

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:	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:	

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

(c)		(f)	(g)	(h)	(i)	(j)	(k)	(l)	(m)	(n)	(o)	(p)
Service Category	Util Type	Total Benefits			Allowed PMPM	Util. Adjustments to Contract Period				Unit Cost/ Intensity Trend	Additive Adjustments	
		Annualized Util/1000	Avg Cost			Util/1000 Trend	Benefit Plan Change	Population Change	Other Factor		Util/1000	PMPM
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					\$0.00							
t. Subtotal Medicare-covered services					\$0.00							

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

--

WORKSHEET 2 - MA PROJECTED ALLOWED COSTS PMPM

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: 0.0%

II. Projected Allowed Costs

Contract Year Allowed Costs at Plan's non-ESRD Risk Factor:												
(c)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(l)	(m)	(n)	(o)	(p)
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	
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	
s. Total Medical Expenses				\$0.00			\$0.00				\$0.00	
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 3 - MA PROJECTED COST SHARING PMPM

I. General Information

1. Contract No:	5. Org 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		
4. Contract Year:	2009	8. MA-PD:	12. SNP:	
			14. % of CY Enrollees that are Dually-Eligible:	0.0%

II. Maximum Cost Sharing Per Member Per Year

1. In Network		2. Out of Network		3. Combined	
4. Briefly explain the methodology for reflecting the impact of maximum cost sharing in Section III (1000 character limit):					

III. Development of Contract Year Cost Sharing PMPM (Plan's non-ESRD Risk Factor)

(c)		(d)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(l)	(m)	(n)	(o)	
Service Category		Description/ Note	Measure- ment Unit Code	In-Network Effective Plan-Level Deduct PMPM*	In-Network Cost Sharing After Plan-Level Deductible				Total In-Network Cost Share PMPM	Out-of-Network Description of Cost Sharing / . . . Benefit Limits	Out-of-Network Cost Sharing PMPM***	Grand Total Cost Share PMPM (INN+OON)		
					In-Network Util/1000 or PMPM	Description of Cost Sharing / Add'l Days / Benefit Limits	Effective Copay / Coin Before OOP Max	**Effective Copay / Coin After OOP Max					In-Network PMPM	
a.1.	Inpatient Facility	Acute Mental Health DME Prosthetics/Supplies Lab Radiology Observation Renal Dialysis Other PCP Specialist excl. MH Mental Health (MH) Therapy (PT/OT/ST) Radiology Other							\$0.00	\$0.00			\$0.00	
a.2.	Inpatient Facility									0.00	0.00			0.00
b.	Skilled Nursing Facility									0.00	0.00			0.00
c.	Home Health									0.00	0.00			0.00
d.	Ambulance									0.00	0.00			0.00
e.1.	DME/Prosthetics/Supplies									0.00	0.00			0.00
e.2.	DME/Prosthetics/Supplies									0.00	0.00			0.00
f.	OP Facility - Emergency									0.00	0.00			0.00
g.	OP Facility - Surgery									0.00	0.00			0.00
h.1.	OP Facility - Other								0.00	0.00			0.00	
h.2.	OP Facility - Other								0.00	0.00			0.00	
h.3.	OP Facility - Other								0.00	0.00			0.00	
h.4.	OP Facility - Other								0.00	0.00			0.00	
h.5.	OP Facility - Other								0.00	0.00			0.00	
i.1.	Professional								0.00	0.00			0.00	
i.2.	Professional								0.00	0.00			0.00	
i.3.	Professional								0.00	0.00			0.00	
i.4.	Professional								0.00	0.00			0.00	
i.5.	Professional								0.00	0.00			0.00	
i.6.	Professional								0.00	0.00			0.00	
j.	Part B Rx								0.00	0.00			0.00	
k.	Other Medicare Part B								0.00	0.00			0.00	
l.	Transportation (Non-Covered)								0.00	0.00			0.00	
m.	Dental (Non-Covered)								0.00	0.00			0.00	
n.1.	Vision (Non-Covered)								0.00	0.00			0.00	
n.2.	Vision (Non-Covered)								0.00	0.00			0.00	
o.1.	Hearing (Non-Covered)								0.00	0.00			0.00	
o.2.	Hearing (Non-Covered)								0.00	0.00			0.00	
p.	Health & Education (Non-Covered)								0.00	0.00			0.00	
q.	Other Non-Covered								0.00	0.00			0.00	
									0.00	0.00			0.00	
									0.00	0.00			0.00	
									0.00	0.00			0.00	
									0.00	0.00			0.00	
									0.00	0.00			0.00	
									0.00	0.00			0.00	
									0.00	0.00			0.00	
									0.00	0.00			0.00	
									0.00	0.00			0.00	
									0.00	0.00			0.00	
									0.00	0.00			0.00	
									0.00	0.00			0.00	
									0.00	0.00			0.00	
									0.00	0.00			0.00	
									0.00	0.00			0.00	
									0.00	0.00			0.00	
									0.00	0.00			0.00	
									0.00	0.00			0.00	
									0.00	0.00			0.00	
									0.00	0.00			0.00	
									0.00	0.00			0.00	
									0.00	0.00			0.00	
									0.00	0.00			0.00	
									0.00	0.00			0.00	
									0.00	0.00			0.00	
									0.00	0.00			0.00	
									0.00	0.00			0.00	
									0.00	0.00			0.00	
									0.00	0.00			0.00	
									0.00	0.00			0.00	
									0.00	0.00			0.00	
									0.00	0.00			0.00	
									0.00	0.00			0.00	
									0.00	0.00			0.00	
									0.00	0.00			0.00	
									0.00	0.00			0.00	
									0.00	0.00			0.00	
									0.00	0.00			0.00	
									0.00	0.00			0.00	
									0.00	0.00			0.00	
									0.00	0.00			0.00	
									0.00	0.00			0.00	
									0.00	0.00			0.00	
									0.00	0.00			0.00	
									0.00	0.00			0.00	
									0.00	0.00			0.00	
									0.00	0.00			0.00	
									0.00	0.00			0.00	
									0.00	0.00			0.00	
									0.00	0.00			0.00	
									0.00	0.00			0.00	
									0.00	0.00			0.00	
									0.00	0.00			0.00	
									0.00	0.00			0.00	
									0.00	0.00			0.00	
									0.00	0.00			0.00	
									0.00	0.00			0.00	
									0.00	0.00			0.00	
									0.00	0.00			0.00	
									0.00	0.00			0.00	
									0.00	0.00			0.00	
									0.00	0.00			0.00	
									0.00	0.00			0.00	
									0.00	0.00			0.00	
									0.00	0.00			0.00	
									0.00	0.00			0.00	
									0.00	0.00			0.00	

