WORKSHEET 1 - MA BASE PERIOD EXPERIENCE AND PROJECTION ASSUMPTIONS

Note: See bid instructions for ESRD and hospice exclusions.

MA-2012.1

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:	2012	8. MA-PD:		12. SNP:		14. SNP Type:	N/A	15. EGWP:	N

II. Base Period Background Information

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

			Total	Non-DE#	DE#		Contract-Plan ID	Member Months	Contract-Plan ID	Member Months
1. Time Period Definition		2. Member Months			0	5. Plans In Base				
Incurred from:	01/01/2010	3. Risk Score			0.0000					
Incurred to:	12/31/2010	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 Risk Factor) for 1/1/2010-12/31/2010

IV. Projection Assumptions

	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(l)	(m)	(n)	(o)	(p)	(q)
					Total Benefits			Util. Adjustments to Contract Period				Unit Cost Adjustment		Additive Adjustments	
	Service Category	Net PMPM	Cost Sharing	Util Type	Annualized Util/1000	Avg Cost	Allowed PMPM	Util/1000 Trend	Benefit Plan Change	Population Change	Other Factor	Provider Payment Change	Other Factor	Util/1000	PMPM
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 1/1/2010-12/31/2010 (excludes Optional Supplemental)

	ESRD	Hospice	All Other	Total				
1. CMS Revenue				$0.00	Non-Benefit Expenses:		8. Gain/(Loss) Margin	$0.00
2. Premium Revenue				$0.00	7a. Marketing & Sales			
3. Total Revenue	$0.00	$0.00	$0.00	$0.00	7b. Direct Administration		Percentage of Revenue:	
					7c. Indirect Administration		9a. Net Medical Expenses	0.0%
4. Net Medical Expenses				$0.00	7d. Net Cost of Private Reinsurance		9b. Non-Benefit Expenses	0.0%
					7e. Total Non-Benefit Expenses	$0.00	9c. Gain/(Loss) Margin	0.0%
5. Member Months			0	0				
PMPMs:								
6a. Revenue PMPM	$0.00	$0.00	$0.00	$0.00				
6b. Net Medical PMPM	$0.00	$0.00	$0.00	$0.00				
6c. Non-Benefit PMPM				$0.00				
6d. Gain/(Loss) Margin PMPM				$0.00				

WORKSHEET 2 - MA PROJECTED ALLOWED COSTS PMPM

Note: See bid instructions for ESRD and hospice exclusions.

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:	2012	8. MA-PD:		12. SNP:		14. SNP Type:	N/A

15. EGWP N

II. Projected Allowed Costs

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

Contract Year Allowed Costs at Plan's 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)
		Projected Experience Rate			Manual Rate				Blended Rate					
Service Category	Util Type	Annual Util/1000	Avg Cost	Allowed PMPM	Annual Util/1000	Avg Cost	Allowed PMPM	Exper. Cred. %	Annual Util/1000	Avg Cost	Total Allowed PMPM	Non-DE# Allowed PMPM	DE# Allowed PMPM	% of svcs provided OON
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**	
								0%	CMS Guideline Credibility					
t. Subtotal Medicare-covered service categories				$0.00			$0.00	0%			$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

Note: See bid instructions for ESRD and hospice exclusions.

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:	2012	8. MA-PD:	12. SNP:		14. SNP Type:	N/A	15. EGWP:	N

II. Maximum Cost Sharing Per Member Per Year

Is there a plan-level OOP maximum? (Yes/No, then enter amount) 1. In Network NO 2. Out of Network NO 3. Combined NO

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 Risk Factor)

