Contract Number: Plan ID:	5. Organization Name 6. Plan Name:		9. Enrollee Type: 10. MA Region: N/A	13. Region	n Name: N/A	
Segment ID:	7. Plan Type: 13 8. MA-PD:		11. Act. Swap/Equiv Apply: 12. SNP:	14. SNP T	ype: N/A	15. EGWP: N
Base Period Background Information		Note: DE# refers to Dual Elig	gible Beneficiaries without full Medicare cost sha Total Non-DE# D	ring liability E#		
Time Period Definition		2. Member Months	Total Non-DE# D	0 5. Plans In Base	Contract-Plan ID Member Month	s Contract-Plan ID Member Mor
Incurred from:	01/01/2011	Risk Score		0.0000		
	12/31/2011	Completion Factor				
Incurred to:						
Incurred to: Paid through:						

Base Period Data (at Plan's Risk F	(c)	(d)	(e)	(f)	(g)	(h)	(i)	IV. Projectio	(k)	(I)	(m)	(n)	(o)	(p)	(q)
(2)	(5)	(4)	(0)	(•)		Total Benefits	(•)	I Util Adiust	ments to Contra		()	Unit Cost Adju		Additiv	
		Net	Cost	Util	Annualized		Allowed	Util/1000	Benefit Plan	Population	Other	Provider Payment	Other	Adjusti	
ervice Category	Utilizers	PMPM	Sharing	Type	Util/1000	Avg Cost	PMPM	Trend	Change	Change	Factor	Change	Factor	Util/1000	PMPM
Trice Gategory	Othizers		Onaring	Турс	Oth, 1000	Avg oost	1 1011 101	Trond	Onlange	Onlange	i dotoi	Onlinge	1 40101	1 0111/1000	1 1011 101
Inpatient Facility			\$0.00			\$0.00									
Skilled Nursing Facility			0.00			0.00									
Home Health			0.00			0.00									
Ambulance			0.00			0.00									
DME/Prosthetics/Supplies			0.00			0.00									
OP Facility - Emergency			0.00			0.00									
OP Facility - Surgery			0.00			0.00									
OP Facility - Other			0.00			0.00									
Professional			0.00			0.00									
Part B Rx			0.00			0.00									
Other Medicare Part B			0.00			0.00									
Transportation (Non-Covered)			0.00			0.00									
Dental (Non-Covered)			0.00			0.00									
Vision (Non-Covered)			0.00			0.00									
Hearing (Non-Covered)			0.00			0.00									
Health & Education (Non-Covered)			0.00			0.00									
Other Non-Covered			0.00			0.00									
COB/Subrg. (outside claim system)	Ļ	0.00	0.00			<u>_</u>									
Total Medical Expenses	L	\$0.00	\$0.00				\$0.00								

V. Description of Other Utilization Adjustment Factor, Other Unit Cost Adjustment Factor, and Additive Adjustments										

\$0.00

VI. Base Period Summary for 1/1/2011-12/31/2011 (excludes Optional Supplemental) <u>ESRD</u> <u>Hospice</u> All Other Total 1. CMS Revenue \$0 Non-Benefit Expenses: 8. Gain/(Loss) Margin \$0 2. Premium Revenue \$0 7a. Sales & Marketing 3. Total Revenue \$0 7b. Direct Administration \$0 \$0 Percentage of Revenue: 9a. Net Medical Expenses 0.0% 7c. Indirect Administration \$0 9b. Non-Benefit Expenses 4. Net Medical Expenses 7d. Net Cost of Private Reinsurance 0.0% 7e. Quality Initiatives 9c. Gain/(Loss) Margin 0.0% 5. Member Months 7f. Taxes and Fees 7g. Total Non-Benefit Expenses PMPMs: 6a. Revenue PMPM \$0.00 \$0.00 \$0.00 \$0.00 6b. Net Medical PMPM \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 6c. Non-Benefit PMPM \$0.00 6d. Gain/(Loss) Margin PMPM

CMS - 10142 (3/31/2012)