*Actual in-network plan level deductible:

** PMPM impact of in-network OOP max:

***Actual OON plan level deductible:

***PMPM impact of OON OOP max:

WORKSHEET 4 - MA PROJECTED REVENUE REQUIREMENT PMPM
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: 0.0%

II. Development of Projected Revenue Requirement

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

(c)		(e)	(f)	(g)	(h)	(i)	(j)	(k)	(l)	(m)	(n)	(o)	(p)	(q)
Service Category		Total Benefits			% for Cov. Svcs		FFS Medicare Actl. Equiv. cost sharing	Plan cost shr for Medicare- covered svcs.	Medicare Covered (w/AE cost shr)			A/B Mand Suppl (MS) Benefits		
		Allowed PMPM	Cost Sharing	Net PMPM	Allowed	Cost Sharing			Allowed PMPM	FFS AE Cost Sharing	Net PMPM	Net PMPM for Add'l Svcs.	Reduction of A/B Cost Sh.	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
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
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
d.	Ambulance	0.00	0.00	0.00			0.0%	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
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
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
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
i.	Professional	0.00	0.00	0.00			0.0%	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
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
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
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
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
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
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
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
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
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
t.	COB/Subrg. (outside claim system)	0.00	0.00	0.00		0.00%	0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00
u.	Total Medical Expenses	\$0.00	\$0.00	\$0.00			\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
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			\$0.00							\$0.00	0.00	0.00	\$0.00
w.	Gain/(Loss) Margin										\$0.00	0.00	0.00	\$0.00
x.	Total Revenue Requirement			\$0.00							\$0.00	0.00	0.00	\$0.00
y.	Percent of Revenue (excluding ESRD)													
1.	Net Medical Expense			0.0%							0.0%			0.0%
2.	Non-Benefit			0.0%							0.0%			0.0%
3.	Gain/(Loss) Margin			0.0%							0.0%			0.0%

III. Development of Projected Contract Year ESRD "subsidy"

Non-ESRD CY member months	0
ESRD CY member months	
<u>Basic benefits (user entries should be reported as "per ESRD member per month")</u>	
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
Total CY ESRD "subsidy" = \$0.00	

Supplemental Benefits

Non-ESRD CY cost sharing reductions	\$0.00
Non-ESRD CY additional benefits	\$0.00
ESRD CY cost sharing reductions	
ESRD CY additional benefits	
Incremental CY cost of cost sharing reductions	\$0.00
Incremental CY cost of additional benefits	\$0.00

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

1. PMPM for additional/ unspecified MS benefits (see instructions for additional information)	
---	--

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

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

1. Statutory Component - Region N/A

Weighting

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)																					
(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		Original Medicare cost sharing (c.s.)			FFS costs to weight Medicare c.s.			FFS equiv cost sharing		Metropolitan Statistical Area	
										A only	B only	Inpatient	SNF	Pt B (excl HH)	Inpatient	SNF	Pt B (excl HH)	Part A	Part B	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
3. County Level Detail:																					0% predominant MSA
	#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

