

**WORKSHEET 1 - MA BASE PERIOD EXPERIENCE AND PROJECTION ASSUMPTIONS**

MA-2009.1  
OMB Approved # 0938-0944

**I. General Information**

1. Contract Number:	5. Organization Name:	9. Enrollee Type:	13. Region Name:
2. Plan ID:	6. Plan Name:	10. MA Region:	N/A
3. Segment ID:	7. Plan Type:	11. Act. Swap/Equiv Apply:	
4. Contract Year: 2009	8. MA-PD:	12. SNP:	14. % of CY Enrollees that are Dually-Eligible:

**II. Base Period Background Information**

1. Time Period Definition	2. Member Months (excl ESRD)	5. Plans In Base	Contract-Plan ID	% of MMs
Incurred from:	3. Non-ESRD Risk Score		a.	
Incurred to:	4. Completion Factor		b.	
Paid through:			c.	
6. Describe the source of the base period experience data (1000 character limit)			d.	

**III. Base Period Data (at Plan's non-ESRD Risk Factor)**

**IV. Projection Assumptions**

Service Category	Util Type	Total Benefits			Util. Adjustments to Contract Period				Unit Cost/ Intensity Trend	Additive Adjustments		
		Annualized Util/1000	Avg Cost	Allowed PMPM	Util/1000 Trend	Benefit Plan Change	Population Change	Other Factor		Util/1000	PMPM	
												(c)
a. Inpatient Facility			\$0.00									
b. Skilled Nursing Facility			0.00									
c. Home Health			0.00									
d. Ambulance			0.00									
e. DME/Prosthetics/Supplies			0.00									
f. OP Facility - Emergency			0.00									
g. OP Facility - Surgery			0.00									
h. OP Facility - Other			0.00									
i. Professional			0.00									
j. Part B Rx			0.00									
k. Other Medicare Part B			0.00									
l. Transportation (Non-Covered)			0.00									
m. Dental (Non-Covered)			0.00									
n. Vision (Non-Covered)			0.00									
o. Hearing (Non-Covered)			0.00									
p. Health & Education (Non-Covered)			0.00									
q. Other Non-Covered			0.00									
r. COB/Subrg. (outside claim system)												
s. Total Medical Expenses												
t. Subtotal Medicare-covered services												

**V. Description of Other Utilization Factor and Additive Values (1000 character limit)**

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**WORKSHEET 2 - MA PROJECTED ALLOWED COSTS PMPM**

**I. General Information**

1. Contract Number:	5. Organization Name:	9. Enrollee Type:	13. Region Name:	N/A
2. Plan ID:	6. Plan Name:	10. MA Region:	N/A	
3. Segment ID:	7. Plan Type:	11. Act. Swap/Equiv Apply		
4. Contract Year: 2009	8. MA-PD:	12. SNP:	14. % of CY Enrollees that are Dually-Eligible:	0.0%

**II. Projected Allowed Costs**

Contract Year Allowed Costs at Plan's non-ESRD Risk Factor:												
Service Category	Util Type	Projected Experience Rate			Manual Rate			Exper. Cred. %	Contract Year Rate			% of svcs provided OON
		Annual Util/1000	Avg Cost	Allowed PMPM	Annual Util/1000	Avg Cost	Allowed PMPM		Annual Util/1000	Avg Cost	Allowed PMPM	
		(c)	(e)	(f)	(g)	(h)	(i)		(j)	(k)	(l)	
a. Inpatient Facility		0	\$0.00	\$0.00		\$0.00			0	\$0.00	\$0.00	
b. Skilled Nursing Facility		0	0.00	0.00		0.00			0	0.00	0.00	
c. Home Health		0	0.00	0.00		0.00			0	0.00	0.00	
d. Ambulance		0	0.00	0.00		0.00			0	0.00	0.00	
e. DME/Prosthetics/Supplies		0	0.00	0.00		0.00			0	0.00	0.00	
f. OP Facility - Emergency		0	0.00	0.00		0.00			0	0.00	0.00	
g. OP Facility - Surgery		0	0.00	0.00		0.00			0	0.00	0.00	
h. OP Facility - Other		0	0.00	0.00		0.00			0	0.00	0.00	
i. Professional		0	0.00	0.00		0.00			0	0.00	0.00	
j. Part B Rx		0	0.00	0.00		0.00			0	0.00	0.00	
k. Other Medicare Part B		0	0.00	0.00		0.00			0	0.00	0.00	
l. Transportation (Non-Covered)		0	0.00	0.00		0.00			0	0.00	0.00	
m. Dental (Non-Covered)		0	0.00	0.00		0.00			0	0.00	0.00	
n. Vision (Non-Covered)		0	0.00	0.00		0.00			0	0.00	0.00	
o. Hearing (Non-Covered)		0	0.00	0.00		0.00			0	0.00	0.00	
p. Health & Education (Non-Covered)		0	0.00	0.00		0.00			0	0.00	0.00	
q. Other Non-Covered		0	0.00	0.00		0.00			0	0.00	0.00	
r. COB/Subrg. (outside claim system)				0.00							0.00	
<b>s. Total Medical Expenses</b>				<b>\$0.00</b>				<b>\$0.00</b>			<b>\$0.00</b>	
t. Subtotal Medicare-covered services				\$0.00				\$0.00			\$0.00	
u. Briefly describe the source for the manual rate, including what trend assumptions were used, if applicable (1000 character limit)												



