

**LOUISIANA HEALTH PLAN**  
**P. O. Drawer 83880**  
**Baton Rouge, Louisiana 70884-3880**  
**(225) 926-6245 800-736-0947 Fax (225) 927-3873**

**TO:** All Policyholders in the High Risk Pool  
**FROM:** Leah Barron, Executive Director  
**DATE:** December 10, 2007  
**RE:** Renewal Forms – To be completed and returned by December 21, 2007

Enclosed please find:

- a. Renewal form to elect deductible for the year 2008 (beige)
- b. Proof of Eligibility (purple)
- c. Medical Form (yellow)
- d. Reminder Form
- e. Rate sheet for the year 2008
- f. Income Questionnaire Form (light pink)
- g. Envelope to send your January premium payment to Covenant Administrators
- h. Return envelope to send completed renewal forms to Louisiana Health Plan

Please complete and return these forms so that they are **received at the Louisiana Health Plan office by December 21, 2007**. Before mailing, please refer to the check-off list on the bright green form. Please be sure that that you have enclosed all pages, **completed, signed and dated**, as well as a copy of the front and back of your Louisiana Drivers License. An envelope is enclosed for your convenience.

**ALL POLICYHOLDERS MUST COMPLETE ALL RENEWAL FORMS TO CONTINUE THEIR COVERAGE**, including those who became effective in October, November or December, 2007. Renewal papers must be completed and received at the LHP office before your January premium will be accepted.

**PREMIUM INVOICES will NOT be mailed for January because the renewal information must be entered into the computer system.** Please use the enclosed rate sheet to calculate your premium and use the enclosed envelope to mail your premium payment to Covenant Administrators. You may call LHP or Covenant to confirm the amount of your premium. **Premiums are due January 1, 2008. Please PRINT your NAME and SOCIAL SECURITY NUMBER on your check (or include it on a piece of paper) and send your January premium payment to:**

(envelope is enclosed for your convenience)  
**Covenant Administrators, Inc.**  
**LHP Premium Payment Dept.**  
**P. O. Box 7**  
**Suwanee, GA 30024-0007**

If you have any questions, please feel free to contact our office at 1-800-736-0947.

**HR POOL PROOF OF ELIGIBILITY 2008**

(Initial and Date EACH page and sign and date at the end)

Page 1 of 4 (see back of page for pages 2 and 4)

**1. Medicaid**

\_\_\_\_\_ I am not currently receiving Medicaid Benefits

\_\_\_\_\_ I am currently receiving Medicaid Benefits

If yes, as of what date? \_\_\_\_\_

\_\_\_\_\_ I have applied for Medicaid Benefits

If yes, date of application: \_\_\_\_\_ Office: \_\_\_\_\_

**2. Medicare**

\_\_\_\_\_ I am not currently receiving Medicare Benefits

\_\_\_\_\_ I am currently receiving Medicare Benefits

If yes, as of what date? \_\_\_\_\_

\_\_\_\_\_ I have applied for Medicare Benefits

If yes, date of application: \_\_\_\_\_ Office: \_\_\_\_\_

**3. Individual Insurance**

\_\_\_\_\_ I am not currently covered under an Individual Insurance Plan (other than LHP coverage)

\_\_\_\_\_ I am currently covered under an Individual Insurance Plan (other than LHP coverage)

If yes, Name of Company: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: (\_\_\_\_) \_\_\_\_\_

Policy Number: \_\_\_\_\_

Date Coverage Began: \_\_\_\_\_

\_\_\_\_\_ I have applied for an Individual Insurance Policy

If yes, Name of Company: \_\_\_\_\_

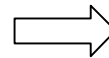
Address: \_\_\_\_\_

Telephone Number: (\_\_\_\_) \_\_\_\_\_

**Initial:** \_\_\_\_\_

**Date:** \_\_\_\_\_

(Continued on Back)



**4. Group Coverage**

\_\_\_\_\_ I am not currently covered under a Group Insurance Plan

\_\_\_\_\_ I am currently covered under a Group Insurance Plan

If yes, Name of Employer: \_\_\_\_\_

Address of Employer: \_\_\_\_\_

Telephone Number of Employer: (\_\_\_\_\_) \_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_

Address of Insurance Company: \_\_\_\_\_

Telephone # of Group Insurance Co.: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Member Number: \_\_\_\_\_

Initial Date of Coverage: \_\_\_\_\_

\_\_\_\_\_ I have applied for a Group Insurance Policy

If yes, Name of Employer: \_\_\_\_\_

Address of Employer: \_\_\_\_\_

Telephone Number of Employer: (\_\_\_\_\_) \_\_\_\_\_

Name of Group Insurance Company: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number of Group Ins. Co. (\_\_\_\_\_) \_\_\_\_\_

**5. Employment**

A. Are you or your spouse employed? If you are a dependent child, are either of your parents or legal guardians employed?