WORKSHEET 6 - MA BID SUMMARY

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: 0.0%

II. Other Information

A. Part B Information		3. Maximum for Part A Package on 'Part B Only' Members		B. Rebate Allocation for Contract Year Part B Premium	
1. CMS Estimate of CY Part B Premium	\$96.40	a. Required Revenue for Part A Services	n/a	1. PMPM rebate allocation for Part B premium (max value=\$96.40)	
2. Part B % of USPPC (risk)	48.20%	b. Average benchmark rate for Part A	n/a	2. Part B Rebate Allocation - rounded (see instructions)	\$0.00
		c. CMS Part A Charge	n/a	3. Does plan intend to reduce the entire standard Part B premium using rebates?	
		d. Mandatory Suppl. Prem for Part A Package		Enter Yes/No. (See instructions for further info.)	No reduction

III. Plan A/B Bid Summary

A. Overview			B. MA Rebate Allocation					C. Development of Estimated Plan Premium	
	Medicare-covered	A/B Mandatory Supplemental		Rebate PMPM Allocation				Maximum Value	
				Medical	Admin	Gain / (Loss)	Total		
1. Allowed medical cost	\$0.00	n/a	1. MA Rebate	n/a	n/a	n/a	\$0.00		1. A/B Mandatory Supplemental revenue requirements \$0.00
2. Less cost sharing	0.00	n/a							2. Less rebate allocations:
3. Net medical cost	\$0.00	\$0.00	2. Reduce A/B Cost Sharing						2a. Reduce A/B Cost Sharing 0.00
4. Non-benefit expense	\$0.00	\$0.00	3. Other A/B Mand Suppl Benefits	0.00	0.00	0.00		0.00	2b. Other A/B Mand Supplemental Benefits 0.00
5. Gain / loss margin	0.00	0.00	4. Pt B Premium Buydown	0.00	n/a	n/a	0.00	96.40	3. A/B Mandatory Supplemental premium 0.00
6. Total revenue requirement	\$0.00	\$0.00	5. Pt D Premium Buydown Basic	0.00	n/a	n/a	0.00	0.00	4. Basic MA premium 0.00
			6. Pt D Premium Buydown Suppl	0.00	n/a	n/a	0.00	0.00	5. Total MA Enrollee Premium (excl. Opt. Suppl.) 0.00
7. Standardized A/B Benchmark	\$0.00		7. Total	\$0.00	\$0.00	\$0.00	\$0.00		6. Rounded MA Premium (excl. Opt. Suppl.) \$0.00
8. Plan A/B Benchmark	\$0.00					Unalloc. rebate	\$0.00		
9. Non-ESRD Risk Factor	0.0000								7. Part D Basic Premium
10. Conversion Factor	0.0000								7a. Prior to rebates (rounded value from Rx BPT)

IV. Contact Information

MA Plan Bid Contact:	
Name, Position	
Phone Number	
Email Address	
MA Certifying Actuary:	
Name, Credentials	
Phone Number	
Email Address	
MA Additional BPT Contact:	
Name, Credentials	
Phone Number	
Email Address	
Date Prepared	

* The premiums shown in lines 7 and 9 are estimates. Actual plan premiums will be calculated by CMS when the Part D National Average is determined by CMS. The premiums shown in lines 7 and 9 may not be final.

Note: Premiums are rounded to one decimal (i.e., to the nearest dime) to comply with premium withhold system requirements. See instructions for more information

I. General Information

II. Optional Supplemental Packages

12/28/2007

(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(l)	(m)	(n)	(o)	(p)	(q)
Package ID	Service category	Benefit category or pricing component	Allowed medical expense				Enrollee cost sharing				Net PMPM value	Non-Benefit Expense	Gain/ (Loss) Margin	Premium	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						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

--

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
1. Revenue									
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
c. Total	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	n/a	n/a	n/a
2. Net Medical Expenses [2]									
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
d. Total	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	n/a	n/a	n/a
3. Non-Benefit Expense									
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
e. Total	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	n/a	n/a	n/a
4. Profit/(Loss) Bef Taxes and Investment Income	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	n/a	n/a	n/a
5. Key Statistics									
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	\$0.00

Claim Reserves

Individual	EGWP	Total
		\$0.00
		\$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

(c)		(f)	(g)	(h)	(i)	(j)	(k)	(l)	(m)	(n)	(o)	(p)
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
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)												
m. Total Medicare Covered Medical Expenses					\$0.00							

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)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(l)	(m)	(n)	(o)	(p)
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	
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. COB/Subrg. (outside claim system)				0.00							0.00	
m. Total Medicare Covered Medical Expenses				\$0.00			\$0.00				\$0.00	

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

MSA Plan Contact Person:	
Name, Position	
Phone Number	
Email Address	
MSA Certifying Actuary:	
Name, Credentials	
Phone Number	
Email Address	
MSA Alternate BPT Contact:	
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	
Total			0.00%	\$0.00	\$0.00

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

I. General Information

II. Optional Supplemental Packages

12/28/2007

[illegible]

(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(l)	(m)	(n)	(o)	(p)	(q)
Package ID	Service category	Benefit category or pricing component	Allowed medical expense			PMPM	Enrollee cost sharing				Net PMPM value	Non-Benefit expense	Gain/(Loss) Margin	Premium	Projected Member Months
			Util. type	Annual Util / 1000	Average cost		Measurment 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						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