**WORKSHEET 4 - MA PROJECTED REVENUE REQUIREMENT PMPM**

**I. General Information**

1. Contract Number:	5. Organization Name:	9. Enrollee Type:	13. Region Name:	N/A
2. Plan ID:	6. Plan Name:	10. MA Region:	N/A	
3. Segment ID:	7. Plan Type:	11. Act. Swap/Equiv Apply:		
4. Contract Year: 2009	8. MA-PD:	12. SNP:	14. % of CY Enrollees that are Dually-Eligible:	0.0%

**II. Development of Projected Revenue Requirement**

Cost and Required Revenue PMPM at Plan's non-ESRD Risk Factor:

(c) Service Category	(e) Total Benefits			(g) % for Cov. Svcs		(j) FFS Medicare Actl. Equiv. cost sharing	(k) Plan cost shr for Medicare-covered svcs.	(l) Medicare Covered (w/AE cost shr)			(o) A/B Mand Suppl (MS) Benefits			
	(f) Allowed PMPM	(f) Cost Sharing	(f) Net PMPM	(h) Allowed	(h) Cost Sharing			(m) Allowed PMPM	(m) FFS AE Cost Sharing	(n) Net PMPM	(o) Net PMPM for Add'l Svcs.	(p) Reduction of A/B Cost Sh.	(q) Total	
a. Inpatient Facility	\$0.00	\$0.00	\$0.00			0.0%	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
b. Skilled Nursing Facility	0.00	0.00	0.00			0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
c. Home Health	0.00	0.00	0.00			0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
d. Ambulance	0.00	0.00	0.00			0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
e. DME/Prosthetics/Supplies	0.00	0.00	0.00			0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
f. OP Facility - Emergency	0.00	0.00	0.00			0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
g. OP Facility - Surgery	0.00	0.00	0.00			0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
h. OP Facility - Other	0.00	0.00	0.00			0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
i. Professional	0.00	0.00	0.00			0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
j. Part B Rx	0.00	0.00	0.00			0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
k. Other Medicare Part B	0.00	0.00	0.00			0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
l. Transportation (Non-Covered)	0.00	0.00	0.00	0.00%	0.00%	0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
m. Dental (Non-Covered)	0.00	0.00	0.00	0.00%	0.00%	0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
n. Vision (Non-Covered)	0.00	0.00	0.00	0.00%	0.00%	0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
o. Hearing (Non-Covered)	0.00	0.00	0.00	0.00%	0.00%	0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
p. Health & Education (Non-Covered)	0.00	0.00	0.00	0.00%	0.00%	0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
q. Other Non-Covered	0.00	0.00	0.00	0.00%	0.00%	0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
r. ESRD (Section IV)	0.00	0.00	0.00	0.00%	0.00%	0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
s. Additional Benefits (employer bids only)	0.00	0.00	0.00	0.00%	0.00%	0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
t. COB/Subrg. (outside claim system)	0.00	0.00	0.00	0.00%	0.00%	0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
u. Total Medical Expenses	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>				<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>
v. Non-Benefit Expense:														
1. Marketing & Sales											\$0.00			\$0.00
2. Direct Administration											0.00			0.00
3. Indirect Administration											0.00			0.00
4. Net Cost of Private Reinsurance											0.00			0.00
5. Total Non-Benefit Expense			<b>\$0.00</b>								<b>\$0.00</b>	0.00	0.00	<b>\$0.00</b>
w. Gain/(Loss) Margin											<b>\$0.00</b>	0.00	0.00	<b>\$0.00</b>
x. Total Revenue Requirement			<b>\$0.00</b>								<b>\$0.00</b>	0.00	0.00	<b>\$0.00</b>
y. Percent of Revenue (excluding ESRD)														
1. Net Medical Expense			<b>0.0%</b>								<b>0.0%</b>			<b>0.0%</b>
2. Non-Benefit			<b>0.0%</b>								<b>0.0%</b>			<b>0.0%</b>
3. Gain/(Loss) Margin			<b>0.0%</b>								<b>0.0%</b>			<b>0.0%</b>