(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(l)	(m)	(n)	(o)
				In-Network Cost Sharing After Plan-Level Deductible								
Service Category	Description	Measure-ment Unit Code	In-Network Effective Plan-Level Deduct PMPM*	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	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)
a.1. Inpatient Facility	Acute							$0.00	$0.00			$0.00
a.2. Inpatient Facility	Mental Health							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	DME							0.00	0.00			0.00
e.2. DME/Prosthetics/Supplies	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	Lab							0.00	0.00			0.00
h.2. OP Facility - Other	Radiology							0.00	0.00			0.00
h.3. OP Facility - Other	Mental Health							0.00	0.00			0.00
h.4. OP Facility - Other	Renal Dialysis							0.00	0.00			0.00
h.5. OP Facility - Other	Other							0.00	0.00			0.00
i.1. Professional	PCP							0.00	0.00			0.00
i.2. Professional	Specialist excl. MH							0.00	0.00			0.00
i.3. Professional	Mental Health (MH)							0.00	0.00			0.00
i.4. Professional	Therapy (PT/OT/ST)							0.00	0.00			0.00
i.5. Professional	Radiology							0.00	0.00			0.00
i.6. Professional	Other							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)	Professional							0.00	0.00			0.00
n.2. Vision (Non-Covered)	Hardware							0.00	0.00			0.00
o.1. Hearing (Non-Covered)	Professional							0.00	0.00			0.00
o.2. Hearing (Non-Covered)	Hardware							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
Total			$0.00					$0.00	**$0.00**		**$0.00**	**$0.00**

Actual combined plan level deductible:

Does combined ded apply to Pt B only?

*Actual in-network plan level deductible:

Does in-network ded apply to Pt B only?

** PMPM impact of in-network OOP max:

***Actual OON plan level deductible:

Does OON ded apply to Pt B only?

***PMPM impact of OON OOP max:

WORKSHEET 4 - MA PROJECTED REVENUE REQUIREMENT PMPM

Note: See bid instructions for ESRD and hospice exclusions.

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:	2012	8. MA-PD:		12. SNP:		14. SNP Type:	N/A

15. EGWP: N

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 Risk Factor: 0.0000

(c)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(l)	(m)	(n)	(o)	(p)	(q)	(r)
	Total Benefits				**% for Cov. Svcs**		FFS Medicare	Plan cost sh.	**Medicare Covered (w/AE cost sh.)**			**A/B Mand Suppl (MS) Benefits**		
Service Category	Allowed PMPM	Plan Cost Sharing		Net PMPM	Allowed	Cost Sharing	Actl. Equiv. cost sharing	for Medicare-covered svcs.	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. 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
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 Risk Factor: 0.0000

(c)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(l)	(m)	(n)	(o)	(p)	(q)	(r)
	Total Benefits				**% for Cov. Svcs**		State Medicaid	Actual cost sh.	**Medicare Covered (w/Medicaid cost sh.)**			**A/B Mand Suppl (MS) Benefits**		
Service Category	Reimb + Actual Cost Sh.	Plan Cost Sharing	Actual Cost Sharing	Plan Reimb	Allowed	Cost Sharing	Required Bene. cost sharing	for Medicare-covered svcs.	Allowed PMPM	Medicaid 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	$0.00				$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	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**	**$0.00**

WORKSHEET 4 - MA PROJECTED REVENUE REQUIREMENT PMPM

Note: See bid instructions for ESRD and hospice exclusions.

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:	2012	8. MA-PD:		12. SNP:		14. SNP Type:	N/A

15. EGWP: N

II. Development of Projected Revenue Requirement

C. All Beneficiaries

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

(c)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(l)	(m)	(n)	(o)	(p)	(q)	(r)
	Total Benefits								Medicare Covered			A/B Mand Suppl (MS) Benefits		
Service Category				Net PMPM							Net PMPM	Net PMPM for Add'l Svcs.	Reduction of A/B Cost Sh.	Total
a. Inpatient Facility				$0.00							$0.00	$0.00	$0.00	$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. Percentage of Revenue (excl. ESRD line)														
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:

Basic benefits (user entries must be reported as "per ESRD member per month")

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

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

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 Cost* (not in bid)

*Cost includes benefit expenses and non-benefit expenses.

WORKSHEET 5 - MA BENCHMARK PMPM

Note: See bid instructions for ESRD and hospice exclusions.

