	1.8
34	Family Rate Ratio	3.0

35		**Jul 2010 - Sept 2010**	
	Individual Rate	420.87	420.87
	Employee+Spouse Rate	968	968
	Employee Children Rate	2226.4	757.57
	Family Rate	5120.72	1262.61

Rates will not increase more than 4 % each quarter

DIRIGOCHOICE RFP
Premium Rate Bid Sheets
Fiscal Year 11
Alternative Option

1	Health Plan	Centene	
2	Population	Small Group	
3	Option Number	5 - Basic	2500 Deductible Plan
4	Income Category (ies)	B,C,D,E,F	
5	FY 11 Member Distribution	14.1%	
6	Actuarial Value of Option	0.77581536	

7	Base Medical Claims	$8,525,269	
8	Base Member Months	35202	
9	Base Medical Claims PMPM	242.181394	
10	Medical Benefit Adjustment Factor	1	
11	Medical Trend Adjustment Factor	1.18429377	
12	Adjustment Factor 1	0.99	
13	Adjustment Factor 2	0.95	
14	Adjustment Factor 3		
15	Adjustment Factor 4		
16	Projected Medical Claims PMPM	269.356609	*Projected Period: FY 11*

17	Base Pharmacy Claims	$1,972,865
18	Base Member Months	35202
19	Base Pharmacy Claims PMPM	56.0441069
20	Pharmacy Benefit Adjustment Factor	1
21	Pharmacy Trend Adjustment Factor	1.18429377
22	Adjustment Factor 1	0.98585658
23	Adjustment Factor 2	0.81
24	Adjustment Factor 3	
25	Adjustment Factor 4	
26	Projected Pharmacy Claims PMPM	53.1376699

27	Total Projected Claims PMPM	322.494279
28	Target Medical Loss Ratio	0.9
29	Admin+Contribution PMPM	35.8326977
30	**FY11 Revenue PMPM**	**358.32698**

31	Conversion Factor	1.12428372
32	Employee+Spouse Rate Ratio	2.3
33	Employee Children Rate Ratio	1.8
34	Family Rate Ratio	3.0

35		**Jul 2010 - Sept 2010**	
	Individual Rate	402.86	402.86
	Employee+Spouse Rate	926.58	926.58
	Employee Children Rate	2131.13	725.15
	Family Rate	4901.6	1208.58

Rates will not increase more than 4 % each quarter

DIRIGOCHOICE RFP
Premium Rate Bid Sheets
Fiscal Year 11
Alternative Option

1	Health Plan	Centene	
2	Population	Small Group	
3	Option Number	6 - HDHP	5000 Deductible Plan
4	Income Category (ies)	B,C,D,E,F	
5	FY 11 Member Distribution	3.5%	
6	Actuarial Value of Option	0.78318773	

7	Base Medical Claims	$8,625,269	
8	Base Member Months	35202	
9	Base Medical Claims PMPM	242.181394	
10	Medical Benefit Adjustment Factor	1	
11	Medical Trend Adjustment Factor	1.18429377	
12	Adjustment Factor 1	0.99	
13	Adjustment Factor 2	0.95	
14	Adjustment Factor 3		
15	Adjustment Factor 4		
16	Projected Medical Claims PMPM	268.24592	*Projected Period: FY 11*

17	Base Pharmacy Claims	$1,972,865
18	Base Member Months	35202
19	Base Pharmacy Claims PMPM	56.0441069
20	Pharmacy Benefit Adjustment Factor	1
21	Pharmacy Trend Adjustment Factor	1.18429377
22	Adjustment Factor 1	0.98585668
23	Adjustment Factor 2	0.92
24	Adjustment Factor 3	
25	Adjustment Factor 4	
26	Projected Pharmacy Claims PMPM	59.8740279

27	Total Projected Claims PMPM	328.119948
28	Target Medical Loss Ratio	0.9
29	Admin+Contribution PMPM	36.457772
30	**FY11 Revenue PMPM**	**364.57772**

31	Conversion Factor	1.12428372
32	Employee+Spouse Rate Ratio	2.3
33	Employee Children Rate Ratio	1.8
34	Family Rate Ratio	3.0

35		**Jul 2010 - Sept 2010**	
	Individual Rate	409.89	409.89
	Employee+Spouse Rate	942.75	942.75
	Employee Children Rate	2168.33	737.8
	Family Rate	4987.16	1229.67

Rates will not increase more than 4 % each quarter

DIRIGOCHOICE RFP
Premium Rate Bid Sheets
Fiscal Year 11
Alternative Option
Additional Tables

Table 1

Trend Assumptions												
	CY 09			CY 10			CY 11			CY 12		
	Cost	Utilization	Total	Cost	Utilization	Total	Cost	Utilization	Total	Cost	Utilization	Total
Inpatient Hospital	7.0%	0.0%	7.0%	7.0%	0.0%	7.0%	6.0%	0.0%	6.0%	6.0%	0.0%	6.0%
Outpatient Hospital	9.0%	0.0%	9.0%	9.0%	0.0%	9.0%	8.5%	0.0%	8.5%	8.5%	0.0%	8.5%
Physician	6.0%	0.0%	6.0%	6.0%	0.0%	6.0%	6.5%	0.0%	6.5%	6.5%	0.0%	6.5%
Lab/Radiology	6.0%	0.0%	6.0%	6.0%	0.0%	6.0%	6.5%	0.0%	6.5%	6.5%	0.0%	6.5%
Inpatient MH/SA	7.0%	0.0%	7.0%	7.0%	0.0%	7.0%	6.0%	0.0%	6.0%	6.0%	0.0%	6.0%
Outpatient MH/SA	6.0%	0.0%	6.0%	6.0%	0.0%	6.0%	6.5%	0.0%	6.5%	6.5%	0.0%	6.5%
Pharmacy	5.5%	0.0%	5.5%	5.5%	0.0%	5.5%	5.5%	0.0%	5.5%	5.5%	0.0%	5.5%
Rebate												
Other	8.0%	0.0%	8.0%	8.0%	0.0%	8.0%	9.0%	0.0%	9.0%	9.0%	0.0%	9.0%
Total	7.0%	0.0%	7.0%	7.0%	0.0%	7.0%	8.0%	0.0%	8.0%	8.0%	0.0%	8.0%

Table 2 - Retention Table

Medical Loss Ratio/Target Retention	Admin Charge	Investment	Other	Contribution
90% Loss Ratio/10% Retention	7.0%	0.0%	0.0%	3.0%

DIRIGOCHOICE RFP
Fiscal Year 11
Data Book

Membership Distributions

		September 2009 Member Distribution				FY 11 Member Month Distribution			
Type	Discount	1250 Deductible	1750 Deductible	2500 Deductible	Total	1250 Deductible	1750 Deductible	2500 Deductible	Total
Individual	B	0%	16%	16%	32%	0%	15%	15%	29%
Individual	C	0%	3%	3%	7%	0%	4%	4%	9%
Individual	D	0%	1%	1%	3%	0%	1%	1%	3%
Individual	E	0%	1%	0%	1%	0%	1%	0%	1%
Individual	F	0%	1%	1%	3%	0%	1%	1%	3%
Small Group	B	2%	2%	3%	7%	2%	2%	3%	6%
Small Group	C	2%	1%	2%	5%	2%	2%	2%	6%
Small Group	D	1%	2%	1%	4%	1%	2%	1%	4%
Small Group	E	1%	1%	1%	2%	1%	1%	1%	2%
Small Group	F	3%	3%	2%	9%	3%	3%	2%	9%
Sole Prop	B	0%	7%	9%	16%	0%	6%	8%	14%
Sole Prop	C	0%	3%	2%	5%	0%	4%	3%	7%
Sole Prop	D	0%	1%	1%	2%	0%	1%	1%	2%
Sole Prop	E	0%	0%	0%	1%	0%	0%	0%	1%
Sole Prop	F	0%	2%	2%	4%	0%	2%	2%	4%

Small Group	FY 11 Distribution
Value	10.0%
Basic	14.1%
HDHP Health Savings Account	3.5%

Subscriber Distributions

DIRIGOCHOICE RFP
Fiscal Year 11
Data Book

Subscriber Distribution	Individual	Employee + Spouse	Employee + Children	Family
Individual/Sole Prop	67.8%	17.6%	5.0%	9.6%
Small Group	62.8%	13.3%	8.6%	15.3%

County	Small Group	Individual and Sole Prop
None	3%	3%
Androscoggin	7%	5%
Aroostook	6%	6%
Cumberland	15%	19%
Franklin	5%	3%
Hancock	4%	6%
Kennebec	8%	6%
Knox	5%	5%
Lincoln	4%	5%
Oxford	8%	5%
Penobscot	7%	10%
Piscataquis	1%	2%
Sagadahoc	3%	3%
Somerset	4%	3%
Waldo	4%	4%
Washington	2%	3%
York	14%	14%

Small Group

Age Band	Single	Employee + Spouse	Employee + Child(ren)	Family
<30	12.4%	0.7%	0.7%	0.7%
30-39	9.5%	1.0%	2.8%	1.0%
40-44	6.5%	1.0%	1.7%	1.0%
45-49	9.1%	2.1%	1.6%	2.1%
50-54	10.3%	2.7%	1.2%	2.7%
55-59	8.8%	3.4%	0.6%	3.4%
60-64	5.5%	2.2%	0.1%	2.2%
65+	0.7%	0.3%	0.0%	0.3%

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Individual/Sole Prop

Age Band	Subscribers
<30	8.3%
30-39	9.1%
40-44	7.9%
45-49	9.9%
50-54	12.4%
55-59	18.5%
60-64	29.8%
65+	4.2%

Note: effective July 1, 2010, the Agency will no longer subsidize members who are 65 or older who are eligible for Medicare

Rating Factors

Age Factors

Individual/Sole Prop

Age Band	Subscriber Age Factors
<30	0.510
30-39	0.712
40-44	0.857
45-49	1.086
50-54	1.234
55-59	1.476
60-64	1.719
65+	1.823

