

WORKSHEET 1 - MA BASE PERIOD EXPERIENCE AND PROJECTION ASSUMPTIONS

MA-2011.1
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:	2011	8. MA-PD:		12. SNP:		14. SNP Type:	N/A

II. Base Period Background Information

Note: DE# refers to Dual Eligible Beneficiaries without full Medicare cost sharing liability

1. Time Period Definition		2. Member Months (excl ESRD)	Total	Non-DE#	DE#	5. Plans In Base	Contract-Plan ID	Member Months	Contract-Plan ID	Member Months
Incurring from:	01/01/2009	3. Non-ESRD Risk Score			0.0000					
Incurring to:	12/31/2009	4. Completion Factor								
Paid through:										
6. Describe the source of the base period experience data (1000 character limit)										

III. Base Period Data (at Plan's non-ESRD Risk Factor) for 1/1/2009-12/31/2009

IV. Projection Assumptions

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

V. Description of Other Utilization Adjustment Factor, Other Unit Cost Adjustment Factor, and Additive Adjustments (1000 character limit)

--	--

VI. Base Period Summary for 1/1/2009-12/31/2009 (excludes Optional Supplemental)

1. CMS Revenue		Non-Benefit Expenses:		6. Gain/(Loss) Margin	\$0.00
2. Premium Revenue		5a. Marketing & Sales		Percent of Revenue:	
3. Total Revenue	\$0.00	5b. Direct Administration		7a. Net Medical Expenses	0.0%
3b. Subset Revenue (ESRD and hospice)		5c. Indirect Administration		7b. Non-Benefit Expenses	0.0%
4. Net Medical Expenses		5d. Net Cost of Private Reinsurance		7c. Gain/(Loss) Margin	0.0%
4b. Subset Net Medical Expense (ESRD and hospice)		5e. Total Non-Benefit Expenses	\$0.00		

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: 2011	8. MA-PD:	12. SNP:	14. SNP Type:

II. Projected Allowed Costs

Note: DE# refers to Dual Eligible Beneficiaries without full Medicare cost sharing liability

Contract Year Allowed Costs at Plan's non-ESRD Risk Factor:													Total	Non-DE#	DE#	
													1. Projected member months	0	0	0
													2. Projected risk factor	0.0000	0.0000	0.0000
(c)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(l)	(m)	(n)	(o)	(p)	(q)	(r)		
Service Category	Util Type	Projected Experience Rate			Manual Rate			Exper. Cred. %	Blended Rate					% of svcs provided OON		
		Annual Util/1000	Avg Cost	Allowed PMPM	Annual Util/1000	Avg Cost	Allowed PMPM		Annual Util/1000	Avg Cost	Total Allowed PMPM	Non-DE# Allowed PMPM	DE# 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%		\$0.00	\$0.00	\$0.00			
t. Subtotal Medicare-covered service categories				\$0.00				\$0.00	0%	CMS Guideline Credibility	\$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:
2. Plan ID:	6. Plan Name:	10. MA Region: N/A	N/A
3. Segment ID:	7. Plan Type:	11. Act. Swap/Equiv Apply:	
4. Contract Year: 2011	8. MA-PD:	12. SNP:	14. SNP Type:

II. Development of Projected Revenue Requirement

A. Non-DE# (Non-Dual Eligible Beneficiaries AND Dual Eligible Beneficiaries with full Medicare cost sharing liability)

Cost and Required Revenue PMPM at Plan's non-ESRD Risk Factor: 0.0000

(c) Service Category	(e) Total Benefits			(h) Net PMPM	(i) % for Cov. Svcs		(k) FFS Medicare Actl. Equiv. cost sharing	(l) Plan cost sh. for Medicare-covered svcs.	(m) Medicare Covered (w/AE cost sh.)			(p) A/B Mand Suppl (MS) Benefits		
	(e) Allowed PMPM	(f) Plan Cost Sharing	(g) Net PMPM		(i) Allowed	(j) Cost Sharing			(m) Allowed PMPM	(n) FFS AE Cost Sharing	(o) Net PMPM	(p) Net PMPM for Add'l Svcs.	(q) Reduction of A/B Cost Sh.	(r) 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. COB/Subrg. (outside claim system)	0.00	0.00	0.00				0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00
s. 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