Yes \_\_\_\_\_

No \_\_\_\_\_

If yes, please state the name, address and telephone number of the employer(s).

**Initial:** \_\_\_\_\_

**Date:** \_\_\_\_\_

B. If you or your spouse are employed, does the employer offer major medical insurance coverage? If you are a dependent child, and either of your parents or legal guardians are employed, does the employer offer major medical insurance coverage?

Yes \_\_\_\_\_

No \_\_\_\_\_

If yes, please state the policy and group number, the name of the insured, whether or not you are eligible for the insurance coverage, and if not, why not.

**6. Citizenship**

\_\_\_\_\_ I am currently a citizen of the United States of America

\_\_\_\_\_ I am not currently a citizen of the United States of America

If not a U. S. Citizen,

\_\_\_\_\_ I am a resident alien

\_\_\_\_\_ Proof of resident alien status is attached

\_\_\_\_\_ I have applied for resident alien status

\_\_\_\_\_ Proof of application (including date and place of filing and copy thereof is attached)

\_\_\_\_\_ I am not a resident alien and have not applied for resident alien status

**7. Residency**

A. \_\_\_\_\_ **I am currently a resident of the State of Louisiana**

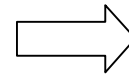
\_\_\_\_\_ **PLEASE ENCLOSE a copy of the front and back of your current Louisiana Driver's license**

\_\_\_\_\_ I do not have a Louisiana Driver's license, but have attached copies of the last six months of lease, homestead exemption filing, utility or other receipts showing my physical address in Louisiana

\_\_\_\_\_ **I additionally certify that I have not resided in any other state for a period of more than six months between the periods of December 31, 2006 and November 30, 2007**

**Initial:** \_\_\_\_\_  
**Date:** \_\_\_\_\_

(Continued on Back)



C. \_\_\_\_\_ I certify that I have lived in another state (or states) during the last year (between December 31, 2006 and November 30, 2007). I currently reside in the State of Louisiana. I have lived in the State of Louisiana since \_\_\_\_\_ (date) and have attached written documentation establishing proof of residency since that date

\_\_\_\_\_ I am not currently a resident of the State of Louisiana

My new address and telephone number is as follows:

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_

\_\_\_\_\_  
**Signature of Policyholder or  
Signature of Parent or Legal Guardian** if the Policyholder is  
Under 18 years of age, interdicted or a full-time student at an  
out-of-state educational facility maintaining Louisiana  
residency and paying out-of-state tuition at the non-Louisiana  
educational facility.

\_\_\_\_\_  
**Date**

From: Louisiana Health Plan  
P. O. Drawer 83880  
Baton Rouge, LA 70884-3880  
(800) 736-0947 or (225) 926-6245  
Fax: (225) 927-3873 e-mail: www.lahealthplan.org

Page 1 of 2  
Renewal/HR/2008

1. Check one of the following:  
 YES, I want to renew my LHP policy for the year 2008.  
 NO, I do NOT want to renew my LHP policy for the year 2008.  
**I understand that if I choose not to renew my policy, that my policy will automatically terminate on December 31, 2007.**
2. **For the year 2008, I verify that**  
 I **have not** smoked cigarettes, cigars, pipe, or utilized other tobacco products in the past 12 consecutive months. Therefore, I am eligible for the "**Discounted Rate**".  
 I **have** smoked cigarettes, cigars, pipe, or utilized tobacco products within the past 12 months and therefore I am eligible for the "**Standard Rate**".  
*Anyone changing from Smoker to Non-Smoker status for 2008 will be sent an affidavit requiring a notarized signature in order to obtain the Non-Smoker "Discounted" rates.*
3. **I understand that at this time (and for the lifetime of my policy) that I will ONLY BE ALLOWED TO SELECT THE SAME OR HIGHER DEDUCTIBLE.** Therefore, if I select a \$2,000 deductible for the year 2008, I will be allowed to remain at the same \$2,000 deductible or select a \$3,500 or \$5,000 deductible in the future. If I select a \$5,000 deductible, I will not be allowed to change to a lower deductible.
4. **For the year 2008, I would like the following deductible plan: (check one – your current deductible is listed on lower right corner of the above address label). I understand that if my age at my next birthday places me in a different age band, that my premium will change.** This is applicable for policyholders who were born in a year ending with "8" or "3"; such as 1948, 1953, 1958, 1963, etc. I also understand that **if I move to a different geographic location during the year, my premium will change** to the premium in the new geographic location.