**III. Development of Projected Contract Year ESRD "subsidy"**

Non-ESRD CY member months	0	
ESRD CY member months		
<b>Basic benefits (user entries should be reported as "per ESRD member per month")</b>		
CY Revenue		
- CMS capitation		
CY Medical Expenses for Basic Services		
CY Non-Benefit Expenses for Basic Services		
CY Margin Requirement for Basic Services	\$0.00	
CY Gain/(Loss) Margin for Basic Services	\$0.00	
Cost for CY basic benefits allocated to all plan members	\$0.00	
<b>Total CY ESRD "subsidy" = \$0.00</b>		

**IV. For Employer Bid Use Only ("800-series")**

1. PMPM for additional/ unspecified MS benefits (see instructions for additional information)	
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**WORKSHEET 5 - MA BENCHMARK PMPM**

**I. General Information**

1. Contract Number:	5. Organization Name:	9. Enrollee Type:	13. Region Name:	N/A
2. Plan ID:	6. Plan Name:	10. MA Region:		
3. Segment ID:	7. Plan Type:	11. Act. Swap/Equiv		
4. Contract Year: 2009	8. MA-PD:	12. SNP:	14. % of CY Enrollees that are Dually-Eligible:	0.0%

**II. Benchmark and Bid Development**

1. Standardized A/B Benchmark (@ 1,000)	\$0.00
2. Medicare Secondary Payer Adjustment	
3. Weighted Avg Factor (excl ESRD)	0
4. Conversion Factor	0
5. Plan A/B Benchmark	\$0.00
6. Plan A/B Bid	\$0.00
7. Standardized A/B Bid (@ 1,000)	\$0.00

**IV. Standardized A/B Benchmark - Regional Plans Only**

	<b>Weighting</b>	
1. Statutory Component - Region N/A	82.9%	
2. Plan Bid Component (from CMS)*	17.1%	N/A
3. Standardized A/B Benchmark	100.0%	

\* See instructions - if Line 2 is not filled in, then Line 7 of Section II will be used

**III. Savings/Basic Member Premium Development**

1. Savings	\$0.00
2. Rebate	\$0.00
3. Basic Member Premium	\$0.00

**V. County Level Detail and Service Area Summary (excl ESRD)**

**VI. Other Medicare Information**

1. Use of plan-provided ISAR factors? (Regional Plans only - enter Yes or No)											VI. Other Medicare Information																					
(b)		(c)	(d)		(e)	(f)	(g)	(h)	(i)	(j)	(k)	(l)		(m)	(n)			(o)	(p)			(q)	(r)	(s)			(t)	(u)		(v)	(w)	
State/County Code	State	County Name	Proj Member Months	Proj Risk Factors	Plan Provided ISAR factors for risk rates	MA Risk Ratebook Unadjusted	MA Risk Ratebook Risk-Adjusted	ISAR scale	ISAR-Adjusted Bid	Risk Payment Rate A only	B only	Original Medicare cost sharing (c.s.) Inpatient	SNF	Pt B (excl HH)	FFS costs to weight Medicare c.s. Inpatient	SNF	Pt B (excl HH)	FFS equiv cost sharing Part A	Part B	Metropolitan Statistical Area MM	MSA name											
2. Total or Weighted Average for Service Area:			0	0	0.00	\$0.00	\$0.00	0	\$0.00	51.795%	48.205%	0.0%	0.0%	0.0%	n/a	n/a	n/a	\$0.00	\$0.00	0	n/a	0% predominant MSA										
3. County Level Detail:			#N/A	#N/A		#N/A	#N/A					#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A										