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			
4. Contract Year:	2012	8. MA-PD:		12. SNP:		14. SNP Type:	N/A 15. EGWP: N

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	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

III. Savings/Basic Member Premium Development

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

IV. Standardized A/B Benchmark - Regional Plans Only

	Weighting	
1. Statutory Component - Region N/A	74.6%	
2. Plan Bid Component (from CMS)*	25.4%	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.*

V. Quality Rating

1. Quality Bonus Rating (per CMS)	
2. New plan/low enrollment plan (per CMS)	
3. Rebate %	66.7%

VI: County Level Detail and Service Area Summary

VII: 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 A only	Risk Payment Rate B only	Original Medicare cost sharing (c.s.) Inpatient	Original Medicare cost sharing (c.s.) SNF	Original Medicare cost sharing (c.s.) Pt B (excl HH)	FFS costs to weight Medicare c.s. Inpatient	FFS costs to weight Medicare c.s. SNF	FFS costs to weight Medicare c.s. Pt B (excl HH)	Metropolitan Statistical Area MM	Metropolitan Statistical Area 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

Note: See bid instructions for ESRD and hospice exclusions.

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:	2012	8. MA-PD:		12. SNP:		14. SNP Type:	N/A

15. EGWP: N

II. Other Information

A. Part B Information

1. Maximum Pt B premium buydown amt., per CMS	$96.40

B. Rebate Allocation for Part B Premium

1. PMPM rebate allocation for Part B premium (maximum value=$96.40)	
2. Part B Rebate Allocation, rounded to one decimal (see instructions)	$0.00

C. Rebate Allocations

1. Reduce A/B Cost Sharing (max. value=$0.00)	
2. Other A/B Mand Suppl Benefits (max. value=$0.00)	

III. Plan A/B Bid Summary

A. Overview

	Medicare-covered	A/B Mandatory Supplemental
1. Net medical cost	$0.00	$0.00
2. Non-benefit expense	$0.00	$0.00
3. Gain / loss margin	0.00	0.00
4. Total revenue requirement	$0.00	$0.00
5. Standardized A/B Benchmark	$0.00	
6. Plan A/B Benchmark	$0.00	
7. Risk Factor	0.0000	
8. Conversion Factor	0.0000	

B. MA Rebate Allocation

	Rebate PMPM Allocation				Maximum Value
	Medical	Admin	Gain / (Loss)	Total	
1. MA Rebate	n/a	n/a	n/a	$0.00	
2. Reduce A/B Cost Sharing	$0.00	$0.00	$0.00	$0.00	$0.00
3. Other A/B Mand Suppl Benefits	0.00	0.00	0.00	0.00	0.00
4. Pt B Premium Buydown	0.00	n/a	n/a	0.00	96.40
5. Pt D Premium Buydown Basic	0.00	n/a	n/a	0.00	0.00
6. Pt D Premium Buydown Suppl	0.00	n/a	n/a	0.00	0.00
7. Total	$0.00	$0.00	$0.00	$0.00	
			Unalloc. rebate	$0.00	

C. Development of Estimated Plan Premium

1. A/B Mandatory Supplemental revenue requirements	$0.00
2. Less rebate allocations:	
2a. Reduce A/B Cost Sharing	0.00
2b. Other A/B Mand Supplemental Benefits	0.00
3. A/B Mandatory Supplemental premium	0.00
4. Basic MA premium	0.00
5. Total MA Enrollee Premium (excl. Opt. Suppl.)	0.00
6. Rounded MA Premium (excl. Opt. Suppl.)	**$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	

* 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.

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.

WORKSHEET 7 - OPTIONAL SUPPLEMENTAL BENEFITS

Note: See bid instructions for ESRD and hospice exclusions.

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: 2012	8. MA-PD:	12. SNP:	14. SNP Type: N/A 15. EGWP N