<input type="checkbox"/> \$1,000 Deductible, Plan A	<b>I have calculated my monthly premium as of 1-1-08 and am <u>sending it to Covenant in the envelope enclosed</u></b>
<input type="checkbox"/> \$2,000 Deductible, Plan B	
<input type="checkbox"/> \$3,500 Deductible, Plan C	
<input type="checkbox"/> \$5,000 Deductible, Plan D	
	<b>\$ _____ per month</b>

5. **I verify that my address and telephone number is correct as listed below:**

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_, LA \_\_\_\_\_ Zip Code

Telephone: Home (including area code) (\_\_\_\_\_) \_\_\_\_\_  
Work (including area code) (\_\_\_\_\_) \_\_\_\_\_

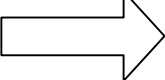
E-Mail: \_\_\_\_\_ Parish: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age as of 1/1/08 \_\_\_\_\_ Male: \_\_\_\_\_ Female: \_\_\_\_\_

**I have carefully read number 3 above and understand my Deductible Options.**

Initial: \_\_\_\_\_  
Date: \_\_\_\_\_ **Page 1 of 2**

(Continued on Back ) 

6. I have enclosed the completed **PROOF OF ELIGIBILITY** (purple colored sheets) and all needed attachments, including a copy of my **DRIVER'S LICENSE** (front & back if renewed on the back).
7. I have attached my Confidential Medical Questionnaire (yellow colored sheets).
8. I have enclosed the confidential "Income Questionnaire Form" (light pink form).
9. I understand that premiums will be adjusted according to the enclosed rate schedules provided to me and that the effective date of the new premiums is January 1, 2008. **Premium adjustments will be made for age and geographic region changes only. I understand that once this deductible plan is chosen, I must maintain the same deductible for the entire calendar year 2008. I will not be permitted to change my deductible or smoking status at any time during the plan year.**
10. I understand that this renewal notice must be **received** on or before **December 21, 2007** at:  

**Louisiana Health Plan  
P. O. Drawer 83880  
Baton Rouge, LA 70884-3880**
11. I verify that all of the information contained on this Renewal Form, Proof of Eligibility, and Medical Questionnaire and Income Questionnaire Form is correct.
12. I understand that any untruthful or misleading information will subject the policyholder to immediate or retroactive termination.
13. I further understand that each policyholder must continue to maintain all eligibility requirements. At the time that any event occurs which makes someone non-eligible, the person is subject to termination retroactively to the date of non-eligibility. These include eligibility for group coverage, Medicaid, Medicare, etc.
14. I understand that this policy is an individual policy and that under the terms of the Louisiana statutes it is not subject to mandated benefits or group coverage benefits.
15. I understand that my premium is due on the first of each month. **I understand that an envelope is enclosed for me to send my January premium payment to Covenant Administrators.**

\_\_\_\_\_  
**Signature of Policyholder or  
Signature of Parent or Legal Guardian** if the Policyholder is  
under 18 years of age, interdicted or a full-time student  
at an out-of-state educational facility maintaining Louisiana  
residency and paying out-of-state tuition at the non-Louisiana  
educational facility.

\_\_\_\_\_  
**Date**

## MEDICAL QUESTIONNAIRE 2008

You must fill out all of these medical questions. (If you have any questions about filling out this information, please contact your doctor's office.) All medical information provided by you will not be subject to any public records examination and will be held in strictest confidence by the Louisiana Health Plan.

Please check yes or no to the following questions. For each question with several conditions listed, please circle the most appropriate answer (or write it in). Thank you!