B. DE# (Dual Eligible Beneficiaries without full Medicare cost sharing liability)

Cost and Required Revenue PMPM at Plan's non-ESRD Risk Factor: 0.0000

(c) Service Category	(e) Total Benefits				(i) % for Cov. Svcs		(k) State Medicaid Required Bene. cost sharing	(l) Actual cost sh. for Medicare-covered svcs.	(m) Medicare Covered (w/Medicaid cost sh.)			(p) A/B Mand Suppl (MS) Benefits		
	(e) Reimb + Actual Cost Sh.	(f) Plan Cost Sharing	(g) Actual Cost Sharing	(h) Plan Reimb	(i) Allowed	(j) Cost Sharing			(m) Allowed PMPM	(n) Medicaid Cost Sharing	(o) Net PMPM	(p) Net PMPM for Add'l Svcs.	(q) Reduction of A/B Cost Sh.	(r) Total
a. Inpatient Facility	\$0.00	\$0.00	\$0.00	\$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	0.00				0.00	0.00	0.00	0.00	0.00	0.00	0.00
c. Home Health	0.00	0.00	0.00	0.00				0.00	0.00	0.00	0.00	0.00	0.00	0.00
d. Ambulance	0.00	0.00	0.00	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	0.00				0.00	0.00	0.00	0.00	0.00	0.00	0.00
f. OP Facility - Emergency	0.00	0.00	0.00	0.00				0.00	0.00	0.00	0.00	0.00	0.00	0.00
g. OP Facility - Surgery	0.00	0.00	0.00	0.00				0.00	0.00	0.00	0.00	0.00	0.00	0.00
h. OP Facility - Other	0.00	0.00	0.00	0.00				0.00	0.00	0.00	0.00	0.00	0.00	0.00
i. Professional	0.00	0.00	0.00	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	0.00				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	0.00				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%	0.00%		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%	0.00%		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%	0.00%		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%	0.00%		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%	0.00%		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%	0.00%		0.00	0.00	0.00	0.00	0.00	0.00	0.00
r. COB/Subrg. (outside claim system)	0.00	0.00	0.00	0.00				0.00	0.00	0.00	0.00	0.00	0.00	0.00
s. 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

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	N/A
3. Segment ID:	7. Plan Type:	11. Act. Swap/Equiv Apply:	
4. Contract Year: 2011	8. MA-PD:	12. SNP:	14. SNP Type:

II. Development of Projected Revenue Requirement

C. All Beneficiaries

Cost and Required Revenue PMPM at Plan's non-ESRD Risk Factor: 0.0000

(c) Service Category	(e) Total Benefits				(i)	(j)	(k)	(l)	(m) Medicare Covered		(p) A/B Mand Suppl (MS) Benefits		
	(f)	(g)	(h) Net PMPM	(n) Net PMPM					(o) Net PMPM	(q) Net PMPM for Add'l Svcs.	(r) Reduction of A/B Cost Sh.	(r) Total	
a. Inpatient Facility			\$0.00							\$0.00	\$0.00	\$0.00	\$0.00
b. Skilled Nursing Facility			0.00							0.00	0.00	0.00	0.00
c. Home Health			0.00							0.00	0.00	0.00	0.00
d. Ambulance			0.00							0.00	0.00	0.00	0.00
e. DME/Prosthetics/Supplies			0.00							0.00	0.00	0.00	0.00
f. OP Facility - Emergency			0.00							0.00	0.00	0.00	0.00
g. OP Facility - Surgery			0.00							0.00	0.00	0.00	0.00
h. OP Facility - Other			0.00							0.00	0.00	0.00	0.00
i. Professional			0.00							0.00	0.00	0.00	0.00
j. Part B Rx			0.00							0.00	0.00	0.00	0.00
k. Other Medicare Part B			0.00							0.00	0.00	0.00	0.00
l. Transportation (Non-Covered)			0.00							0.00	0.00	0.00	0.00
m. Dental (Non-Covered)			0.00							0.00	0.00	0.00	0.00
n. Vision (Non-Covered)			0.00							0.00	0.00	0.00	0.00
o. Hearing (Non-Covered)			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
q. Other Non-Covered			0.00							0.00	0.00	0.00	0.00
r. ESRD			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
t. COB/Subrg. (outside claim system)			0.00							0.00	0.00	0.00	0.00
u. Total Medical Expenses			\$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 must be reported as "per ESRD member per month")</u>		<u>Supplemental Benefits</u>	
CY Revenue			
- CMS capitation		Non-ESRD CY cost sharing reductions	\$0.00
CY Medical Expenses for Basic Services		Non-ESRD CY additional benefits	\$0.00
CY Non-Benefit Expenses for Basic Services		ESRD CY cost sharing reductions	
CY Margin Requirement for Basic Services	\$0.00	ESRD CY additional benefits	
CY Gain/(Loss) Margin for Basic Services	\$0.00	Incremental CY cost of cost sharing reductions	\$0.00
Cost for CY basic benefits allocated to all plan members	\$0.00	Incremental CY cost of additional benefits	\$0.00
Total CY ESRD "subsidy" =			\$0.00

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

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

V. Projected Medicaid Data for DE#

Entries must be reported as "Per DE# Member Per Month."	
1. Medicaid Projected Revenue	
2. Medicaid Projected Benefits (not in bid)	