Small Group

Age Band	Age Rating Factors			Contract Type Factors		
	Individual	Employee +Spouse/Family	Employee +Children	Individual	Employee +Spouse/Family	Employee +Children
<30	0.510	2.005	1.219	1.000	2.500	1.700
30-39	0.712	2.060	1.394	1.000	2.500	1.700
40-44	0.857	2.148	1.520	1.000	2.500	1.700
45-49	1.086	2.546	1.756	1.000	2.500	1.700
50-54	1.234	2.868	1.900	1.000	2.500	1.700
55-59	1.476	3.411	2.169	1.000	2.500	1.700
60-64	1.719	3.912	2.428	1.000	2.500	1.700
65+	1.823	3.229	2.763	1.000	2.500	1.700

Area Factors

Individual/Sole Prop

County	Area Factor
Androscoggin	0.970
Aroostook	1.150
Cumberland	0.900
Franklin	1.025
Hancock	1.150
Kennebec	0.925
Knox	0.950
Lincoln	0.975
Oxford	0.975
Penobscot	1.150
Piscataquis	1.150
Sagadahoc	0.950
Somerset	1.150
Waldo	1.050
Washington	1.150
York	0.900

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Rate Ratios	Individual/Sole Prop	Small Group
Individual	1.0	1.0
Employee + Spouse	2.0	2.3
Employee + Children	1.8	1.8
Family	3.0	3.0

Member Zip Code Distribution

EXHIBIT E

Attachment A

DirigoChoice PPO Plan – Status Quo and Alternate Plan ($1,200 Deductible)

Features/Benefits	Status Quo	Status Quo (Out-of-Network Benefit)	Alternate	Alternate (Out-of-Network Benefit)
Plan Type (s)	PPO		PPO	PPO
Calendar Year Deductibles: General Deductible Mental Health (Non-Biologically Based Illness)	$1,250 Individual $2,500 Family $150		$1,250 Individual $4,000 Family $150	
Deductible Rollover Your plan has a deductible rollover. This allows you to apply any deductible amount incurred for covered benefits during the last three months of a calendar year toward the deductible for the next year. In order for the deductible Rollover to apply, you, or your covered family, must have had continuous coverage under DirigoChoice at the time the charges for the prior year were incurred.				
Calendar Year Out-of-Pocket Limit	$4,0000 Individual Limit $8,000 Family Limit		$4,000 Individual Limit $8,000 Family Limit	
Lifetime Benefit Maximum	No limit		No limit	
	In-Network Benefit	Out-of-Network Benefit	In-Network Benefit	Out-of-Network Benefit
Coinsurance	Plan pays 70% The Member pays 30% Unless otherwise indicated	Plan pays 50% The Member pays 50% Unless otherwise indicated	Plan pays 70% The Member pays 30% Unless otherwise indicated	Plan pays 50% The Member pays 50% Unless otherwise indicated
Copayment	$25 Copayment where indicated	$35 Copayment where indicated		
Service	In-Network Benefit The Plan Pays:	Out-of-Network Benefit The Plan Pays:	In-Network Benefit The Plan Pays:	Out-of-Network Benefit The Plan Pays:
Hospital Services Inpatient Outpatient	70% after Deductible	50% after deductible	70% after Deductible	50% after deductible
Emergency Room Services	70% after Deductible	70% after Deductible	$300 Copayment if not admitted to the hospital (no deductible or coinsurance)	$350 Copayment if not admitted to the hospital (no deductible or coinsurance)
Screening Mammograms	100%, no Copayment or Deductible	100%, no Copayment or Deductible	100%, no Copayment or Deductible	100%, no Copayment or Deductible
Professional Services Inpatient Outpatient Diagnostic tests, x-rays, and surgery	70% after Deductible	50% after deductible	70% after Deductible	50% after deductible
Endoscopic Procedures (including	70% after Deductible	50% after deductible	70% after Deductible	50% after deductible

EXHIBIT E

Atta. .nent A

DirigoChoice PPO Plan – Status Quo and Alternate Plan ($1,200 Deductible)

Features/Benefits	Status Quo	Status Quo (Out-of-Network Benefit)	Alternate	Alternate (Out-of-Network Benefit)
Colonoscopies)				
Maternity Pre- & Post-natal Delivery	$25 Copayment first prenatal visit, 100% 70% after deductible	$35 Copayment first prenatal visit, 70% 50% after deductible	$0 Copayment for prenatal visits, 100% 60% after deductible	$35 Copayment first prenatal visit, 70% 50% after deductible
Service	In-Network Benefit The Plan Pays:	Out-of-Network Benefit The Plan Pays:	In-Network Benefit The Plan Pays:	Out-of-Network Benefit The Plan Pays:
Physician Office Visits Routine/Preventive (including any associated diagnostics tests and x-rays Sick Care Specialists Community Health Center	100%, no Copayment or Deductible 100% after $25 Copayment, Deductible does not apply NA	50% after $35 Copayment, Deductible does not apply 70% after $35 Copayment, Deductible does not apply NA	100%, no Copayment or Deductible 100% after $30 Copayment, 100% after $50 Copayment Deductible does not apply 100%, no Copayment or Deductible	50% after $35 Copayment, Deductible does not apply 70% after $40 Copayment, 70% after $100 Copayment Deductible does not apply 100%, no Copayment or Deductible
Hearing aids For Members through the age limit required by Maine law. Limited to one hearing aid every 36 months, per hearing impaired ear, up to a limit of $1,400.	70% after Deductible	50% after deductible	70% after Deductible	50% after deductible
Other Services:	In-Network Benefit The Plan Pays:	Out-of-Network Benefit The Plan Pays:	In-Network Benefit The Plan Pays:	Out-of-Network Benefit The Plan Pays:
Occupational, Speech, and Physical Therapies – Combined limit of $3,000 per calendar year	70% after Deductible	50% after deductible	70% after Deductible	50% after deductible
Chiropractic Care/Manipulative Therapy Combined limit of 12 visits per calendar year	70% after Deductible	50% after deductible	70% after Deductible	50% after deductible
Skilled Nursing Facility – Up to 100 days per member per Calendar year	70% after Deductible	50% after deductible	70% after Deductible	50% after deductible

Atta. .nent A
DirigoChoice PPO Plan – Status Quo and Alternate Plan ($1,200 Deductible)

Features/Benefits	Status Quo	Status Quo (Out-of-Network Benefit)	Alternate	Alternate (Out-of-Network Benefit)
Hospice	100% after $25 Copayment, Deductible does not apply	50% after $35 Copayment, Deductible does not apply	100% after $30 Copayment, per day Deductible does not apply	50% after $30 Copayment, per day Deductible does not apply
Home Health Care (limited to 30 visits, per calendar year)	70% after Deductible	50% after deductible	70% after Deductible	50% after deductible
Ambulance ($10,000 limit per calendar year)	70% after Deductible	70% after deductible	70% after Deductible	70% after deductible
Cardiac Rehabilitation – Up to 24 visits per member per calendar year	70% after Deductible	50% after deductible	70% after Deductible	50% after deductible
Durable Medical Equipment – Up to $3,500 per member per calendar year	70% after Deductible	50% after deductible	70% after Deductible	50% after deductible
Prostheses (excluding limbs)	70% after Deductible	50% after deductible	70% after Deductible	50% after deductible
Prostheses for limb replacement	70%, Deductible does not apply	70%, Deductible does not apply	70% after deductible	70% after deductible
Smoking Cessation: Smoking Cessation Program – up to $35 per program/$70 per lifetime	100% no Copayment or deductible	100% no Copay or deductible.	100% no Copay or deductible	100% no Copay or deductible
Smoking Cessation Medications	See the prescription drug section for additional information	See the prescription drug section for additional information	See the prescription drug section for additional info	See the prescription drug section for additional info
Mental Health and Substance Abuse services				
Mental Health and Substance Abuse services are managed and all Inpatient and Day Treatment services require reauthorization. Failure to comply with the requirements outlined in your Benefit Handbook may result in a penalty up to $150. Coinsurance for Non-Biologically Based Mental Illness services does not count toward meeting the annual Coinsurance limit. Coinsurance continues to apply to these services after the Coinsurance limit is met.				
Service	**In-Network Benefit The Plan Pays:**	**Out-of-Network Benefit The Plan Pays:**	**In-Network Benefit The Plan Pays:**	**Out-of-Network Benefit The Plan Pays:**
*Biologically Based Mental Illness including Substance Abuse services:	70% after Deductible	50% after deductible	70% after Deductible	50% after deductible
Inpatient, day treatment, outpatient Office Visits	100% after $25 Copayment, Deductible Does not apply	70% after $35 Copayment, Deductible Does not apply	100% after $30 Copayment, Deductible Does not apply	70% after $40 Copayment, Deductible Does not apply
Community Health Center	NA	NA	100% no Copayment or deductible	100% no Copayment or deductible

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DirigoChoice PPO Plan – Status Quo and Alternate Plan ($1,200 Deductible)

Features/Benefits	Status Quo	Status Quo (Out-of-Network Benefit)	Alternate	Alternate (Out-of-Network Benefit)
Home Health Care Services	70% after Deductible	50% after deductible	70% after Deductible	50% after deductible
Non-Biologically Based Mental Illness: Deductible – combined in and out of network Ipatient – Combined limit of 30 days per calendar year. Twodays of Day Treatment equal one day of Inpatient Treatment Outpatient – Combined limit 40 visits per member per calendar year Home Health Care Services	$150 70% after mental health Deductible 70% after mental health Deductible 70% after Deductible	$150 50% after mental health Deductible 50% after mental health Deductible 50% after Deductible	$150 70% after mental health Deductible 70% after mental health Deductible 70% after Deductible	$150 50% after mental health Deductible 50% after mental health Deductible 50% after Deductible
Prescription Drug Coverage Tier 1 Tier 2 Tier 3	$10 Copay, up to 30-day supply $30 Copay, up to 30-day supply $50 Copay, up to 30-day supply	$10 Copay, up to 30-day supply $30 Copay, up to 30-day supply $50 Copay, up to 30-day supply	1st $2,500 of charges: $0 Copay up to 30-day supply $50 Copay up to 30-day supply $75 Copay up to 30-day supply Next $2,500 of charges: $0 Copay up to 30-day supply Tier 2 & 3: No Coverage After $5,000 of chareges $0 Copay up to 30-day supply $50 Copay up to 30-day supply $75 Copay up to 30-day supply	1st $2,500 of charges: $0 Copay up to 30-day supply $50 Copay up to 30-day supply $75 Copay up to 30-day supply Next $2,500 of charges: $0 Copay up to 30-day supply Tier 2 & 3: No Coverage After $5,000 of chareges $0 Copay up to 30-day supply $50 Copay up to 30-day supply $75 Copay up to 30-day supply
Vision			100% no Copayment or deductible One vision exam per calendar year (includes lenses and contact lenses up to $125)	
Nurtur (Health & Wellness Programs)			100%, no Copayment or Deductible	
Healthy Rewards Program			Members can earn up to $100	

Note: Celtic may waive Tier 2 Copay in certain circumstances when a generic drug is not available.