### **HAVE YOU EVER BEEN DIAGNOSED OR TREATED FOR ANY OF THE FOLLOWING**

	<b>YES</b>	<b>NO</b>
01. Asthma or other bronchial condition	_____	_____
02. Emphysema, tuberculosis, progressive or chronic lung disease or other breathing problems	_____	_____
03. Cancer, (of any type or any malignancy), Leukemia or Hodgkins disease	_____	_____
04. Benign tumors, cysts and polyps	_____	_____
05. Colitis or intestinal disorder	_____	_____
06. Gall bladder disease or gall stones	_____	_____
07. Ulcers or other stomach or esophagus disorders	_____	_____
08. Chronic renal failure or polycystic-kidney disease	_____	_____
09. Urinary problems, kidney disease/stones or other urinary system disorder	_____	_____
10. Stroke or paralysis, CVA or cerebrovascular accident	_____	_____
11. High blood pressure or hypertension (indicate latest reading) _____/_____ (Systolic/Diastolic)	_____	_____
12. Third degree burns	_____	_____
13. Heart attack, myocardial infarction, heart disease, angina (heart related chest pain) or congestive heart failure	_____	_____
14. Other disorders of the heart or circulatory system	_____	_____
15. Diabetes (elevated blood sugar) (indicate latest blood sugar level) _____/_____ (mg/dl)	_____	_____
16. Thyroid disorder or goiter	_____	_____
17. Chronic hepatitis (Please list type _____)	_____	_____
18. Other liver disorder (including cirrhosis)	_____	_____
19. Disorder of the spleen or pancreas	_____	_____
20. Seizure disorder	_____	_____
21. Multiple Sclerosis, Muscular dystrophy or other neuromuscular condition	_____	_____

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_



**PRESCRIPTION INFORMATION**

1. Have you taken prescribed medications within the last year? \_\_\_\_Yes \_\_\_\_No

If yes, please complete the following:

Name of Medicine \_\_\_\_\_ Dosage \_\_\_\_\_  
Reason \_\_\_\_\_ Prescribing Doctor \_\_\_\_\_  
Address and telephone of prescribing physician: \_\_\_\_\_  
\_\_\_\_\_

Name of Medicine \_\_\_\_\_ Dosage \_\_\_\_\_  
Reason \_\_\_\_\_ Prescribing Doctor \_\_\_\_\_  
Address and telephone of prescribing physician: \_\_\_\_\_  
\_\_\_\_\_

Name of Medicine \_\_\_\_\_ Dosage \_\_\_\_\_  
Reason \_\_\_\_\_ Prescribing Doctor \_\_\_\_\_  
Address and telephone of prescribing physician: \_\_\_\_\_  
\_\_\_\_\_

Name of Medicine \_\_\_\_\_ Dosage \_\_\_\_\_  
Reason \_\_\_\_\_ Prescribing Doctor \_\_\_\_\_  
Address and telephone of prescribing physician: \_\_\_\_\_  
\_\_\_\_\_

Name of Medicine \_\_\_\_\_ Dosage \_\_\_\_\_  
Reason \_\_\_\_\_ Prescribing Doctor \_\_\_\_\_  
Address and telephone of prescribing physician: \_\_\_\_\_  
\_\_\_\_\_

**Initial:** \_\_\_\_\_  
**Date:** \_\_\_\_\_

**PRESCRIPTION INFORMATION CONTINUED**

Name of Medicine \_\_\_\_\_ Dosage \_\_\_\_\_  
Reason \_\_\_\_\_ Prescribing Doctor \_\_\_\_\_  
Address and telephone of prescribing physician: \_\_\_\_\_  
\_\_\_\_\_

Name of Medicine \_\_\_\_\_ Dosage \_\_\_\_\_  
Reason \_\_\_\_\_ Prescribing Doctor \_\_\_\_\_  
Address and telephone of prescribing physician: \_\_\_\_\_  
\_\_\_\_\_

Name of Medicine \_\_\_\_\_ Dosage \_\_\_\_\_  
Reason \_\_\_\_\_ Prescribing Doctor \_\_\_\_\_  
Address and telephone of prescribing physician: \_\_\_\_\_  
\_\_\_\_\_

Name of Medicine \_\_\_\_\_ Dosage \_\_\_\_\_  
Reason \_\_\_\_\_ Prescribing Doctor \_\_\_\_\_  
Address and telephone of prescribing physician: \_\_\_\_\_  
\_\_\_\_\_