WORKSHEET 5 - MA BENCHMARK 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	N/A
3. Segment ID:	7. Plan Type:	11. Act. Swap/Equiv	
4. Contract Year: 2011	8. MA-PD:	12. SNP:	14. SNP Type:

II. Benchmark and Bid Development

	Total	Non-DE#	DE#
1. Projected Member Months	0		0
2. Standardized A/B Benchmark (@ 1.000)	\$0.00		
3. Medicare Secondary Payer Adjustment			
4. Weighted Avg Risk Factor (excl ESRD)	0		0
5. Conversion Factor	0		
6. Plan A/B Benchmark	\$0.00		
7. Plan A/B Bid	\$0.00		
8. Standardized A/B Bid (@ 1.000)	\$0.00		

Note: DE# refers to Dual Eligible Beneficiaries without full Medicare cost sharing liability

IV. Standardized A/B Benchmark - Regional Plans Only

	Weighting	
1. Statutory Component - Region N/A	76.3%	
2. Plan Bid Component (from CMS)*	23.7%	N/A
3. Standardized A/B Benchmark	100.0%	

* See instructions - if Line 2 is not filled in, then Line 8 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)
State/County Code	State	County Name	Proj Member Months	Proj Risk Factors	Plan Provided ISAR factors	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.			Metropolitan Statistical Area	
										A only	B only	Inpatient	SNF	Pt B (excl HH)	Inpatient	SNF	Pt B (excl HH)	MM	MSA name
2. Total or Weighted Average for Service Area:			0	0	0.00	\$0.00	\$0.00	0	\$0.00	53.070%	46.930%	0.0%	0.0%	0.0%	n/a	n/a	n/a	0	n/a
3. County Level Detail:																			0% predominant MSA

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	N/A
3. Segment ID:	7. Plan Type:	11. Act. Swap/Equiv Apply:	
4. Contract Year: 2011	8. MA-PD:	12. SNP:	14. SNP Type:

II. Other Information

A. Part B Information		B. Rebate Allocation for Part B Premium	
1. CMS Estimate of Part B Premium	\$96.40	1. PMPM rebate allocation for standard Part B premium (maximum value=\$96.40)	
		2. Part B Rebate Allocation, rounded to one decimal (see instructions)	\$0.00

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. Net medical cost	\$0.00	\$0.00	n/a	n/a	n/a	\$0.00		1. A/B Mandatory Supplemental revenue requirements	\$0.00
2. Non-benefit expense	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00		\$0.00	2. Less rebate allocations:	
3. Gain / loss margin	0.00	0.00	0.00	0.00	0.00		0.00	2a. Reduce A/B Cost Sharing	0.00
4. Total revenue requirement	\$0.00	\$0.00	0.00	n/a	n/a	0.00	96.40	2b. Other A/B Mand Supplemental Benefits	0.00
5. Standardized A/B Benchmark	\$0.00		0.00	n/a	n/a	0.00	0.00	3. A/B Mandatory Supplemental premium	0.00
6. Plan A/B Benchmark	\$0.00		0.00	n/a	n/a	0.00	0.00	4. Basic MA premium	0.00
7. Non-ESRD Risk Factor	0.0000		0.00	n/a	n/a	0.00	0.00	5. Total MA Enrollee Premium (excl. Opt. Suppl.)	0.00
8. Conversion Factor	0.0000		\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	6. Rounded MA Premium (excl. Opt. Suppl.)	\$0.00
					Unalloc. rebate	\$0.00		7. Part D Basic Premium	
								7a. Prior to rebates (rounded value from Rx BPT)	
								7b. A/B rebates allocated to Part D Basic Premium	
								7c. A/B rebates for Part D Basic Premium (rounded)	\$0.00
								7d. Part D Basic Premium*	\$0.00
								8. Part D Supplemental Premium	
								8a. Prior to rebates (rounded value from Rx BPT)	
								8b. A/B rebates allocated to Part D Suppl Premium	
								8c. A/B rebates for Part D Suppl Premium (rounded)	\$0.00
								8d. Part D Supplemental Premium	\$0.00
								9. Total estimated plan premium*	\$0.00
								10. Plan Intention for target PD basic premium	N/A - EGWP bid

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, Position	
Phone Number	
Email Address	
Date Prepared	

V. Working Model Text Box

This section can be used at the discretion of the Plan sponsor. The contents are NOT uploaded in the bid submission, and will be deleted during finalization. See instructions for details.

* 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.