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DirigoChoice PPO Plan – Status Quo and Alternate Plan ($1,750 Deductible)

Features/Benefits	Status Quo	Status Quo (Out-of-Network Benefit)	Alternate	Alternate (Out-of-Network Benefit)
Plan Type (s)	PPO		PPO	PPO
Calendar Year Deductibles: General Deductible Mental Health (Non-Biologically Based Illness)	$1,750 Individual $3,500 Family $150		$1,750 Individual $3,500 Family $150	
Deductible Rollover Your plan has a deductible rollover. This allows you to apply any deductible amount incurred for covered benefits during the last three months of a calendar year toward the deductible for the next year. In order for the deductible Rollover to apply, you, or your covered family, must have had continuous coverage under DirigoChoice at the time the charges for the prior year were incurred.				
Calendar Year Out-of-Pocket Limit	$5,600 Individual Limit $11,200 Family Limit		$5,600 Individual Limit $11,200 Family Limit	
Lifetime Benefit Maximum	No limit		No limit	
	In-Network Benefit	Out-of-Network Benefit	In-Network Benefit	Out-of-Network Benefit
Coinsurance	Plan pays 70% The Member pays 30% Unless otherwise indicated	Plan pays 50% The Member pays 50% Unless otherwise indicated	Plan pays 70% The Member pays 30% Unless otherwise indicated	Plan pays 50% The Member pays 50% Unless otherwise indicated
Copayment	$25 Copayment where indicated	$35 Copayment where indicated		
Service	In-Network Benefit The Plan Pays:	Out-of-Network Benefit The Plan Pays:	In-Network Benefit The Plan Pays:	Out-of-Network Benefit The Plan Pays:
Hospital Services Inpatient Outpatient	70% after Deductible	50% after deductible	70% after Deductible	50% after deductible
Emergency Room Services	70% after Deductible	70% after Deductible	$300 Copayment if not admitted to the hospital (no deductible or coinsurance)	$350 Copayment if not admitted to the hospital (no deductible or coinsurance)
Screening Mammograms	100%, no Copayment or Deductible	100%, no Copayment or Deductible	100%, no Copayment or Deductible	100%, no Copayment or Deductible
Professional Services Inpatient Outpatient Diagnostic tests, x-rays, and surgery	70% after Deductible	50% after deductible	70% after Deductible	50% after deductible
Endoscopic Procedures (including	70% after Deductible	50% after deductible	70% after Deductible	50% after deductible

Attachment A
DirigoChoice PPO Plan – Status Quo and Alternate Plan ($1,750 Deductible)

Features/Benefits	Status Quo	Status Quo (Out-of-Network Benefit)	Alternate	Alternate (Out-of-Network Benefit)
Colonoscopies)				
Maternity Pre- & Post-natal Delivery	$25 Copayment first prenatal visit, 100% 70% after deductible	$35 Copayment first prenatal visit, 70% 50% after deductible	$0 Copayment for prenatal visits, 100% 60% after deductible	$35 Copayment first prenatal visit, 70% 50% after deductible
Service	**In-Network Benefit: The Plan Pays:**	**Out-of-Network Benefit: The Plan Pays:**	**In-Network Benefit: The Plan Pays:**	**Out-of-Network Benefit: The Plan Pays:**
Physician Office Visits Routine/Preventive (including any associated diagnostics tests and x-rays Sick Care Specialists Community Health Center	100%, no Copayment or Deductible 100% after $25 Copayment, Deductible does not apply NA	50% after $35 Copayment, Deductible does not apply 70% after $35 Copayment, Deductible does not apply NA	100%, no Copayment or Deductible 100% after $30 Copayment, 100% after $50 Copayment Deductible does not apply 100%, no Copayment or Deductible	50% after $35 Copayment, Deductible does not apply 70% after $40 Copayment, 70% after $100 Copayment Deductible does not apply 100%, no Copayment or Deductible
Hearing aids For Members through the age limit required by Maine law. Limited to one hearing aid every 36 months, per hearing impaired ear, up to a limit of $1,400.	70% after Deductible	50% after deductible	70% after Deductible	50% after deductible
Other Services	**In-Network Benefit: The Plan Pays:**	**Out-of-Network Benefit: The Plan Pays:**	**In-Network Benefit: The Plan Pays:**	**Out-of-Network Benefit: The Plan Pays:**
Occupational, Speech, and Physical Therapies – Combined limit of $3,000 per calendar year	70% after Deductible	50% after deductible	70% after Deductible	50% after deductible
Chiropractic Care/Manipulative Therapy Combined limit of 12 visits per calendar year	70% after Deductible	50% after deductible	70% after Deductible	50% after deductible
Skilled Nursing Facility – Up to 100 days per member per Calendar year	70% after Deductible	50% after deductible	70% after Deductible	50% after deductible

Attachment A

DirigoChoice PPO Plan – Status Quo and Alternate Plan ($1,750 Deductible)

Features/Benefits	Status Quo	Status Quo (Out-of-Network Benefit)	Alternate	Alternate (Out-of-Network Benefit)
Hospice	100% after $25 Copayment, Deductible does not apply	50% after $35 Copayment, Deductible does not apply	100% after $30 Copayment, per day Deductible does not apply	50% after $30 Copayment, per day Deductible does not apply
Home Health Care (limited to 30 visits, per calendar year)	70% after Deductible	50% after deductible	70% after Deductible	50% after deductible
Ambulance ($10,000 limit per calendar year)	70% after Deductible	70% after deductible	70% after Deductible	70% after deductible
Cardiac Rehabilitation – Up to 24 visits per member per calendar year	70% after Deductible	50% after deductible	70% after Deductible	50% after deductible
Durable Medical Equipment – Up to $3,500 per member per calendar year	70% after Deductible	50% after deductible	70% after Deductible	50% after deductible
Prostheses (excluding limbs)	70% after Deductible	50% after deductible	70% after Deductible	50% after deductible
Prostheses for limb replacement	70%, Deductible does not apply	70%, Deductible does not apply	70% after deductible	70% after deductible
Smoking Cessation: Smoking Cessation Program – up to $35 per program/$70 per lifetime	100% no Copayment or deductible	100% no Copay or deductible.	100% no Copay or deductible	100% no Copay or deductible
Smoking Cessation Medications	See the prescription drug section for additional information	See the prescription drug section for additional information	See the prescription drug section for additional info	See the prescription drug section for additional info
Mental Health and Substance Abuse services				
Mental Health and Substance Abuse services are managed and all Inpatient and Day Treatment services require reauthorization. Failure to comply with the requirements outlined in your Benefit Handbook may result in a penalty up to $150. Coinsurance for Non-Biologically Based Mental Illness services does not count toward meeting the annual Coinsurance limit. Coinsurance continues to apply to these services after the Coinsurance limit is met.				
Service	**In-Network Benefit The Plan Pays:**	**Out-of-Network Benefit The Plan Pays:**	**In-Network Benefit The Plan Pays:**	**Out-of-Network Benefit The Plan Pays:**
*Biologically Based Mental Illness including Substance Abuse services:	70% after Deductible	50% after deductible	70% after Deductible	50% after deductible
Inpatient, day treatment, outpatient Office Visits	100% after $25 Copayment, Deductible Does not apply	70% after $35 Copayment, Deductible Does not apply	100% after $30 Copayment, Deductible Does not apply	70% after $40 Copayment, Deductible Does not apply
Community Health Center	NA	NA	100% no Copayment or deductible	100% no Copayment or deductible

Attachment A

DirigoChoice PPO Plan – Status Quo and Alternate Plan ($1,750 Deductible)

Features/Benefits	Status Quo	Status Quo (Out-of-Network Benefit)	Alternate	Alternate (Out-of-Network Benefit)
Home Health Care Services	70% after Deductible	50% after deductible	70% after Deductible	50% after deductible
Non-Biologically Based Mental Illness: Deductible – combined in and out of network Ipatient – Combined limit of 30 days per calendar year. Twodays of Day Treatment equal one day of Inpatient Treatment Outpatient – Combined limit 40 visits per member per calendar year Home Health Care Services	$150 70% after mental health Deductible 70% after mental health Deductible 70% after Deductible	$150 50% after mental health Deductible 50% after mental health Deductible 50% after Deductible	$150 70% after mental health Deductible 70% after mental health Deductible 70% after Deductible	$150 50% after mental health Deductible 50% after mental health Deductible 50% after Deductible
Prescription Drug Coverage Tier 1 Tier 2 Tier 3	$10 Copay, up to 30-day supply $30 Copay, up to 30-day supply $50 Copay, up to 30-day supply	$10 Copay, up to 30-day supply $30 Copay, up to 30-day supply $50 Copay, up to 30-day supply	1st $2,500 of charges: $0 Copay up to 30-day supply $50 Copay up to 30-day supply $75 Copay up to 30-day supply Next $2,500 of charges: $0 Copay up to 30-day supply Tier 2 & 3: No Coverage After $5,000 of chareges $0 Copay up to 30-day supply $50 Copay up to 30-day supply $75 Copay up to 30-day supply	1st $2,500 of charges: $0 Copay up to 30-day supply $50 Copay up to 30-day supply $75 Copay up to 30-day supply Next $2,500 of charges: $0 Copay up to 30-day supply Tier 2 & 3: No Coverage After $5,000 of chareges $0 Copay up to 30-day supply $50 Copay up to 30-day supply $75 Copay up to 30-day supply
Vision			100% no Copayment or deductible One vision exam per calendar year (includes lenses and contact lenses up to $125)	
Nurtur (Health & Wellness Programs)			100%, no Copayment or Deductible	
Healthy Rewards Program			Members can earn up to $100	

Note: Celtic may waive Tier 2 Copay in certain circumstances when a generic drug is not available.