Name of Medicine \_\_\_\_\_ Dosage \_\_\_\_\_  
Reason \_\_\_\_\_ Prescribing Doctor \_\_\_\_\_  
Address and telephone of prescribing physician: \_\_\_\_\_  
\_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**LOUISIANA HEALTH PLAN**  
**P. O. Drawer 83880**  
**Baton Rouge, Louisiana 70884-3880**  
**(225) 926-6245 800-736-0947 Fax (225) 927-3873**

**INCOME QUESTIONNAIRE**

Please complete the following questionnaire and return it with the enclosed forms.

If your family income is equal to, or less than, the figures in the chart, Louisiana Health Plan may contact you. Further information may be required.

I, \_\_\_\_\_, have reviewed the family income schedule below.  
(please print your name)

**Income Amounts through March 31, 2007**

Number in Family	*Gross Weekly Income	Gross Monthly Income
1	\$363	\$1,575
2	\$487	\$2,111
3	\$611	\$2,648
4	\$735	\$3,184
5	\$858	\$3,721
6	\$982	\$4,257
7	\$1,106	\$4,794
8	\$1,230	\$5,330
More than 8	For each extra person, add \$580 to the monthly amount for 8 people	

\*Gross Income is your income without any deductions  
*Please note that no exact dollar figure is required at this time*

My family income:

- is EQUAL to, or LESS than, the schedule above  
 is GREATER than the schedule above

Please check all that apply:

- I have a spouse  
 I have a child aged 18 or younger living in my house. If yes, how many children ages 18 or younger live in your house? \_\_\_\_\_  
 I have a disabled dependent child older than 18 years living with me

\_\_\_\_\_  
Signature of Policyholder

\_\_\_\_\_  
Date

Or

Signature of Parent or Legal Guardian if the Policyholder is  
Under 18 years of age, interdicted or a full-time student at an out-of-  
State tuition at the non-Louisiana educational facility

## 2008 HIGH RISK RATES

## 2008 HIGH RISK RATES

**Louisiana Health Plan**  
 LA High Risk Health Pool  
 150% of Average Rates for the Top Five Carriers After Benefit Adjustment  
 Rates for 1/1/2008 Effective Date

Standard Rate				Discounted Rate*			
\$1,000 Ded.		\$2,000 Ded.		\$1,000 Ded.		\$2,000 Ded.	
Male	Female	Male	Female	Male	Female	Male	Female

### New Orleans Zip Codes: 700, 701

To-24	338.62	375.98	238.06	262.24	293.21	326.55	206.35	228.78
25-29	359.20	432.14	253.03	302.63	306.79	369.54	216.77	260.33
30-34	417.05	535.65	293.98	377.15	344.98	443.33	243.31	312.47
35-39	502.99	642.63	359.38	459.41	406.83	519.15	291.56	371.88
40-44	620.87	762.11	452.47	550.73	497.36	607.60	362.22	439.05
45-49	778.77	895.60	569.33	651.87	619.57	708.22	452.33	515.05
50-54	1,031.03	1,093.04	749.89	802.80	801.06	844.08	582.15	617.64
55-59	1,386.66	1,338.27	990.28	989.40	1,042.19	1,005.94	746.31	738.64
60-64	1,725.54	1,600.43	1,220.44	1,170.42	1,288.99	1,194.48	916.17	871.32

### Baton Rouge & Shreveport Zip Codes: 707, 708, 710, or 711

To-24	285.72	316.93	200.36	221.26	247.01	276.05	173.79	192.74
25-29	303.82	365.64	212.66	255.40	258.72	312.88	182.32	219.35
30-34	351.95	453.44	247.18	318.01	290.68	374.55	204.67	263.13
35-39	424.60	543.56	302.54	388.41	343.49	439.93	245.02	313.64
40-44	525.34	644.46	381.37	465.03	419.76	513.48	304.90	370.46
45-49	658.77	758.01	480.84	550.39	521.44	596.79	380.47	433.61
50-54	870.29	925.68	631.75	676.78	673.47	711.71	488.02	519.52
55-59	1,171.99	1,132.34	834.69	833.79	875.79	847.35	626.52	620.41
60-64	1,460.13	1,353.42	1,028.81	987.01	1,084.64	1,004.30	768.82	730.54