II. Optional Supplemental Packages

(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(l)	(m)	(n)	(o)	(p)	(q)
			Allowed medical expense				Enrollee cost sharing				Net	Non-	Gain/		Projected
Package ID	Service category	Benefit category or pricing component	Util. type	Annual Util / 1000	Average cost	PMPM	Measurment unit code	Util/1000 or PMPM	Average cost shr	PMPM	PMPM value	Benefit Expense	(Loss) Margin	Premium	Member Months
Description															
1						$0.00				$0.00	$0.00	n/a	n/a	n/a	n/a
1						0.00				0.00	0.00	n/a	n/a	n/a	n/a
1						0.00				0.00	0.00	n/a	n/a	n/a	n/a
1						0.00				0.00	0.00	n/a	n/a	n/a	n/a
1						0.00				0.00	0.00	n/a	n/a	n/a	n/a
1						0.00				0.00	0.00	n/a	n/a	n/a	n/a
1						0.00				0.00	0.00	n/a	n/a	n/a	n/a
1						0.00				0.00	0.00	n/a	n/a	n/a	n/a
1						0.00				0.00	0.00	n/a	n/a	n/a	n/a
1						0.00				0.00	0.00	n/a	n/a	n/a	n/a
1						0.00				0.00	0.00	n/a	n/a	n/a	n/a
1						0.00				0.00	0.00	n/a	n/a	n/a	n/a
1						0.00				0.00	0.00	n/a	n/a	n/a	n/a
1						0.00				0.00	0.00	n/a	n/a	n/a	n/a
1						0.00				0.00	0.00	n/a	n/a	n/a	n/a
1						0.00				0.00	0.00	n/a	n/a	n/a	n/a
1						0.00				0.00	0.00	n/a	n/a	n/a	n/a
1						0.00				0.00	0.00	n/a	n/a	n/a	n/a
1						0.00				0.00	0.00	n/a	n/a	n/a	n/a
1						0.00				0.00	0.00	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
2						0.00				0.00	0.00	n/a	n/a	n/a	n/a
2						0.00				0.00	0.00	n/a	n/a	n/a	n/a
2						0.00				0.00	0.00	n/a	n/a	n/a	n/a
2						0.00				0.00	0.00	n/a	n/a	n/a	n/a
2						0.00				0.00	0.00	n/a	n/a	n/a	n/a
2						0.00				0.00	0.00	n/a	n/a	n/a	n/a
2						0.00				0.00	0.00	n/a	n/a	n/a	n/a
2						0.00				0.00	0.00	n/a	n/a	n/a	n/a
2						0.00				0.00	0.00	n/a	n/a	n/a	n/a
2						0.00				0.00	0.00	n/a	n/a	n/a	n/a
2						0.00				0.00	0.00	n/a	n/a	n/a	n/a
2						0.00				0.00	0.00	n/a	n/a	n/a	n/a
2						0.00				0.00	0.00	n/a	n/a	n/a	n/a
2						0.00				0.00	0.00	n/a	n/a	n/a	n/a
2						0.00				0.00	0.00	n/a	n/a	n/a	n/a
2						0.00				0.00	0.00	n/a	n/a	n/a	n/a
2						0.00				0.00	0.00	n/a	n/a	n/a	n/a
2						0.00				0.00	0.00	n/a	n/a	n/a	n/a
2						0.00				0.00	0.00	n/a	n/a	n/a	n/a
2	**Package Total**					**$0.00**				**$0.00**	**$0.00**			**$0.00**	

WORKSHEET 7 - OPTIONAL SUPPLEMENTAL BENEFITS

Note: See bid instructions for ESRD and hospice exclusions.

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:	2012	8. MA-PD:	12. SNP:		14. SNP Type:	N/A	15. EGWP N			