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Attachment A

DirigoChoice PPO Plan – Status Quo and Alternate Plan ($2,500 Deductible)

Features/Benefits	Status Quo	Status Quo (Out-of-Network Benefit)	Alternate	Alternate (Out-of-Network Benefit)
Plan Type (s)	PPO		PPO	PPO
Calendar Year Deductibles: General Deductible Mental Health (Non-Biologically Based Illness)	$2,500 Individual $5,000 Family $150		$2,500 Individual $5,000 Family $150	
Deductible Rollover Your plan has a deductible rollover. This allows you to apply any deductible amount incurred for covered benefits during the last three months of a calendar year toward the deductible for the next year. In order for the deductible Rollover to apply, you, or your covered family, must have had continuous coverage under DirigoChoice at the time the charges for the prior year were incurred.				
Calendar Year Out-of-Pocket Limit	$3,500 Individual Limit $7,000 Family Limit		$5,500 Individual Limit $11,000 Family Limit	
Lifetime Benefit Maximum	No limit		No limit	
	In-Network Benefit	Out-of-Network Benefit	In-Network Benefit	Out-of-Network Benefit
Coinsurance	Plan pays 70% The Member pays 30% Unless otherwise indicated	Plan pays 50% The Member pays 50% Unless otherwise indicated	Plan pays 70% The Member pays 30% Unless otherwise indicated	Plan pays 50% The Member pays 50% Unless otherwise indicated
Copayment	$25 Copayment where indicated	$35 Copayment where indicated		
Service	In-Network Benefit The Plan Pays:	Out-of-Network Benefit The Plan Pays:	In-Network Benefit The Plan Pays:	Out-of-Network Benefit The Plan Pays:
Hospital Services Inpatient Outpatient	70% after Deductible	50% after deductible	70% after Deductible	50% after deductible
Emergency Room Services	70% after Deductible	70% after Deductible	$300 Copayment if not admitted to the hospital (no deductible or coinsurance)	$350 Copayment if not admitted to the hospital (no deductible or coinsurance)
Screening Mammograms	100%, no Copayment or Deductible	100%, no Copayment or Deductible	100%, no Copayment or Deductible	100%, no Copayment or Deductible
Professional Services Inpatient Outpatient Diagnostic tests, x-rays, and surgery	70% after Deductible	50% after deductible	70% after Deductible	50% after deductible
Endoscopic Procedures (including	70% after Deductible	50% after deductible	70% after Deductible	50% after deductible

Attachment A
DirigoChoice PPO Plan – Status Quo and Alternate Plan ($2,500 Deductible)

Features/Benefits	Status Quo	Status Quo (Out-of-Network Benefit)	Alternate	Alternate (Out-of-Network Benefit)
Colonoscopies)				
Maternity Pre- & Post-natal Delivery	$25 Copayment first prenatal visit, 100% 70% after deductible	$35 Copayment first prenatal visit, 70% 50% after deductible	$0 Copayment for prenatal visits, 100% 60% after deductible	$35 Copayment first prenatal visit, 70% 50% after deductible
Service	In-Network Benefit The Plan Pays:	Out-of-Network Benefit The Plan Pays:	In-Network Benefit The Plan Pays:	Out-of-Network Benefit The Plan Pays:
Physician Office Visits Routine/Preventive (including any associated diagnostics tests and x-rays Sick Care Specialists Community Health Center	100%, no Copayment or Deductible 100% after $25 Copayment, Deductible does not apply NA	50% after $35 Copayment, Deductible does not apply 70% after $35 Copayment, Deductible does not apply NA	100%, no Copayment or Deductible 100% after $30 Copayment, 100% after $50 Copayment Deductible does not apply 100%, no Copayment or Deductible	50% after $35 Copayment, Deductible does not apply 70% after $40 Copayment, 70% after $100 Copayment Deductible does not apply 100%, no Copayment or Deductible
Hearing aids For Members through the age limit required by Maine law. Limited to one hearing aid every 36 months, per hearing impaired ear, up to a limit of $1,400.	70% after Deductible	50% after deductible	70% after Deductible	50% after deductible
Other Services	In-Network Benefit The Plan Pays:	Out-of-Network Benefit The Plan Pays:	In-Network Benefit The Plan Pays:	Out-of-Network Benefit The Plan Pays:
Occupational, Speech, and Physical Therapies – Combined limit of $3,000 per calendar year	70% after Deductible	50% after deductible	70% after Deductible	50% after deductible
Chiropractic Care/Manipulative Therapy Combined limit of 12 visits per calendar year	70% after Deductible	50% after deductible	70% after Deductible	50% after deductible
Skilled Nursing Facility – Up to 100 days per member per Calendar year	70% after Deductible	50% after deductible	70% after Deductible	50% after deductible

Attachment A
DirigoChoice PPO Plan – Status Quo and Alternate Plan ($2,500 Deductible)

Features/Benefits	Status Quo	Status Quo (Out-of-Network Benefit)	Alternate	Alternate (Out-of-Network Benefit)
Hospice	100% after $25 Copayment, Deductible does not apply	50% after $35 Copayment, Deductible does not apply	100% after $30 Copayment, per day Deductible does not apply	50% after $30 Copayment, per day Deductible does not apply
Home Health Care (limited to 30 visits, per calendar year)	70% after Deductible	50% after deductible	70% after Deductible	50% after deductible
Ambulance ($10,000 limit per calendar year)	70% after Deductible	70% after deductible	70% after Deductible	70% after deductible
Cardiac Rehabilitation – Up to 24 visits per member per calendar year	70% after Deductible	50% after deductible	70% after Deductible	50% after deductible
Durable Medical Equipment – Up to $3,500 per member per calendar year	70% after Deductible	50% after deductible	70% after Deductible	50% after deductible
Prostheses (excluding limbs)	70% after Deductible	50% after deductible	70% after Deductible	50% after deductible
Prostheses for limb replacement	70%, Deductible does not apply	70%, Deductible does not apply	70% after deductible	70% after deductible
Smoking Cessation: Smoking Cessation Program – up to $35 per program/$70 per lifetime	100% no Copayment or deductible	100% no Copay or deductible.	100% no Copay or deductible	100% no Copay or deductible
Smoking Cessation Medications	See the prescription drug section for additional information	See the prescription drug section for additional information	See the prescription drug section for additional info	See the prescription drug section for additional info
Mental Health and Substance Abuse services				
Mental Health and Substance Abuse services are managed and all Inpatient and Day Treatment services require reauthorization. Failure to comply with the requirements outlined in your Benefit Handbook may result in a penalty up to $150. Coinsurance for Non-Biologically Based Mental Illness services does not count toward meeting the annual Coinsurance limit. Coinsurance continues to apply to these services after the Coinsurance limit is met.				
Service	**In-Network Benefit The Plan Pays:**	**Out-of-Network Benefit The Plan Pays:**	**In-Network Benefit The Plan Pays:**	**Out-of-Network Benefit The Plan Pays:**
*Biologically Based Mental Illness including Substance Abuse services:	70% after Deductible	50% after deductible	70% after Deductible	50% after deductible
Inpatient, day treatment, outpatient Office Visits	100% after $25 Copayment, Deductible Does not apply	70% after $35 Copayment, Deductible Does not apply	100% after $30 Copayment, Deductible Does not apply	70% after $40 Copayment, Deductible Does not apply
Community Health Center	NA	NA	100% no Copayment or deductible	100% no Copayment or deductible

Attachment A

DirigoChoice PPO Plan – Status Quo and Alternate Plan ($2,500 Deductible)

Features/Benefits	Status Quo	Status Quo (Out-of-Network Benefit)	Alternate	Alternate (Out-of-Network Benefit)
Home Health Care Services	70% after Deductible	50% after deductible	70% after Deductible	50% after deductible
Non-Biologically Based Mental Illness: Deductible – combined in and out of network Ipatient – Combined limit of 30 days per calendar year. Twodays of Day Treatment equal one day of Inpatient Treatment Outpatient – Combined limit 40 visits per member per calendar year Home Health Care Services	$150 70% after mental health Deductible 70% after mental health Deductible 70% after Deductible	$150 50% after mental health Deductible 50% after mental health Deductible 50% after Deductible	$150 70% after mental health Deductible 70% after mental health Deductible 70% after Deductible	$150 50% after mental health Deductible 50% after mental health Deductible 50% after Deductible
Prescription Drug Coverage Tier 1 Tier 2 Tier 3	$10 Copay, up to 30-day supply $30 Copay, up to 30-day supply $50 Copay, up to 30-day supply	$10 Copay, up to 30-day supply $30 Copay, up to 30-day supply $50 Copay, up to 30-day supply	1st $2,500 of charges: $0 Copay up to 30-day supply $50 Copay up to 30-day supply $75 Copay up to 30-day supply Next $2,500 of charges: $0 Copay up to 30-day supply Tier 2 & 3: No Coverage After $5,000 of chareges $0 Copay up to 30-day supply $50 Copay up to 30-day supply $75 Copay up to 30-day supply	1st $2,500 of charges: $0 Copay up to 30-day supply $50 Copay up to 30-day supply $75 Copay up to 30-day supply Next $2,500 of charges: $0 Copay up to 30-day supply Tier 2 & 3: No Coverage After $5,000 of chareges $0 Copay up to 30-day supply $50 Copay up to 30-day supply $75 Copay up to 30-day supply
Vision			100% no Copayment or deductible One vision exam per calendar year (includes lenses and contact lenses up to $125)	
Nurtur (Health & Wellness Programs)			100%, no Copayment or Deductible	
Healthy Rewards Program			Members can earn up to $100	

Note: Celtic may waive Tier 2 Copay in certain circumstances when a generic drug is not available.