### All Others Zip Codes: Any Other

To-24	283.27	314.68	198.41	218.80	245.20	273.97	172.12	191.08
25-29	300.68	362.46	211.01	252.95	256.95	310.25	180.89	217.56
30-34	348.87	449.29	244.99	314.92	288.72	372.01	203.16	261.59
35-39	421.17	539.94	299.92	384.30	340.98	436.63	243.23	311.08
40-44	520.67	639.57	377.90	460.81	417.81	510.29	302.43	367.35
45-49	653.69	751.89	476.16	545.07	519.36	593.82	378.28	430.83
50-54	863.82	917.80	626.36	670.62	670.13	707.67	486.04	515.67
55-59	1,163.46	1,123.30	827.00	826.21	872.16	842.80	622.64	616.82
60-64	1,449.56	1,343.74	1,020.57	978.80	1,080.10	1,000.45	765.04	727.25

\*Discounted rates are available to persons who have not smoked cigarettes, cigars, pipe, or utilized other tobacco products in the last year.

## 2008 HIGH RISK RATES

## 2008 HIGH RISK RATES

Louisiana Health Plan  
LA High Risk Health Pool  
150% of Average Rates for the Top Five Carriers After Benefit Adjustment  
Rates for 1/1/2008 Effective Date

Standard Rate				Discounted Rate*			
\$3,500 Ded.		\$5,000 Ded.		\$3,500 Ded.		\$5,000 Ded.	
Male	Female	Male	Female	Male	Female	Male	Female

### New Orleans Zip Codes: 700, 701

To-24	203.41	224.08	154.35	176.08	176.33	195.49	135.08	154.62
25-29	216.22	258.60	164.98	204.35	185.22	222.46	142.93	176.15
30-34	251.20	322.27	191.95	255.00	207.91	267.01	161.74	214.00
35-39	307.09	392.56	235.82	312.00	249.13	317.76	193.68	254.47
40-44	386.64	470.60	300.71	375.33	309.52	375.17	244.49	302.24
45-49	486.49	557.02	385.78	440.11	386.52	440.11	310.60	351.11
50-54	640.78	686.00	508.17	543.77	497.45	527.77	399.59	424.36
55-59	846.19	845.45	667.87	674.66	637.72	631.18	510.68	510.70
60-64	1,042.87	1,000.12	821.52	801.80	782.87	744.55	627.03	603.85

### Baton Rouge & Shreveport Zip Codes: 707, 708, 710, or 711

To-24	171.21	189.06	130.17	148.36	148.50	164.70	114.18	130.40
25-29	181.72	218.23	138.71	172.01	155.80	187.43	120.43	149.15
30-34	211.21	271.73	161.71	215.60	174.89	224.85	135.73	179.86
35-39	258.52	331.90	198.18	263.42	209.37	268.00	163.34	214.61
40-44	325.88	397.37	253.21	317.30	260.53	316.55	205.08	254.60
45-49	410.88	470.31	325.08	371.55	325.11	370.53	260.48	295.88
50-54	539.83	578.31	427.71	458.89	417.01	443.93	334.75	356.29
55-59	713.25	712.47	562.32	568.86	535.37	530.14	428.56	429.27
60-64	879.12	843.41	692.40	675.58	656.96	624.25	525.31	506.60

### All Others Zip Codes: Any Others

To-24	169.55	186.97	128.97	147.01	147.08	163.28	113.14	129.37
25-29	180.30	216.15	137.67	170.92	154.57	185.90	119.40	147.69
30-34	209.35	269.10	160.29	213.15	173.59	223.52	135.05	178.90
35-39	256.28	328.37	196.66	260.98	207.84	265.82	162.00	213.11
40-44	322.91	393.76	251.06	314.27	258.43	313.90	204.04	253.03
45-49	406.88	465.77	322.36	368.35	323.25	368.15	259.03	293.86
50-54	535.22	573.04	424.64	454.78	415.32	440.64	332.95	354.30
55-59	706.68	706.00	558.02	564.38	532.04	527.07	426.87	426.65
60-64	872.08	836.39	687.32	670.20	653.73	621.44	523.21	504.42

\*Discounted rates are available to persons who have not smoked cigarettes, cigars, pipe, or utilized other tobacco products in the last year.