WORKSHEET 7 - OPTIONAL SUPPLEMENTAL BENEFITS

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: 2011	8. MA-PD:	12. SNP:	14. SNP Type:	

II. Optional Supplemental Packages

(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	
			(e) Util. type	(f) Annual Util / 1000	(g) Average cost	(h) PMPM	(i) Measurement unit code	(j) Util/1000 or PMPM	(k) Average cost shr	(l) PMPM						
Description																
1						\$0.00			\$0.00	\$0.00	n/a	n/a	n/a	n/a	n/a	n/a
1						0.00			0.00	0.00	n/a	n/a	n/a	n/a	n/a	n/a
1						0.00			0.00	0.00	n/a	n/a	n/a	n/a	n/a	n/a
1						0.00			0.00	0.00	n/a	n/a	n/a	n/a	n/a	n/a
1						0.00			0.00	0.00	n/a	n/a	n/a	n/a	n/a	n/a
1						0.00			0.00	0.00	n/a	n/a	n/a	n/a	n/a	n/a
1						0.00			0.00	0.00	n/a	n/a	n/a	n/a	n/a	n/a
1						0.00			0.00	0.00	n/a	n/a	n/a	n/a	n/a	n/a
1						0.00			0.00	0.00	n/a	n/a	n/a	n/a	n/a	n/a
1						0.00			0.00	0.00	n/a	n/a	n/a	n/a	n/a	n/a
1						0.00			0.00	0.00	n/a	n/a	n/a	n/a	n/a	n/a
1						0.00			0.00	0.00	n/a	n/a	n/a	n/a	n/a	n/a
1						0.00			0.00	0.00	n/a	n/a	n/a	n/a	n/a	n/a
1						0.00			0.00	0.00	n/a	n/a	n/a	n/a	n/a	n/a
1						0.00			0.00	0.00	n/a	n/a	n/a	n/a	n/a	n/a
1						0.00			0.00	0.00	n/a	n/a	n/a	n/a	n/a	n/a
1						0.00			0.00	0.00	n/a	n/a	n/a	n/a	n/a	n/a
1						0.00			0.00	0.00	n/a	n/a	n/a	n/a	n/a	n/a
1						0.00			0.00	0.00	n/a	n/a	n/a	n/a	n/a	n/a
1	Package Total					\$0.00			\$0.00	\$0.00				\$0.00		
Description																
2						\$0.00			\$0.00	\$0.00	n/a	n/a	n/a	n/a	n/a	n/a
2						0.00			0.00	0.00	n/a	n/a	n/a	n/a	n/a	n/a
2						0.00			0.00	0.00	n/a	n/a	n/a	n/a	n/a	n/a
2						0.00			0.00	0.00	n/a	n/a	n/a	n/a	n/a	n/a
2						0.00			0.00	0.00	n/a	n/a	n/a	n/a	n/a	n/a
2						0.00			0.00	0.00	n/a	n/a	n/a	n/a	n/a	n/a
2						0.00			0.00	0.00	n/a	n/a	n/a	n/a	n/a	n/a
2						0.00			0.00	0.00	n/a	n/a	n/a	n/a	n/a	n/a
2						0.00			0.00	0.00	n/a	n/a	n/a	n/a	n/a	n/a
2						0.00			0.00	0.00	n/a	n/a	n/a	n/a	n/a	n/a
2						0.00			0.00	0.00	n/a	n/a	n/a	n/a	n/a	n/a
2						0.00			0.00	0.00	n/a	n/a	n/a	n/a	n/a	n/a
2						0.00			0.00	0.00	n/a	n/a	n/a	n/a	n/a	n/a
2						0.00			0.00	0.00	n/a	n/a	n/a	n/a	n/a	n/a
2						0.00			0.00	0.00	n/a	n/a	n/a	n/a	n/a	n/a
2						0.00			0.00	0.00	n/a	n/a	n/a	n/a	n/a	n/a
2						0.00			0.00	0.00	n/a	n/a	n/a	n/a	n/a	n/a
2						0.00			0.00	0.00	n/a	n/a	n/a	n/a	n/a	n/a
2						0.00			0.00	0.00	n/a	n/a	n/a	n/a	n/a	n/a
2						0.00			0.00	0.00	n/a	n/a	n/a	n/a	n/a	n/a
2						0.00			0.00	0.00	n/a	n/a	n/a	n/a	n/a	n/a
2						0.00			0.00	0.00	n/a	n/a	n/a	n/a	n/a	n/a
2	Package Total					\$0.00			\$0.00	\$0.00				\$0.00		

WORKSHEET 1 - MSA BASE PERIOD EXPERIENCE AND PROJECTION ASSUMPTIONS

MSA-2011.1
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:	2011	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)									

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. 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: 2011	8. Deductible Amount:		

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. COB/Subrg. (outside claim system)				0.00							0.00	
m. Total Medicare Covered Medical Expenses				\$0.00				\$0.00	0%		\$0.00	
								0%	CMS Guideline Credibility			
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: 2011	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 Additional 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	
1. Total or Weighted Average for Service Area:			0	0	\$0.00	\$0.00	Plan Benchmark
2. County Level Detail:							

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: 2011	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