CELTIC

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12/2/2009

EXHIBIT F

Milliman

Attachment C
Actuarial Memorandum on DirigoChoice Bid

SCOPE

Celtic Insurance Company (Celtic), a subsidiary of Centene, Inc., engaged Milliman to support the actuarial pricing for the DirigoChoice bid. This attachment documents the methods and assumptions used for the pricing of the bids, which we understood were submitted to the State of Maine on November 16, 2009.

BID RESULTS

Exhibit 1a and 1b summarize the projected claims and revenue rates for the Status Quo and Alternative benefits, respectively. The bids submitted on November 16, 2009 are consistent with the rates shown in these exhibits. The Status Quo benefits consist of 25 premium rate groups (five income categories for two Individual and three Small Group PPO plan designs) whereas the Alternative benefits consist of six groups (one Individual plan design for three income category groupings and three Small Group plan designs for all income categories), although we have shown the details for all 20 income and population combinations (five income categories for one Individual and three Small Group PPO plan designs).

Exhibits 2a and 2b summarize the resulting single "Employee Only" premium rates for the Status Quo and Alternative plans, respectively. Exhibit 2a also compares the projected premium to the 2010 premium rates, which were set equal to the (current) 2009 premium rates increased by 8.1% (per the RFP documents, 2009 premium rates will increase 8.1 – 8.4%). Exhibit 2b compares the Alternative premium rates to the FY2011 Status Quo rates.

METHODOLOGY AND ASSUMPTIONS

The data provided with the DirigoChoice bid was limited and did not contain sufficient detail in order to develop the pricing for the bid solely on experience data. In order to supplement for the provided data, the pricing for the DirigoChoice bid relied on the Milliman *Health Cost Guidelines (HCGs)*, which contains detailed utilization and unit costs for a commercial (working) population. The Milliman HCGs are developed as a result of Milliman's continuing research on healthcare costs. They were first developed in 1954 and have been updated and expanded annually since then. These guidelines are continually monitored as we use them in measuring the experience, or evaluating the rates of our clients, and as we compare them to other data sources. The HCGs are a cooperative effort of all Milliman health actuaries and represent a combination of their experience, research, and judgment. An extensive amount of data is used in developing these guidelines, including published and unpublished data. In most instances, cost assumptions are based upon our evaluation of several data sources and, hence, are not specifically attributable to a single source.

The Milliman models were adjusted by uninsured morbidity factors to adjust the HCG's underlying commercial utilization levels to those appropriate for a low-income, uninsured population. The uninsured adjustment factors are based on several data sources, both public and private, including claims experience from other state plans.

The RFP and databook contained fragmented data and assumptions. We did our best to interpret the information and used as much as we could in our analysis. Below we have summarized key assumptions as they pertain to the pricing

- RFP Basics
  - The premiums and claims have been projected to plan year FY2011 (July 1, 2010 through June 30, 2011) with a center date of January 1, 2011.
  - The premium rates assume 10% retention, as defined in the RFP.
- RFP Databook
  - We adjusted the Milliman HCG models to reflect the following assumptions from the RFP databook
    - Age and gender (demographic) distribution for Individual and Small Group.
      - The databook did not contain demographic information by income category. We used actuarial judgment to vary the final modeled claims costs to reflect differences due to selection and demographic mix. These adjustments are shown in Exhibits 1a and 1b. The adjustments composite to 1.00 and are based on a review of the current premiums and actuarial judgment.
    - Census by county. We adjusted the Milliman utilization and underlying billed charges for the current enrollment's regional mix.
  - Exhibit 3a and 3b (Status Quo and Alternative) summarize the assumed effective deductible and out-of-pocket maximums by plan, adjusted for the subsidy for each income group. The alternative cost sharing parameters were provided by Celtic. The copays and coinsurance amounts are the same for each plan; only the deductible and out-of-pocket maximums are different.
  - The premium rates were adjusted for the tier ratios contained in the databook. Note that the Employee+Spouse ratio is 2.0 for Individual and 2.3 for Small Group. However, the ratio in the current Harvard-Pilgrim premium rates is 2.1 for Small Group. We also relied on the databook's subscriber distribution by tier to develop the PMPM to Employee tier "Conversion Factor". The Conversion Factor is one of the bid form's inputs.

    As requested in Question #8 in the State's November 24, 2009 letter, the following documents the calculation of the bid's "Conversion Factor".

All pricing was performed on a per member per month, or PMPM basis. To convert the PMPM amounts to a tiered rate, you multiply the PMPM by total assumed members and divide by the total tier weights. Alternatively, you multiply the PMPM by the average family size and divide by the average tier weight. The tier weights were defined in the RFP databook. Below is an example calculation for the Status Quo Individual $1,750 deductible plan for Income Group B.

Tier	A. Subcriber Distribution	B. Tier Weight	C. Avg Family Size
Single	68%	1.0	1.00
EE+Sp	18%	2.0	2.00
EE + Child(ren)	5%	1.8	2.45
Family	10%	3.0	3.72
Subtotal	100%	1.41	1.51
Conversion Factor [D = C / B]			1.07

- Supplemental Data. We received several other data and information from the state (received October 26, 2009 and November 9, 2009) and from Celtic. We reviewed the data and relied on several pieces in order to calibrate the pricing models to experience.
  - Incurred Claims. We reviewed the calendar year 2008 and year-to-date (through July 31, 2009) incurred claims. We adjusted the 2008 claims to reflect the in-network benefit change from 20% coinsurance to 30% coinsurance, effective January 1, 2009. Exhibit 4c summarizes the historical and projected claims data for the current population.

    On November 6, 2009 we received claims for members Age 65+. This data is summarized in Exhibit 4b.

    Exhibit 4a summarizes the claims experience relied on in the calibration of the models. Although the state projects approximately 50% of the age 65+ members will remain with the plan, we decreased the percentage remaining to one-third given the proposed Alternative plan designs. This additional shift is reasonable given the "donut hole" Rx plan design since we assumed this would drive out more seniors than what the state has originally assumed.

  - Other utilization statistics. We also reviewed several other utilization metrics, including inpatient bed days, emergency room visits, and pharmacy scripts. The modeled utilization statistics were compared to the historical results and adjustments were made to the HCG models through the calibration such that the resulting models were consistent with experience.

- Milliman modeling
  - The databook contained subscriber demographic information by tier, but not member distributions. We extrapolated the number of dependents using Milliman's nationwide average population statistics. Note that the databook contains demographic factors and average family size; however the average household size contained in the databook may not match the average family size of covered members. Our average family size ranges from 1.51 – 1.74 by income group, which is lower than the databook's range of 1.89 – 2.22.
  - As discussed previously, we relied on additional morbidity factors for an uninsured population. These factors are considered proprietary.
  - We composited the in-network and out-of-network utilization assuming a 95% / 5% split.
  - To reflect competitive commercial reimbursement, and based on discussions with Celtic, we assumed 9% hospital and 36% professional discounts off billed charges for in-network benefits. For pharmacy, we assumed 60% discount for generics and 17% for brand drugs, and approximately a $1.65 per script dispensing fee. The pharmacy assumptions are based on Milliman nationwide average pharmacy. For the out-of-network benefits, we assumed no discounts off billed charges.
  - Medical Management Savings. The bids assume an approximate additional 1.5% savings off of the current medical management levels. This additional savings is based on a review of the claims experience and discussions with Celtic on the inferred current medical management effectiveness and achievable savings based on Celtic and Centene's experience with similar populations.
  - Alternative plan Rx "Donut Hole" Plan Design. Based on a review of a a Claim Probability Distribution (CPD), we assumed the introduction of a brand drug "donut hole" where beneficiaries would pay 100% of brand drug usage between annual spend of $2,500 and $5,000 would result in a cost savings of 8.8.

CAVEATS AND LIMITATIONS

This memorandum is subject to the terms and conditions of the Consulting Services Agreement between Centene and Milliman, Inc. We understand this memorandum will be shared with the State of Maine to assist in the review of Celtics's DirigoChoice bids. This documentation may contain proprietary information, including data from Milliman's *Health Cost Guidelines* and is to remain confidential and should not be utilized except to review Celtic's bid. In addition, no portion may be provided to any other party without Milliman, Inc.'s prior consent.

This analysis shows projections, not predictions. This analysis provides estimates of financial results that could be achieved, if actual experience exactly replicates the assumptions used in the analysis. Actual experience will likely differ from these results to a degree for a variety of reasons, including the variation of actual results from our assumptions, as well as random fluctuations. Future experience should be monitored to determine the impact these differences may have on this analysis.

In preparation of our analysis, we relied upon the accuracy of data or information provided to us by Celtic, Centene, and the State of Maine, including the data received in preparation of the DirigoChoice bids. We reviewed this information for reasonableness, but we have not audited this information. If the underlying data or information is inaccurate or incomplete, the results of our review may likewise be inaccurate or incomplete.

CLOSING

The undersigned is a qualified consulting actuary of Milliman, a Member of the American Academy of Actuaries, and a Fellow of the Society of Actuaries. I certify that I meet the qualification standards established by the American Academy of Actuaries and have followed the practice standards established from time-to-time by the Actuarial Standards Board. I acknowledge that the information contained in this document was requested by the State of Maine to understand the methodology used to estimate the prospective premium rates for the DirigoChoice program.