(b) Package ID	(c) Service category	(d) Benefit category or pricing component	(e)-(h) Allowed medical expense				(i)-(l) Enrollee cost sharing				(m) Net PMPM value	(n) Non-Benefit Expense	(o) Gain/(Loss) Margin	(p) Premium	(q) Projected Member Months
			Util. type	Annual Util / 1000	Average cost	PMPM	Measurement unit code	Util/1000 or PMPM	Average cost shr	PMPM					
						\$0.00				\$0.00	\$0.00	n/a	n/a	n/a	n/a
0						0.00				0.00	0.00	n/a	n/a	n/a	n/a
0						0.00				0.00	0.00	n/a	n/a	n/a	n/a
0						0.00				0.00	0.00	n/a	n/a	n/a	n/a
0						0.00				0.00	0.00	n/a	n/a	n/a	n/a
0						0.00				0.00	0.00	n/a	n/a	n/a	n/a
0						0.00				0.00	0.00	n/a	n/a	n/a	n/a
0						0.00				0.00	0.00	n/a	n/a	n/a	n/a
0						0.00				0.00	0.00	n/a	n/a	n/a	n/a
0						0.00				0.00	0.00	n/a	n/a	n/a	n/a
0						0.00				0.00	0.00	n/a	n/a	n/a	n/a
0						0.00				0.00	0.00	n/a	n/a	n/a	n/a
0						0.00				0.00	0.00	n/a	n/a	n/a	n/a
0						0.00				0.00	0.00	n/a	n/a	n/a	n/a
0						0.00				0.00	0.00	n/a	n/a	n/a	n/a
0						0.00				0.00	0.00	n/a	n/a	n/a	n/a
0						0.00				0.00	0.00	n/a	n/a	n/a	n/a
0						0.00				0.00	0.00	n/a	n/a	n/a	n/a
0						0.00				0.00	0.00	n/a	n/a	n/a	n/a
0						0.00				0.00	0.00	n/a	n/a	n/a	n/a
0	Package Total					\$0.00				\$0.00	\$0.00			\$0.00	

III. Comments

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**TWO-YEAR LOOK-BACK WORKSHEET**  
**Actual to Projected Comparison for Medicare Advantage Costs PMPM**  
 (Excludes optional supplemental and Part D benefits/revenue)

Contract Number:   
 Organization Name:

Contract Yr: 2009  
 Experience Year: 2007

LB-2009.1  
 OMB Approved # 0938-0944

	(f)	(g)	(h)	(j)	(k)	(l)	(n)	(o)	(p)
	Original Projection [1]			Actual Incurred			Actual/Projected		
	Individual	EGWP	Total	Individual	EGWP	Total	Individual	EGWP	Total
<b>1. Revenue</b>									
a. CMS Revenue			\$0.00			\$0.00	n/a	n/a	n/a
b. Premium			0.00			0.00	n/a	n/a	n/a
<b>c. Total</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>n/a</b>	<b>n/a</b>	<b>n/a</b>
<b>2. Net Medical Expenses [2]</b>									
a. Covered Benefits (excl. risk share)			\$0.00	\$0.00	\$0.00	\$0.00	n/a	n/a	n/a
b. A/B Mandatory Supplemental Benefits			0.00	0.00	0.00	0.00	n/a	n/a	n/a
c. Regional PPO Risk Share Paid/(Rec'd)			0.00	0.00	0.00	0.00	n/a	n/a	n/a
<b>d. Total</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>n/a</b>	<b>n/a</b>	<b>n/a</b>
<b>3. Non-Benefit Expense</b>									
a. Marketing & Sales			\$0.00			\$0.00	n/a	n/a	n/a
b. Direct Administration			0.00			0.00	n/a	n/a	n/a
c. Indirect Administration			0.00			0.00	n/a	n/a	n/a
d. Net Cost of Private Reinsurance [3]			0.00	0.00	0.00	0.00	n/a	n/a	n/a
<b>e. Total</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>n/a</b>	<b>n/a</b>	<b>n/a</b>
<b>4. Profit/(Loss) Bef Taxes and Investment Income</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>n/a</b>	<b>n/a</b>	<b>n/a</b>
<b>5. Key Statistics</b>									
a. Member Months (excl ESRD)			0			0	n/a	n/a	n/a
b. Non-ESRD risk factor			n/a			n/a	n/a	n/a	n/a
c. Loss Ratio	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
d. Non-Benefit Ratio	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
e. Profit Margin	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a

[1] Provided by CMS using bid filings two years prior (than the contract year), re-weighted by actual member months.