Subtotal Medicare-covered service categories

Attachment D-1, CY2013_MA_BPT.xlsm 12/14/2011

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: 2013	8. MA-PD:	12. SNP:	14. SNP Type:	N/A	15. EGWP:N

Contract Year Allowed Costs at Plan's Risk	Factor:								1 Projected n	nember months	<u>Total</u> 0	Non-DE# 0		
	1 40.011								2. Projected ri		0.0000		0.0000	
(c)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(I)	(m)	(n)	(o)	(p)	(q)	(r)
		Proje	cted Experien	ce Rate		Manual Rat	е	Exper.			Blended Rate	9		% of svcs
	Util	Annual		Allowed	Annual		Allowed	Cred.	Annual		Total Allowed	Non-DE#	DE#	provided
Service Category	Туре	Util/1000	Avg Cost	PMPM	Util/1000	Avg Cost	PMPM	%	Util/1000	Avg Cost	PMPM	Allowed PMPM	Allowed PMPM	OON
Inpatient Facility		0	\$0.00	\$0.00		\$0.00			0	\$0.00	\$0.00			
Skilled Nursing Facility		0	0.00	0.00		0.00			0	0.00	0.00			
Home Health		0	0.00	0.00		0.00			0	0.00	0.00			
Ambulance		0	0.00	0.00		0.00			0	0.00	0.00			
DME/Prosthetics/Supplies		0	0.00	0.00		0.00			0	0.00	0.00			
OP Facility - Emergency		0	0.00	0.00		0.00			0	0.00	0.00			
OP Facility - Surgery		0	0.00	0.00		0.00			0	0.00	0.00			
OP Facility - Other		0	0.00	0.00		0.00			0	0.00	0.00			
Professional		0	0.00	0.00		0.00			0	0.00	0.00			
Part B Rx		0	0.00	0.00		0.00			0	0.00	0.00			
Other Medicare Part B		0	0.00	0.00		0.00			0	0.00	0.00			
Transportation (Non-Covered)		0	0.00	0.00		0.00			0	0.00	0.00			
Dental (Non-Covered)		0	0.00	0.00		0.00			0	0.00	0.00			
Vision (Non-Covered)		0	0.00	0.00		0.00			0	0.00	0.00			
Hearing (Non-Covered)		0	0.00	0.00		0.00			0	0.00	0.00			
Health & Education (Non-Covered)		0	0.00	0.00		0.00			0	0.00	0.00			
Other Non-Covered		0	0.00	0.00		0.00			0	0.00	0.00			
COB/Subrg. (outside claim system)				0.00							0.00			
Total Medical Expenses				\$0.00			\$0.00	0%			\$0.00	\$0.00	\$0.00	
					-	_			CMS Guidelin	e Credibility				
Subtotal Medicare-covered service categori	ies		L	\$0.00	_	L	\$0.00	0%		L	\$0.00	\$0.00	\$0.00	
Briefly describe the source for the manual ra	ate includ	ing what tren	d assumptions	were used if	applicable									
Briefly describe the source for the manda re	ato, morad	ing what tron	a assamptions	were asca, ii	арриоаыс									

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:	2013	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)	 In Network 	NO	2. Out of Network	NO	3. Combined NO	////////
		-				
4. Briefly explain the methodology for reflecting the impact of maximu	um cost sharing in S	ection III				
, ,						