Craig B. Keizur, FSA, MAAA
Principal & Consulting Actuary
December 1, 2009

Exhibit 1a
Centene - DirigoChoice RFP
Summary of Projected Claim Costs and Required Revenue
Status Quo Benefit Design

			Claim Cost													
			In-Network		Out-of-Network		Blended PPO									
Population	Benefit	Group	Gross	Net	Gross	Net	Gross	Net	Actuarial Value	IP Bed Days	ER Visits	RX	Rx % of Net	Income Demographic Differential	Needed Revenue	Weight
Individual / Sole Proprietor	$1,750 Ded	B	$605.72	$533.04	$776.61	$655.85	$614.26	$539.18	88%	456.72	299.08	$106.95	20%	1.01	$605.08	21%
Individual / Sole Proprietor	$1,750 Ded	C	$605.76	$520.99	$776.67	$628.67	$614.30	$526.37	86%	456.84	299.08	$106.95	20%	1.00	$584.86	8%
Individual / Sole Proprietor	$1,750 Ded	D	$605.75	$511.10	$776.66	$606.99	$614.29	$515.89	84%	456.84	299.08	$106.95	21%	0.99	$567.49	2%
Individual / Sole Proprietor	$1,750 Ded	E	$605.78	$506.85	$776.67	$593.75	$614.32	$511.20	83%	456.84	299.08	$106.95	21%	0.97	$550.96	1%
Individual / Sole Proprietor	$1,750 Ded	F	$605.72	$494.84	$776.60	$572.01	$614.26	$498.70	81%	456.61	299.08	$106.95	21%	0.96	$531.95	3%
Individual / Sole Proprietor	$2,500 Ded	B	$605.72	$546.44	$776.61	$690.32	$614.26	$553.63	90%	456.72	299.08	$106.95	19%	1.01	$621.30	23%
Individual / Sole Proprietor	$2,500 Ded	C	$605.72	$529.72	$776.60	$657.85	$614.26	$536.13	87%	456.72	299.08	$106.95	20%	1.00	$595.70	8%
Individual / Sole Proprietor	$2,500 Ded	D	$605.72	$517.47	$776.60	$633.98	$614.26	$523.30	85%	456.72	299.08	$106.95	20%	0.99	$575.63	2%
Individual / Sole Proprietor	$2,500 Ded	E	$605.72	$507.04	$776.55	$614.17	$614.26	$512.40	83%	456.49	299.08	$106.95	21%	0.97	$552.25	1%
Individual / Sole Proprietor	$2,500 Ded	F	$605.72	$497.87	$776.60	$597.09	$614.26	$502.83	82%	456.72	299.08	$106.95	21%	0.96	$536.36	3%
Small Group	$1,250 Ded	B	$429.81	$377.75	$577.51	$498.08	$437.19	$383.77	88%	213.29	278.40	$67.22	18%	1.01	$430.67	2%
Small Group	$1,250 Ded	C	$429.79	$362.27	$577.48	$466.89	$437.17	$367.50	84%	213.21	278.40	$67.22	18%	1.00	$408.34	2%
Small Group	$1,250 Ded	D	$429.79	$351.78	$577.48	$445.12	$437.17	$356.45	82%	213.22	278.40	$67.22	19%	0.99	$392.09	1%
Small Group	$1,250 Ded	E	$429.59	$342.91	$577.38	$427.23	$436.97	$347.13	79%	213.05	278.40	$67.22	19%	0.97	$374.13	1%
Small Group	$1,250 Ded	F	$429.70	$339.89	$577.48	$417.61	$437.08	$343.78	79%	213.22	278.40	$67.22	20%	0.96	$366.70	3%
Small Group	$1,750 Ded	B	$429.82	$362.30	$577.52	$466.93	$437.20	$367.53	84%	213.29	278.40	$67.22	18%	1.01	$412.45	2%
Small Group	$1,750 Ded	C	$429.67	$350.51	$577.43	$441.76	$437.05	$355.07	81%	213.14	278.40	$67.22	19%	1.00	$394.53	2%
Small Group	$1,750 Ded	D	$429.82	$341.54	$577.52	$422.36	$437.20	$345.58	79%	213.29	278.40	$67.22	19%	0.99	$380.14	2%
Small Group	$1,750 Ded	E	$429.79	$338.09	$577.47	$411.29	$437.17	$341.75	78%	213.21	278.40	$67.22	20%	0.97	$368.33	1%
Small Group	$1,750 Ded	F	$429.67	$327.17	$577.44	$392.01	$437.05	$330.41	76%	213.13	278.40	$67.22	20%	0.96	$352.44	3%
Small Group	$2,500 Ded	B	$429.70	$375.67	$577.47	$499.61	$437.08	$381.87	87%	213.21	278.40	$67.22	18%	1.01	$428.54	3%
Small Group	$2,500 Ded	C	$429.79	$358.89	$577.48	$467.80	$437.17	$364.34	83%	213.21	278.40	$67.22	18%	1.00	$404.82	2%
Small Group	$2,500 Ded	D	$429.67	$346.79	$577.43	$445.09	$437.05	$351.71	80%	213.13	278.40	$67.22	19%	0.99	$386.88	1%
Small Group	$2,500 Ded	E	$429.85	$336.89	$577.58	$426.89	$437.23	$341.39	78%	213.37	278.40	$67.22	20%	0.97	$367.95	1%
Small Group	$2,500 Ded	F	$429.67	$328.09	$577.43	$411.14	$437.05	$332.24	76%	213.13	278.40	$67.22	20%	0.96	$354.39	2%
Individual			$605.72	$530.38	$776.61	$653.79	$614.27	$536.55	87%	456.73	299.08	$106.95	20%		$597.06	72%
Small Group			$429.73	$350.06	$577.47	$443.76	$437.12	$354.75	81%	213.20	278.40	$67.22	19%		$388.95	28%
Total			$557.10	$480.57	$721.60	$595.77	$565.33	$486.33	86%	389.45	293.37	$95.97	20%		$539.57	100%

Exhibit 1b
Centene - DirigoChoice RFP
Summary of Projected Claim Costs and Required Revenue
Alternative Option Plan Design *

			Claim Cost													
			In-Network		Out-of-Network		Blended PPO									
Population	Benefit	Group	Gross	Net	Gross	Net	Gross	Net	Actuarial Value	IP Bed Days	ER Visits	RX	Rx % of Net	Income Demographic Differential	Needed Revenue	Weight
Small Group	$1,250 Ded	B	$410.35	$355.74	$553.82	$482.00	$417.52	$362.05	87%	210.39	274.75	$53.90	15%	1.01	$406.30	6%
Small Group	$1,250 Ded	C	$410.35	$341.80	$553.83	$459.42	$417.52	$347.68	83%	210.39	274.75	$53.90	16%	1.00	$386.31	6%
Small Group	$1,250 Ded	D	$410.35	$332.31	$553.83	$444.33	$417.52	$337.91	81%	210.39	274.75	$53.90	16%	0.99	$371.70	4%
Small Group	$1,250 Ded	E	$410.35	$324.63	$553.84	$432.10	$417.52	$330.01	79%	210.40	274.75	$53.90	16%	0.97	$355.67	2%
Small Group	$1,250 Ded	F	$410.35	$321.98	$553.83	$427.82	$417.52	$327.27	78%	210.39	274.75	$53.90	16%	0.96	$349.09	9%
Small Group	$2,500 Ded	B	$410.22	$347.71	$553.66	$469.23	$417.40	$353.79	85%	210.39	274.75	$53.90	15%	1.01	$397.03	6%
Small Group	$2,500 Ded	C	$410.29	$330.58	$553.67	$441.67	$417.46	$336.13	81%	210.39	274.75	$53.90	16%	1.00	$373.48	6%
Small Group	$2,500 Ded	D	$410.29	$318.66	$553.67	$423.25	$417.46	$323.89	78%	210.39	274.75	$53.90	17%	0.99	$356.28	4%
Small Group	$2,500 Ded	E	$410.23	$308.99	$553.68	$408.60	$417.41	$313.97	75%	210.40	274.75	$53.90	17%	0.97	$338.39	2%
Small Group	$2,500 Ded	F	$410.22	$301.02	$553.67	$396.59	$417.40	$305.80	73%	210.39	274.75	$53.90	18%	0.96	$326.19	9%
Small Group	$5,000 Ded	B	$418.06	$360.35	$562.12	$482.30	$425.27	$366.45	86%	210.39	274.75	$60.73	17%	1.01	$411.24	6%
Small Group	$5,000 Ded	C	$418.13	$336.76	$562.13	$446.72	$425.33	$342.25	80%	210.39	274.75	$60.73	18%	1.00	$380.28	6%
Small Group	$5,000 Ded	D	$418.13	$323.23	$562.13	$426.69	$425.33	$328.40	77%	210.39	274.75	$60.73	18%	0.99	$361.24	4%
Small Group	$5,000 Ded	E	$418.07	$312.13	$562.14	$410.86	$425.28	$317.06	75%	210.40	274.75	$60.73	19%	0.97	$341.72	2%
Small Group	$5,000 Ded	F	$418.06	$302.53	$562.13	$397.57	$425.27	$307.29	72%	210.39	274.75	$60.73	20%	0.96	$327.77	9%
Individual / Sole Proprietor	$2,500 Ded	B	$576.84	$511.06	$745.01	$660.22	$585.25	$518.52	89%	450.70	295.14	$86.13	17%	1.01	$581.89	44%
Individual / Sole Proprietor	$2,500 Ded	C	$576.76	$493.34	$744.90	$633.27	$585.17	$500.34	86%	450.70	295.14	$86.13	17%	1.00	$555.93	16%
Individual / Sole Proprietor	$2,500 Ded	D	$576.66	$480.53	$744.77	$614.40	$585.07	$487.22	83%	450.70	295.14	$86.13	18%	0.99	$535.94	5%
Individual / Sole Proprietor	$2,500 Ded	E	$576.65	$469.54	$744.77	$599.16	$585.06	$476.02	81%	450.70	295.14	$86.13	18%	0.97	$513.05	2%
Individual / Sole Proprietor	$2,500 Ded	F	$576.70	$460.34	$744.82	$585.67	$585.11	$466.61	80%	450.82	295.14	$86.13	18%	0.96	$497.72	6%
Proposed Bids:																
1	Individual/Sole Prop	B	$576.84	$511.06	$745.01	$660.22	$585.25	$518.52	89%	450.70	295.14	$86.13	17%	1.01	$581.89	44%
2	Individual/Sole Prop	C	$576.76	$493.34	$744.90	$633.27	$585.17	$500.34	86%	450.70	295.14	$86.13	17%	1.00	$555.93	16%
3	Individual/Sole Prop	D,E,F	$576.68	$467.21	$744.80	$595.50	$585.09	$473.62	81%	450.77	295.14	$86.13	18%	0.97	$510.27	13%
4 - Value	Small Group	B,C,D,E,F	$410.35	$336.03	$553.83	$450.31	$417.52	$341.74	82%	210.39	274.75	$53.90	16%	0.99	$374.34	10%
5 - Basic	Small Group	B,C,D,E,F	$410.25	$321.78	$553.67	$428.54	$417.42	$327.12	78%	210.39	274.75	$53.90	16%	0.99	$358.33	14%
6 - HDHP	Small Group	B,C,D,E,F	$418.09	$327.52	$562.13	$433.72	$425.29	$332.83	78%	210.39	274.75	$60.73	18%	0.99	$364.58	4%
	Total		$531.07	$451.88	$692.42	$585.88	$539.14	$458.58	85%	384.32	289.50	$77.47	17%		$508.52	100%

* The results presented in Exhibit 1b are consistent with the bid pricing completed on 11/13/2009. Subsequent benefit package trade-offs resulted in small shifts in final cost projection, but the results were revenue neutral in total.