[2] Enter the net medical expenses below:

*Net Medical Expenses*

- a. Covered Benefits (excl. risk share)
- b. A/B Mandatory Supplemental Benefits
- c. Regional PPO Risk Share Paid/(Rec'd)
- d. Total

Incurred in Experience Year  
 and Pd thru:

Individual	EGWP	Total
		\$0.00
		\$0.00
\$0.00	\$0.00	\$0.00

*Claim Reserves*

Individual	EGWP	Total
		\$0.00
		\$0.00
\$0.00	\$0.00	\$0.00

[3] Actual Incurred components of Net Reinsurance are:

- a. Private Reinsurance Premium
- b. Private Reinsurance Recoveries
- c. Net Reinsurance Cost

Individual	EGWP	Total
		\$0.00
		\$0.00
\$0.00	\$0.00	\$0.00

CMS - 10142 (03/31/2010)

**WORKSHEET 1 - MSA BASE PERIOD EXPERIENCE AND PROJECTION ASSUMPTIONS**

MSA-2009.1  
OMB Approved # 0938-0944

**I. General Information**

1. Contract Number:		5. Organization Name:		9. Enrollee Type:	A/B
2. Plan ID:		6. Plan Name:			
3. Segment ID:		7. Plan Type:			
4. Contract Year:	2009	8. Deductible Amount:			

**II. Base Period Background Information**

1. Time Period Definition		2. Member Months (excl ESRD)		5. Plans In Base	Contract-Plan ID	% of MMs
Incurred from:		3. Non-ESRD Risk Score			a.	
Incurred to:		4. Completion Factor			b.	
Paid through:					c.	
6. Describe the source of the base period experience data (1000 character limit)	d.					

**III. Base Period Data (at Plan's non-ESRD Risk Factor)**

**IV. Projection Assumptions**

Service Category	Util Type	Total Benefits			Util. Adjustments to Contract Period				Unit Cost/ Intensity	Additive Adjustments	
		Annualized	Avg Cost	Allowed	Util/1000	Benefit Plan	Population	Other		Util/1000	PMPM
		Util/1000		PMPM	Trend	Change	Change	Factor	Trend		
a. Inpatient Facility			\$0.00								
b. Skilled Nursing Facility			0.00								
c. Home Health			0.00								
d. Ambulance			0.00								
e. DME/Prosthetics/Supplies			0.00								
f. OP Facility - Emergency			0.00								
g. OP Facility - Surgery			0.00								
h. OP Facility - Other			0.00								
i. Professional			0.00								
j. Part B Rx			0.00								
k. Other Medicare Part B			0.00								
l. COB/Subrg. (outside claim system)											
<b>m. Total Medicare Covered Medical Expenses</b>				<b>\$0.00</b>							

**V. Description of Other Utilization Factor and Additive Values (1000 character limit)**

**WORKSHEET 2 - MSA TOTAL PROJECTED ALLOWED COSTS PMPM**

**I. General Information**

1. Contract Number:	5. Organization Name:	9. Enrollee Type:	A/B
2. Plan ID:	6. Plan Name:		
3. Segment ID:	7. Plan Type:		
4. Contract Year: 2009	8. Deductible Amount:		

**II. Projected Allowed Costs**

Contract Year Allowed Costs at Plan's non-ESRD Risk Factor:													
(c) Service Category	(e) Util Type	(g) Projected Experience Rate			(j) Manual Rate			(l) Exper. Cred. %	(n) Contract Year Rate			(p) % of svcs provided OON	
		(f) Annual Util/1000	(g) Avg Cost	(h) Allowed PMPM	(i) Annual Util/1000	(j) Avg Cost	(k) Allowed PMPM		(m) Annual Util/1000	(n) Avg Cost	(o) Allowed PMPM		
		a. Inpatient Facility		0	\$0.00	\$0.00			\$0.00				0
b. Skilled Nursing Facility		0	0.00	0.00		0.00			0	0.00	0.00		
c. Home Health		0	0.00	0.00		0.00			0	0.00	0.00		
d. Ambulance		0	0.00	0.00		0.00			0	0.00	0.00		
e. DME/Prosthetics/Supplies		0	0.00	0.00		0.00			0	0.00	0.00		
f. OP Facility - Emergency		0	0.00	0.00		0.00			0	0.00	0.00		
g. OP Facility - Surgery		0	0.00	0.00		0.00			0	0.00	0.00		
h. OP Facility - Other		0	0.00	0.00		0.00			0	0.00	0.00		
i. Professional		0	0.00	0.00		0.00			0	0.00	0.00		
j. Part B Rx		0	0.00	0.00		0.00			0	0.00	0.00		
k. Other Medicare Part B		0	0.00	0.00		0.00			0	0.00	0.00		
l. COB/Subrg. (outside claim system)				0.00							0.00		
<b>m. Total Medicare Covered Medical Expenses</b>				<b>\$0.00</b>			<b>\$0.00</b>				<b>\$0.00</b>		
n. Briefly describe the source for the manual rate, including what trend assumptions were used, if applicable (1000 character limit)													