II. Optional Supplemental Packages

(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(l)	(m)	(n)	(o)	(p)	(q)
			Allowed medical expense				**Enrollee cost sharing**								
Package ID	**Service category**	**Benefit category or pricing component**	**Util. type**	**Annual Util / 1000**	**Average cost**	**PMPM**	**Measurment unit code**	**Util/1000 or PMPM**	**Average cost shr**	**PMPM**	**Net PMPM value**	**Non-Benefit Expense**	**Gain/ (Loss) Margin**	**Premium**	**Projected Member Months**
Description															
3						$0.00				$0.00	$0.00	n/a	n/a	n/a	n/a
3						0.00				0.00	0.00	n/a	n/a	n/a	n/a
3						0.00				0.00	0.00	n/a	n/a	n/a	n/a
3						0.00				0.00	0.00	n/a	n/a	n/a	n/a
3						0.00				0.00	0.00	n/a	n/a	n/a	n/a
3						0.00				0.00	0.00	n/a	n/a	n/a	n/a
3						0.00				0.00	0.00	n/a	n/a	n/a	n/a
3						0.00				0.00	0.00	n/a	n/a	n/a	n/a
3						0.00				0.00	0.00	n/a	n/a	n/a	n/a
3						0.00				0.00	0.00	n/a	n/a	n/a	n/a
3						0.00				0.00	0.00	n/a	n/a	n/a	n/a
3						0.00				0.00	0.00	n/a	n/a	n/a	n/a
3						0.00				0.00	0.00	n/a	n/a	n/a	n/a
3						0.00				0.00	0.00	n/a	n/a	n/a	n/a
3						0.00				0.00	0.00	n/a	n/a	n/a	n/a
3						0.00				0.00	0.00	n/a	n/a	n/a	n/a
3						0.00				0.00	0.00	n/a	n/a	n/a	n/a
3						0.00				0.00	0.00	n/a	n/a	n/a	n/a
3						0.00				0.00	0.00	n/a	n/a	n/a	n/a
3						0.00				0.00	0.00	n/a	n/a	n/a	n/a
3	**Package Total**					**$0.00**				**$0.00**	**$0.00**			**$0.00**	
Description															
4						$0.00				$0.00	$0.00	n/a	n/a	n/a	n/a
4						0.00				0.00	0.00	n/a	n/a	n/a	n/a
4						0.00				0.00	0.00	n/a	n/a	n/a	n/a
4						0.00				0.00	0.00	n/a	n/a	n/a	n/a
4						0.00				0.00	0.00	n/a	n/a	n/a	n/a
4						0.00				0.00	0.00	n/a	n/a	n/a	n/a
4						0.00				0.00	0.00	n/a	n/a	n/a	n/a
4						0.00				0.00	0.00	n/a	n/a	n/a	n/a
4						0.00				0.00	0.00	n/a	n/a	n/a	n/a
4						0.00				0.00	0.00	n/a	n/a	n/a	n/a
4						0.00				0.00	0.00	n/a	n/a	n/a	n/a
4						0.00				0.00	0.00	n/a	n/a	n/a	n/a
4						0.00				0.00	0.00	n/a	n/a	n/a	n/a
4						0.00				0.00	0.00	n/a	n/a	n/a	n/a
4						0.00				0.00	0.00	n/a	n/a	n/a	n/a
4						0.00				0.00	0.00	n/a	n/a	n/a	n/a
4						0.00				0.00	0.00	n/a	n/a	n/a	n/a
4						0.00				0.00	0.00	n/a	n/a	n/a	n/a
4						0.00				0.00	0.00	n/a	n/a	n/a	n/a
4						0.00				0.00	0.00	n/a	n/a	n/a	n/a
4	**Package Total**					**$0.00**				**$0.00**	**$0.00**			**$0.00**	

WORKSHEET 7 - OPTIONAL SUPPLEMENTAL BENEFITS

Note: See bid instructions for ESRD and hospice exclusions.

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:	2012	8. MA-PD:	12. SNP:		14. SNP Type:	N/A	15. EGWP	N

II. Optional Supplemental Packages

(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(l)	(m)	(n)	(o)	(p)	(q)
			Allowed medical expense				Enrollee cost sharing				Net	Non-	Gain/		Projected
Package ID	Service category	Benefit category or pricing component	Util. type	Annual Util / 1000	Average cost	PMPM	Measurment unit code	Util/1000 or PMPM	Average cost shr	PMPM	PMPM value	Benefit Expense	(Loss) Margin	Premium	Member Months
Description															
5						$0.00				$0.00	$0.00	n/a	n/a	n/a	n/a
5						0.00				0.00	0.00	n/a	n/a	n/a	n/a
5						0.00				0.00	0.00	n/a	n/a	n/a	n/a
5						0.00				0.00	0.00	n/a	n/a	n/a	n/a
5						0.00				0.00	0.00	n/a	n/a	n/a	n/a
5						0.00				0.00	0.00	n/a	n/a	n/a	n/a
5						0.00				0.00	0.00	n/a	n/a	n/a	n/a
5						0.00				0.00	0.00	n/a	n/a	n/a	n/a
5						0.00				0.00	0.00	n/a	n/a	n/a	n/a
5						0.00				0.00	0.00	n/a	n/a	n/a	n/a
5						0.00				0.00	0.00	n/a	n/a	n/a	n/a
5						0.00				0.00	0.00	n/a	n/a	n/a	n/a
5						0.00				0.00	0.00	n/a	n/a	n/a	n/a
5						0.00				0.00	0.00	n/a	n/a	n/a	n/a
5						0.00				0.00	0.00	n/a	n/a	n/a	n/a
5						0.00				0.00	0.00	n/a	n/a	n/a	n/a
5						0.00				0.00	0.00	n/a	n/a	n/a	n/a
5						0.00				0.00	0.00	n/a	n/a	n/a	n/a
5						0.00				0.00	0.00	n/a	n/a	n/a	n/a
5						0.00				0.00	0.00	n/a	n/a	n/a	n/a
5	**Package Total**					**$0.00**				**$0.00**	**$0.00**			**$0.00**	