Exhibit 2a
Centene - DirigoChoice RFP
Comparison of Single Ee Premium Rates
Status Quo Plan Design

Population	Benefit	Group	Single Ee Premium Rates FY 2010	Single Ee Premium Rates FY 2011	Percentage Change
Individual / Sole Proprietor	$1,750 Ded	B	$683.43	$648.89	-5.05%
Individual / Sole Proprietor	$1,750 Ded	C	$635.36	$627.21	-1.28%
Individual / Sole Proprietor	$1,750 Ded	D	$601.40	$608.57	1.19%
Individual / Sole Proprietor	$1,750 Ded	E	$567.73	$590.85	4.07%
Individual / Sole Proprietor	$1,750 Ded	F	$538.89	$570.46	5.86%
Individual / Sole Proprietor	$2,500 Ded	B	$688.60	$666.28	-3.24%
Individual / Sole Proprietor	$2,500 Ded	C	$633.88	$638.83	0.78%
Individual / Sole Proprietor	$2,500 Ded	D	$596.28	$617.30	3.53%
Individual / Sole Proprietor	$2,500 Ded	E	$564.54	$592.23	4.90%
Individual / Sole Proprietor	$2,500 Ded	F	$539.19	$575.19	6.68%
Small Group	$1,250 Ded	B	$521.19	$484.20	-7.10%
Small Group	$1,250 Ded	C	$484.20	$459.08	-5.19%
Small Group	$1,250 Ded	D	$455.90	$440.82	-3.31%
Small Group	$1,250 Ded	E	$434.49	$420.62	-3.19%
Small Group	$1,250 Ded	F	$413.80	$412.27	-0.37%
Small Group	$1,750 Ded	B	$484.21	$463.71	-4.23%
Small Group	$1,750 Ded	C	$449.98	$443.56	-1.43%
Small Group	$1,750 Ded	D	$425.80	$427.38	0.37%
Small Group	$1,750 Ded	E	$401.87	$414.11	3.04%
Small Group	$1,750 Ded	F	$381.39	$396.24	3.89%
Small Group	$2,500 Ded	B	$487.37	$481.80	-1.14%
Small Group	$2,500 Ded	C	$448.64	$455.13	1.45%
Small Group	$2,500 Ded	D	$422.02	$434.96	3.06%
Small Group	$2,500 Ded	E	$399.56	$413.67	3.53%
Small Group	$2,500 Ded	F	$381.60	$398.44	4.41%

Exhibit 2b
Centene - DirigoChoice RFP
Single Employee Premium Rates
Alternative Option Plan Design

Population	Alternative Benefit	Group	FY 2011 Single Ee Premium Rates: Status Quo	FY 2011 Single Ee Premium Rates: Alternative	Percentage Change	Note
Individual/Sole Prop	$2,500 Ded	B	$657.91	$624.02	-5.15%	SQ ben. is Composite of $1,250 and $1,750 Ded
Individual/Sole Prop	$2,500 Ded	C	$632.83	$596.18	-5.79%	SQ ben. is Composite of $1,250 and $1,750 Ded
Individual/Sole Prop	$2,500 Ded	D,E,F	$590.42	$547.21	-7.32%	SQ ben. is Composite of $1,250 and $1,750 Ded
Small Group	$1,250 Ded	B,C,D,E,F	$442.58	$420.87	-4.90%	SQ ben. is $1,250 Ded
Small Group	$2,500 Ded	B,C,D,E,F	$426.46	$402.86	-5.53%	SQ ben. is $1,750 Ded
Small Group	$5,000 Ded	B,C,D,E,F	$442.20	$409.89	-7.31%	SQ ben. is $2,500 Ded

Exhibit 3a
Centene - DirigoChoice RFP
Summary of Deductibles and Out-of-Pocket Maximums
Status Quo Benefit Design
(See Celtic/Centene plan documents for copays and other benefit parameters)

Option Number	Population	Income Category	Subsidy	Ded	Eff. Ded	OOP Max	Eff OOP Max not incl. ded	Eff OOP Max incl. ded
1 - 1750 Deductible Plan	Individual/Sole Prop	B	80%	$2,500	$500	$8,000	$1,100	$1,600
2 - 1750 Deductible Plan	Individual/Sole Prop	C	60%	$2,000	$800	$6,500	$1,800	$2,600
3 - 1750 Deductible Plan	Individual/Sole Prop	D	40%	$1,875	$1,125	$6,000	$2,475	$3,600
4 - 1750 Deductible Plan	Individual/Sole Prop	E	20%	$1,813	$1,450	$5,750	$3,150	$4,600
5 - 1750 Deductible Plan	Individual/Sole Prop	F	0%	$1,750	$1,750	$5,600	$3,850	$5,600
6 - 2500 Deductible Plan	Individual/Sole Prop	B	80%	$2,500	$500	$3,500	$200	$700
7 - 2500 Deductible Plan	Individual/Sole Prop	C	60%	$2,500	$1,000	$3,500	$400	$1,400
8 - 2500 Deductible Plan	Individual/Sole Prop	D	40%	$2,500	$1,500	$3,500	$600	$2,100
9 - 2500 Deductible Plan	Individual/Sole Prop	E	20%	$2,500	$2,000	$3,500	$800	$2,800
10 - 2500 Deductible Plan	Individual/Sole Prop	F	0%	$2,500	$2,500	$3,500	$1,000	$3,500
11 - 1250 Deductible Plan	Small Group	B	80%	$1,250	$250	$4,000	$550	$800
12 - 1250 Deductible Plan	Small Group	C	60%	$1,250	$500	$4,000	$1,100	$1,600
13 - 1250 Deductible Plan	Small Group	D	40%	$1,250	$750	$4,000	$1,650	$2,400
14 - 1250 Deductible Plan	Small Group	E	20%	$1,250	$1,000	$4,000	$2,200	$3,200
15 - 1250 Deductible Plan	Small Group	F	0%	$1,250	$1,250	$4,000	$2,750	$4,000
16 - 1750 Deductible Plan	Small Group	B	80%	$2,500	$500	$8,000	$1,100	$1,600
17 - 1750 Deductible Plan	Small Group	C	60%	$2,000	$800	$6,500	$1,800	$2,600
18 - 1750 Deductible Plan	Small Group	D	40%	$1,875	$1,125	$6,000	$2,475	$3,600
14 - 1250 Deductible Plan	Small Group	E	20%	$1,250	$1,000	$4,000	$2,200	$3,200
20 - 1750 Deductible Plan	Small Group	F	0%	$1,750	$1,750	$5,600	$3,850	$5,600
21- 2500 Deductible Plan	Small Group	B	80%	$2,500	$500	$3,500	$200	$700
22 - 2500 Deductible Plan	Small Group	C	60%	$2,500	$1,000	$3,500	$400	$1,400
23 - 2500 Deductible Plan	Small Group	D	40%	$2,500	$1,500	$3,500	$600	$2,100
24 - 2500 Deductible Plan	Small Group	E	20%	$2,500	$2,000	$3,500	$800	$2,800
25 - 2500 Deductible Plan	Small Group	F	0%	$2,500	$2,500	$3,500	$1,000	$3,500

Exhibit 3b
Centene - DirigoChoice RFP
Summary of Deductibles and Out-of-Pocket Maximums
Alternative Benefit Design
(See Celtic/Centene plan documents for copays and other benefit parameters)

Option Number	Population	Income Category	Subsidy	Ded	Eff. Ded	OOP Max	Eff OOP Max not incl. ded	Eff OOP Max incl. ded
1	Individual/Sole Prop	B	80%	$2,500	$500	$5,500	$600	$1,100
2	Individual/Sole Prop	C	60%	$2,500	$1,000	$5,500	$1,200	$2,200
3	Individual/Sole Prop	D	40%	$2,500	$1,500	$5,500	$1,800	$3,300
3	Individual/Sole Prop	E	20%	$2,500	$2,000	$5,500	$2,400	$4,400
3	Individual/Sole Prop	F	0%	$2,500	$2,500	$5,500	$3,000	$5,500
4 - Value	Small Group	B	80%	$1,250	$250	$4,000	$550	$800
4 - Value	Small Group	C	60%	$1,250	$500	$4,000	$1,100	$1,600
4 - Value	Small Group	D	40%	$1,250	$750	$4,000	$1,650	$2,400
4 - Value	Small Group	E	20%	$1,250	$1,000	$4,000	$2,200	$3,200
4 - Value	Small Group	F	0%	$1,250	$1,250	$4,000	$2,750	$4,000
5 - Basic	Small Group	B	80%	$2,500	$500	$5,500	$600	$1,100
5 - Basic	Small Group	C	60%	$2,500	$1,000	$5,500	$1,200	$2,200
5 - Basic	Small Group	D	40%	$2,500	$1,500	$5,500	$1,800	$3,300
5 - Basic	Small Group	E	20%	$2,500	$2,000	$5,500	$2,400	$4,400
5 - Basic	Small Group	F	0%	$2,500	$2,500	$5,500	$3,000	$5,500
6 - HDHP	Small Group	B	80%	$5,000	$1,000	$5,000	$0	$1,000
6 - HDHP	Small Group	C	60%	$5,000	$2,000	$5,000	$0	$2,000
6 - HDHP	Small Group	D	40%	$5,000	$3,000	$5,000	$0	$3,000
6 - HDHP	Small Group	E	20%	$5,000	$4,000	$5,000	$0	$4,000
6 - HDHP	Small Group	F	0%	$5,000	$5,000	$5,000	$0	$5,000