**WORKSHEET 3 - MSA BENCHMARK PMPM**

**I. General Information**

1. Contract Number:	5. Organization Name:	9. Enrollee Type: A/B
2. Plan ID:	6. Plan Name:	
3. Segment ID:	7. Plan Type:	
4. Contract Year: 2009	8. Deductible Amount:	

**II. Contact Information**

<b>MSA Plan Contact Person:</b>	
Name, Position	
Phone Number	
Email Address	
<b>MSA Certifying Actuary:</b>	
Name, Credentials	
Phone Number	
Email Address	
<b>MSA Alternate BPT Contact:</b>	
Name, Position	
Phone Number	
Email Address	
Date Prepared (MM/DD/YYYY)	

**III: County Level Detail and Service Area Summary (excl ESRD)**

(b)	(c)	(d)	(e)	(f)	(g)	(h)	
State/County Code	State	County Name	Projected Member Months	Projected Risk Factors	MA Risk Ratebook Unadjusted	MA Risk Ratebook Risk-Adjusted	Plan Benchmark
1. Total or Weighted Average for Service Area:			0	0	\$0.00	\$0.00	
2. County Level Detail:							
	#N/A	#N/A			#N/A	#N/A	

**WORKSHEET 4 - ENROLLEE DEPOSIT AND PLAN PAYMENT PMPM**

**I. General Information**

1. Contract Number:	5. Organization Name:	9. Enrollee Type: A/B
2. Plan ID:	6. Plan Name:	
3. Segment ID:	7. Plan Type:	
4. Contract Year: 2009	8. Deductible Amount:	

**II. Development of Claim Information Intervals (Plan's non-ESRD Risk Factor and Exclude Services Covered Within the Deductible)**

	(c)	(d)	(e)	(f)	(g)
	Annual Projected Claim Interval	Annual Average Claim Amount	Percentage of Member Months (Only Use Highest Claim Interval)	Gross Claims (PMPM)	Gross Claims Over Deductible (PMPM)
1.	\$0-\$250			\$0.00	
2.	\$251-\$2,000			0.00	
3.	\$2001-\$4,000			0.00	
4.	\$4001-\$6,000			0.00	
5.	\$6001-\$8,000			0.00	
6.	\$8001-\$10,000			0.00	
7.	\$10,001-\$12,000			0.00	
8.	\$12,001-\$15,000			0.00	
9.	\$15,001-\$20,000			0.00	
10.	\$20,001-\$30,000			0.00	
11.	\$30,001-\$50,000			0.00	
12.	\$50,001-\$70,000			0.00	
13.	over \$70,000			0.00	
	<b>Total</b>		<b>0.00%</b>	<b>\$0.00</b>	<b>\$0.00</b>

Services Covered Within the Deductible  
Cost Sharing Offset Over Deductible


**III. Development of Summary Information (Plan's non-ESRD Risk Factor)**

	Total	Part A	Part B
a. Plan Medical Expenses	\$0.00		
b. Non-Benefit Expense:			
1. Marketing & Sales			
2. Direct Administration			
3. Indirect Administration			
4. Net cost of private reinsurance			
5. Total Non-Benefit Expense	\$0.00		
c. Gain/(Loss) Margin			
d. Total Plan Revenue Requirement	\$0.00		
e. Projected Plan Benchmark	\$0.00		
f. Projected Monthly Enrollee Deposit	\$0.00	\$0.00	\$0.00
g. Percent of Plan Revenue			
1. Medical Expenses	0.0%		
2. Non-Benefit Expense	0.0%		
3. Gain/(Loss) Margin	0.0%		
h. Standardized Plan Benchmark	\$0.00	\$0.00	\$0.00