III. Comments

WORKSHEET 1 - MSA BASE PERIOD EXPERIENCE AND PROJECTION ASSUMPTIONS

Note: See bid instructions for ESRD and hospice exclusions.

MSA-2012.1

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:	2012	8. Deductible Amount			

II. Base Period Background Information

1. Time Period Definition
   - Incurred from:
   - Incurred to:
   - Paid through:
2. Member Months
3. Risk Score
4. Completion Factor
5. Plans In Base

	Contract-Plan ID	% of MMs
a.		
b.		
c.		
d.		

6. Describe the source of the base period experience data (1000 character limit)

III. Base Period Data (at Plan's Risk Factor)

IV. Projection Assumptions

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

CMS - 10142 (5/31/2011)

WORKSHEET 2 - MSA TOTAL PROJECTED ALLOWED COSTS PMPM

Note: See bid instructions for ESRD and hospice exclusions.

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: 2012	8.	Deductible Amount:		

II. Projected Allowed Costs

Contract Year Allowed Costs at Plan's Risk Factor:

(c)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(l)	(m)	(n)	(o)	(p)
		Projected Experience Rate			Manual Rate			Exper.	Contract Year Rate			% of svcs
Service Category	Util Type	Annual Util/1000	Avg Cost	Allowed PMPM	Annual Util/1000	Avg Cost	Allowed PMPM	Cred. %	Annual Util/1000	Avg Cost	Allowed PMPM	provided OON
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

Note: See bid instructions for ESRD and hospice exclusions.

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:	2012	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)	

IV. Quality Bonus Rating

1. Quality Bonus Rating	

III: County Level Detail and Service Area Summary

(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

Note: See bid instructions for ESRD and hospice exclusions.

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:	2012	8. Deductible Amount		

II. Development of Claim Information Intervals (Plan's 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 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**

WORKSHEET 5 - OPTIONAL SUPPLEMENTAL BENEFITS

Note: See bid instructions for ESRD and hospice exclusions.