Exhibit 4a
Centene - DirigoChoice RFP
Historical and Projected Claims Data
With 2/3 of 65+ Population Removed

Income Category	Population	Year [1]	MMs	Med Claims	Rx Claims	Total Claims	PMPM	*Benefit Changes* 1/1/2009: 20% to 30% IN	*Trended to 1/1/2011 (7/1/2010 - 6/30/2011 year)* Annual Trend Rate	# of Months	Trended PMPM	Blended Claim Projection 50% 2008 50% 2009
B	Small Groups	2008	7,344	$2,247,191	$505,473	$2,752,664	$374.82	0.9954	1.070	30.0	$441.83	
C	Small Groups	2008	5,647	$1,561,411	$291,945	$1,853,356	$328.19	0.9934	1.070	30.0	$386.11	
D	Small Groups	2008	4,925	$737,932	$257,845	$995,777	$202.19	0.9919	1.070	30.0	$237.51	
E	Small Groups	2008	2,834	$892,850	$202,199	$1,095,050	$386.36	0.9904	1.070	30.0	$453.17	
F	Small Groups	2008	14,326	$2,957,195	$699,901	$3,657,096	$255.27	0.9889	1.070	30.0	$298.96	
Total	Small Groups	2008	35,077	$8,396,580	$1,957,362	$10,353,942	$295.18				$346.74	
B	Small Groups	2009	3,723	$1,205,923	$329,459	$1,535,382	$412.36	1.000	1.070	20.5	$462.88	$450.00
C	Small Groups	2009	2,859	$906,939	$205,494	$1,112,433	$389.10	1.000	1.070	20.5	$436.78	$410.00
D	Small Groups	2009	2,509	$484,423	$133,312	$617,735	$246.19	1.000	1.070	20.5	$276.36	$260.00
E	Small Groups	2009	1,428	$625,036	$143,060	$768,096	$537.95	1.000	1.070	20.5	$603.87	$530.00
F	Small Groups	2009	7,289	$1,429,064	$424,676	$1,853,739	$254.33	1.000	1.070	20.5	$285.50	$290.00
Total	Small Groups	2009	17,808	$4,651,385	$1,236,001	$5,887,385	$330.60				$371.11	**$358.00**
B	Ind / Sole P.	2008	58,099	$24,893,631	$4,995,734	$29,889,365	$514.45	0.9962	1.070	30.0	$606.96	
C	Ind / Sole P.	2008	16,419	$4,813,519	$769,056	$5,582,575	$340.01	0.9940	1.070	30.0	$400.25	
D	Ind / Sole P.	2008	8,748	$1,962,323	$797,547	$2,759,870	$315.50	0.9930	1.070	30.0	$371.01	
E	Ind / Sole P.	2008	3,923	$1,136,353	$358,434	$1,494,787	$381.03	0.9912	1.070	30.0	$447.26	
F	Ind / Sole P.	2008	12,715	$4,145,985	$1,309,380	$5,455,365	$429.06	0.9903	1.070	30.0	$503.21	
Total	Ind / Sole P.	2008	99,903	$36,951,812	$8,230,151	$45,181,962	$452.26				$532.85	
B	Ind / Sole P.	2009	29,345	$12,799,104	$2,770,698	$15,569,802	$530.58	1.000	1.070	20.5	$595.59	$600.00
C	Ind / Sole P.	2009	7,847	$2,427,127	$557,491	$2,984,618	$380.34	1.000	1.070	20.5	$426.94	$410.00
D	Ind / Sole P.	2009	3,541	$743,404	$277,602	$1,021,005	$288.37	1.000	1.070	20.5	$323.70	$350.00
E	Ind / Sole P.	2009	1,381	$543,470	$162,827	$706,297	$511.32	1.000	1.070	20.5	$573.97	$510.00
F	Ind / Sole P.	2009	4,726	$1,537,350	$614,193	$2,151,543	$455.26	1.000	1.070	20.5	$511.04	$510.00
Total	Ind / Sole P.	2009	46,840	$18,050,454	$4,382,812	$22,433,266	$478.93				$557.61	**$538.00**
Small Groups			52,885	$13,047,964	$3,193,363	$16,241,327	$307.11					
Individual			146,744	$55,002,266	$12,612,962	$67,615,228	$460.77					

(1) 2008 = CY 2008
2009 = 1/2009 - 7/2009 (7 months, midpoint = 4/15/2009)

(2) Composite PMPMs weighted using most current (2009) plan mix

Exhibit 4b
Centene - DirigoChoice RFP
Historical and Projected Claims Data
65+ Population

Income Category	Population	Year [1]	MMs	Med Claims	Rx Claims	Total Claims	PMPM
B	Small Groups	2008	191	$392,630	$30,152	$422,782	$2,213.52
C	Small Groups	2008	68	$155,328	$8,421	$163,749	$2,408.07
D	Small Groups	2008	84	$84,069	$9,762	$93,831	$1,117.04
E	Small Groups	2008	18	$0	$0	$0	$0.00
F	Small Groups	2008	391	$140,112	$44,679	$184,791	$472.61
Total	Small Groups	2008	752	$772,139	$93,015	$865,154	$1,150.47
B	Small Groups	2009	71	$32,188	$21,205	$53,393	$752.01
C	Small Groups	2009	21	$192,424	$6,156	$198,580	$9,456.20
D	Small Groups	2009	7	$2,076	$1,203	$3,279	$468.40
E	Small Groups	2009	13	$1,743	$3,162	$4,905	$377.31
F	Small Groups	2009	110	$11,322	$19,976	$31,298	$284.53
Total	Small Groups	2009	222	$239,752	$51,703	$291,455	$1,312.86
B	Ind / Sole P.	2008	9,880	$4,799,014	$1,014,196	$5,813,210	$588.38
C	Ind / Sole P.	2008	1,271	$615,508	$119,734	$735,242	$578.48
D	Ind / Sole P.	2008	641	$211,705	$38,131	$249,836	$389.76
E	Ind / Sole P.	2008	297	$120,535	$21,096	$141,630	$476.87
F	Ind / Sole P.	2008	1,190	$535,378	$158,342	$693,720	$582.96
Total	Ind / Sole P.	2008	13,279	$6,282,140	$1,351,499	$7,633,638	$574.87
B	Ind / Sole P.	2009	3,654	$2,132,151	$461,734	$2,593,884	$709.88
C	Ind / Sole P.	2009	379	$200,510	$43,424	$243,934	$643.63
D	Ind / Sole P.	2009	170	$23,992	$11,210	$35,202	$207.07
E	Ind / Sole P.	2009	64	$33,976	$4,114	$38,090	$595.15
F	Ind / Sole P.	2009	315	$265,391	$59,533	$324,924	$1,031.51
Total	Ind / Sole P.	2009	4,582	$2,656,020	$580,015	$3,236,035	$706.25
Small Groups			974	$1,011,891	$144,717	$1,156,609	$1,187.48
Individual			17,861	$8,938,159	$1,931,514	$10,869,673	$608.57

(1) 2008 = CY 2008
2009 = 1/2009 - 7/2009 (7 months, midpoint = 4/15/2009)

Exhibit 4c
Centene - DirigoChoice RFP
Historical and Projected Claims Data
Total Population

Income Category	Population	Year [1]	MMs	Med Claims	Rx Claims	Total Claims	PMPM
B	Small Groups	2008	7,471	$2,508,944	$525,574	$3,034,519	$406.15
C	Small Groups	2008	5,692	$1,664,963	$297,559	$1,962,522	$344.76
D	Small Groups	2008	4,981	$793,978	$264,352	$1,058,331	$212.48
E	Small Groups	2008	2,846	$892,850	$202,199	$1,095,050	$384.74
F	Small Groups	2008	14,587	$3,050,603	$729,687	$3,780,290	$259.16
Total	Small Groups	2008	35,578	$8,911,339	$2,019,372	$10,930,711	$307.23
B	Small Groups	2009	3,771	$1,227,381	$343,596	$1,570,977	$416.62
C	Small Groups	2009	2,873	$1,035,222	$209,598	$1,244,820	$433.29
D	Small Groups	2009	2,514	$485,807	$134,114	$619,921	$246.60
E	Small Groups	2009	1,436	$626,198	$145,168	$771,366	$536.98
F	Small Groups	2009	7,362	$1,436,612	$437,993	$1,874,605	$254.63
Total	Small Groups	2009	17,956	$4,811,219	$1,270,469	$6,081,689	$338.70
B	Ind / Sole P.	2008	64,686	$28,092,973	$5,671,865	$33,764,838	$521.98
C	Ind / Sole P.	2008	17,266	$5,223,858	$848,878	$6,072,736	$351.72
D	Ind / Sole P.	2008	9,175	$2,103,460	$822,967	$2,926,427	$318.96
E	Ind / Sole P.	2008	4,121	$1,216,710	$372,498	$1,589,208	$385.64
F	Ind / Sole P.	2008	13,508	$4,502,904	$1,414,941	$5,917,845	$438.10
Total	Ind / Sole P.	2008	108,756	$41,139,905	$9,131,150	$50,271,055	$462.24
B	Ind / Sole P.	2009	31,781	$14,220,538	$3,078,520	$17,299,058	$544.32
C	Ind / Sole P.	2009	8,100	$2,560,800	$586,441	$3,147,241	$388.55
D	Ind / Sole P.	2009	3,654	$759,398	$285,075	$1,044,473	$285.84
E	Ind / Sole P.	2009	1,424	$566,121	$165,570	$731,691	$513.83
F	Ind / Sole P.	2009	4,936	$1,714,277	$653,882	$2,368,159	$479.77
Total	Ind / Sole P.	2009	49,895	$19,821,134	$4,769,488	$24,590,623	$492.85
Small Groups			53,534	$13,722,558	$3,289,841	$17,012,400	$317.79
Individual			158,651	$60,961,039	$13,900,638	$74,861,677	$471.86

(1) 2008 = CY 2008
2009 = 1/2009 - 7/2009 (7 months, midpoint = 4/15/2009)