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:	2012	8. Deductible Amount			

II. Optional Supplemental Packages

(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(l)	(m)	(n)	(o)	(p)	(q)
			Allowed medical expense				**Enrollee cost sharing**								
Package ID	**Service category**	**Benefit category or pricing component**	**Util. type**	**Annual Util / 1000**	**Average cost**	**PMPM**	**Measurment unit code**	**Util/1000 or PMPM**	**Average cost shr**	**PMPM**	**Net PMPM value**	**Non-Benefit expense**	**Gain/ (Loss) Margin**	**Premium**	**Projected Member Months**
Description															
1						$0.00					$0.00	$0.00	n/a	n/a	n/a	n/a
1						0.00					0.00	0.00	n/a	n/a	n/a	n/a
1						0.00					0.00	0.00	n/a	n/a	n/a	n/a
1						0.00					0.00	0.00	n/a	n/a	n/a	n/a
1						0.00					0.00	0.00	n/a	n/a	n/a	n/a
1						0.00					0.00	0.00	n/a	n/a	n/a	n/a
1						0.00					0.00	0.00	n/a	n/a	n/a	n/a
1						0.00					0.00	0.00	n/a	n/a	n/a	n/a
1						0.00					0.00	0.00	n/a	n/a	n/a	n/a
1						0.00					0.00	0.00	n/a	n/a	n/a	n/a
1						0.00					0.00	0.00	n/a	n/a	n/a	n/a
1						0.00					0.00	0.00	n/a	n/a	n/a	n/a
1						0.00					0.00	0.00	n/a	n/a	n/a	n/a
1						0.00					0.00	0.00	n/a	n/a	n/a	n/a
1						0.00					0.00	0.00	n/a	n/a	n/a	n/a
1						0.00					0.00	0.00	n/a	n/a	n/a	n/a
1						0.00					0.00	0.00	n/a	n/a	n/a	n/a
1						0.00					0.00	0.00	n/a	n/a	n/a	n/a
1						0.00					0.00	0.00	n/a	n/a	n/a	n/a
1						0.00					0.00	0.00	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
2						0.00					0.00	0.00	n/a	n/a	n/a	n/a
2						0.00					0.00	0.00	n/a	n/a	n/a	n/a
2						0.00					0.00	0.00	n/a	n/a	n/a	n/a
2						0.00					0.00	0.00	n/a	n/a	n/a	n/a
2						0.00					0.00	0.00	n/a	n/a	n/a	n/a
2						0.00					0.00	0.00	n/a	n/a	n/a	n/a
2						0.00					0.00	0.00	n/a	n/a	n/a	n/a
2						0.00					0.00	0.00	n/a	n/a	n/a	n/a
2						0.00					0.00	0.00	n/a	n/a	n/a	n/a
2						0.00					0.00	0.00	n/a	n/a	n/a	n/a
2						0.00					0.00	0.00	n/a	n/a	n/a	n/a
2						0.00					0.00	0.00	n/a	n/a	n/a	n/a
2						0.00					0.00	0.00	n/a	n/a	n/a	n/a
2						0.00					0.00	0.00	n/a	n/a	n/a	n/a
2						0.00					0.00	0.00	n/a	n/a	n/a	n/a
2						0.00					0.00	0.00	n/a	n/a	n/a	n/a
2						0.00					0.00	0.00	n/a	n/a	n/a	n/a
2						0.00					0.00	0.00	n/a	n/a	n/a	n/a
2						0.00					0.00	0.00	n/a	n/a	n/a	n/a
2	**Package Total**					**$0.00**					**$0.00**	**$0.00**			**$0.00**	

WORKSHEET 5 - OPTIONAL SUPPLEMENTAL BENEFITS

Note: See bid instructions for ESRD and hospice exclusions.

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: 2012	8. Deductible Amount	

II. Optional Supplemental Packages

(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(l)	(m)	(n)	(o)	(p)	(q)
		Benefit category	Allowed medical expense				Enrollee cost sharing				Net	Non-	Gain/		Projected
Package ID	Service category	or pricing component	Util. type	Annual Util / 1000	Average cost	PMPM	Measurment unit code	Util/1000 or PMPM	Average cost shr	PMPM	PMPM value	Benefit expense	(Loss) Margin	Premium	Member Months
Description															
3						$0.00				$0.00	$0.00	n/a	n/a	n/a	n/a
3						0.00				0.00	0.00	n/a	n/a	n/a	n/a
3						0.00				0.00	0.00	n/a	n/a	n/a	n/a
3						0.00				0.00	0.00	n/a	n/a	n/a	n/a
3						0.00				0.00	0.00	n/a	n/a	n/a	n/a
3						0.00				0.00	0.00	n/a	n/a	n/a	n/a
3						0.00				0.00	0.00	n/a	n/a	n/a	n/a
3						0.00				0.00	0.00	n/a	n/a	n/a	n/a
3						0.00				0.00	0.00	n/a	n/a	n/a	n/a
3						0.00				0.00	0.00	n/a	n/a	n/a	n/a
3						0.00				0.00	0.00	n/a	n/a	n/a	n/a
3						0.00				0.00	0.00	n/a	n/a	n/a	n/a
3						0.00				0.00	0.00	n/a	n/a	n/a	n/a
3						0.00				0.00	0.00	n/a	n/a	n/a	n/a
3						0.00				0.00	0.00	n/a	n/a	n/a	n/a
3						0.00				0.00	0.00	n/a	n/a	n/a	n/a
3						0.00				0.00	0.00	n/a	n/a	n/a	n/a
3						0.00				0.00	0.00	n/a	n/a	n/a	n/a
3						0.00				0.00	0.00	n/a	n/a	n/a	n/a
3						0.00				0.00	0.00	n/a	n/a	n/a	n/a
3	**Package Total**					**$0.00**				**$0.00**	**$0.00**			**$0.00**	
Description															
4						$0.00				$0.00	$0.00	n/a	n/a	n/a	n/a
4						0.00				0.00	0.00	n/a	n/a	n/a	n/a
4						0.00				0.00	0.00	n/a	n/a	n/a	n/a
4						0.00				0.00	0.00	n/a	n/a	n/a	n/a
4						0.00				0.00	0.00	n/a	n/a	n/a	n/a
4						0.00				0.00	0.00	n/a	n/a	n/a	n/a
4						0.00				0.00	0.00	n/a	n/a	n/a	n/a
4						0.00				0.00	0.00	n/a	n/a	n/a	n/a
4						0.00				0.00	0.00	n/a	n/a	n/a	n/a
4						0.00				0.00	0.00	n/a	n/a	n/a	n/a
4						0.00				0.00	0.00	n/a	n/a	n/a	n/a
4						0.00				0.00	0.00	n/a	n/a	n/a	n/a
4						0.00				0.00	0.00	n/a	n/a	n/a	n/a
4						0.00				0.00	0.00	n/a	n/a	n/a	n/a
4						0.00				0.00	0.00	n/a	n/a	n/a	n/a
4						0.00				0.00	0.00	n/a	n/a	n/a	n/a
4						0.00				0.00	0.00	n/a	n/a	n/a	n/a
4						0.00				0.00	0.00	n/a	n/a	n/a	n/a
4						0.00				0.00	0.00	n/a	n/a	n/a	n/a
4						0.00				0.00	0.00	n/a	n/a	n/a	n/a
4	**Package Total**					**$0.00**				**$0.00**	**$0.00**			**$0.00**	

WORKSHEET 5 - OPTIONAL SUPPLEMENTAL BENEFITS

Note: See bid instructions for ESRD and hospice exclusions.

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:	2012	8. Deductible Amount			

II. Optional Supplemental Packages

(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(l)	(m)	(n)	(o)	(p)	(q)
			Allowed medical expense				**Enrollee cost sharing**								
Package ID	**Service category**	**Benefit category or pricing component**	**Util. type**	**Annual Util / 1000**	**Average cost**	**PMPM**	**Measurment unit code**	**Util/1000 or PMPM**	**Average cost shr**	**PMPM**	**Net PMPM value**	**Non-Benefit expense**	**Gain/ (Loss) Margin**	**Premium**	**Projected Member Months**
Description															
5						$0.00				$0.00	$0.00	n/a	n/a	n/a	n/a
5						0.00				0.00	0.00	n/a	n/a	n/a	n/a
5						0.00				0.00	0.00	n/a	n/a	n/a	n/a
5						0.00				0.00	0.00	n/a	n/a	n/a	n/a
5						0.00				0.00	0.00	n/a	n/a	n/a	n/a
5						0.00				0.00	0.00	n/a	n/a	n/a	n/a
5						0.00				0.00	0.00	n/a	n/a	n/a	n/a
5						0.00				0.00	0.00	n/a	n/a	n/a	n/a
5						0.00				0.00	0.00	n/a	n/a	n/a	n/a
5						0.00				0.00	0.00	n/a	n/a	n/a	n/a
5						0.00				0.00	0.00	n/a	n/a	n/a	n/a
5						0.00				0.00	0.00	n/a	n/a	n/a	n/a
5						0.00				0.00	0.00	n/a	n/a	n/a	n/a
5						0.00				0.00	0.00	n/a	n/a	n/a	n/a
5						0.00				0.00	0.00	n/a	n/a	n/a	n/a
5						0.00				0.00	0.00	n/a	n/a	n/a	n/a
5						0.00				0.00	0.00	n/a	n/a	n/a	n/a
5						0.00				0.00	0.00	n/a	n/a	n/a	n/a
5						0.00				0.00	0.00	n/a	n/a	n/a	n/a
5						0.00				0.00	0.00	n/a	n/a	n/a	n/a
5	**Package Total**					**$0.00**				**$0.00**	**$0.00**			**$0.00**	

III. Comments