(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(I)	(m)	(n)	(o)
		Measure-	In-Network		In-Network Cost Sharing Afte	er Plan-Level Deducti	ble		Total	Out-of-Network		Grand Tota
Service Category	Description	ment Unit Code	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	In-Network Cost Share PMPM	Description of Cost Sharing / Benefit Limits****	Out-of-Network Cost Sharing PMPM***	Cost Share PMPM (INN+OON)
. Inpatient Facility	Acute							\$0.00	\$0.00			\$0.0
. Inpatient Facility	Mental Health							0.00	0.00			0.0
Skilled Nursing Facility								0.00	0.00			0.0
Home Health								0.00	0.00			0.0
Ambulance								0.00	0.00			0.0
. DME/Prosthetics/Supplies	DME							0.00	0.00			0.0
DME/Prosthetics/Supplies	Prosthetics/Supplies							0.00	0.00			0.0
OP Facility - Emergency								0.00	0.00			0.0
OP Facility - Surgery								0.00	0.00			0.0
OP Facility - Other	Lab							0.00	0.00			0.0
. OP Facility - Other	Radiology							0.00	0.00			0.0
OP Facility - Other	Mental Health							0.00	0.00			0.0
OP Facility - Other	Renal Dialysis							0.00	0.00			0.0
OP Facility - Other	Other							0.00	0.00			0.0
Professional	PCP							0.00	0.00			0.0
Professional	Specialist excl. MH							0.00	0.00			0.
Professional	Mental Health (MH)							0.00	0.00			0.
Professional	Therapy (PT/OT/ST)							0.00	0.00			0.
Professional	Radiology							0.00	0.00			0.
Professional	Other							0.00	0.00			0.0
Part B Rx								0.00	0.00			0.0
Other Medicare Part B								0.00	0.00			0.0
Transportation (Non-Cove	ered)							0.00	0.00			0.0
Dental (Non-Covered)								0.00	0.00			0.0
Vision (Non-Covered)	Professional							0.00	0.00			0.
Vision (Non-Covered)	Hardware							0.00	0.00			0.
Hearing (Non-Covered)	Professional							0.00	0.00			0.
Hearing (Non-Covered)	Hardware							0.00	0.00			0.
Health & Education (Non-	Covered)							0.00	0.00			0.
Other Non-Covered								0.00	0.00			0.
								0.00	0.00			0.
								0.00	0.00			0.
								0.00	0.00			0.
								0.00	0.00			0.
								0.00	0.00			0.
								0.00	0.00			0.
								0.00	0.00			0.
												0.
								0.00	0.00 0.00			0.
Total			\$0.00					\$0.00	\$ 0.00		\$0.00	0. \$0 .
IUlai		۸ ۵4۰		vol doductible.		*Actual in naturals al	an loval dadustible:			l plan loval dadustible:		Φ U.
			ual combined plan le			*Actual in-network pl				N plan level deductible:		
		Does	combined ded appl	y to Pt B only?		Does in-network ded ** PMPM impact of in-				ded apply to Pt B only? act of OON OOP max:		

n, se .	(555	_
	ng of PBP servi ories to BPT	ICE
PBP line	BPT category	
1a	<u>a1</u>	
1b	a2	
2	b	
3	h5	
4a	f	
4b	f	
5	h5	
6	С	
7a	i1, i5	
7b	i6	
7c	i4	
7d	i6	
7e	i3	
7f	i6	
7g	i6	
7h 7i	i3 i4	
8a	h1	
8b	h2	
9a	h5, g	
9b	g	
9c	9 h5	
9d	k	
10a	d	
10b	I	
11a	e1	
11b	e2	
11c	e2	
12	h4	
13a	q	
13b	q	
13c	q	
13d	q	
13e	q	
14a	i1	
14b	i1	
14c	p :c	
14d	i6	
14e 15	i6	
16a	m	
16b	m m	
17a	n1	
17a 17b	n2	
175 18a	01	
18b	02	
. 5.5		

Attachment D-1, CY2013_MA_BPT.xlsm 12/14/2011

^{****}NOTE: Cells H25:H64 and cells M25:M64 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.

0.00

\$0.00

0.00

\$0.00

0.00

\$0.00

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:	2013	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:

(e) (h) (m) (p) (r) (n) (o) **Total Benefits** FFS Medicare Medicare Covered (w/AE cost sh.) A/B Mand Suppl (MS) Benefits % for Cov. Svcs Plan cost sh. for Medicare-Net PMPM for Allowed Plan Cost Net Cost Actl. Equiv. Allowed FFS AE Net Reduction of **Service Category** PMPM Sharing **PMPM** Allowed Sharing cost sharing covered svcs. **PMPM** Cost Sharing **PMPM** Add'l Svcs. A/B Cost Sh. Total \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 0.0% \$0.00 \$0.00 \$0.00 Inpatient Facility Skilled Nursing Facility 0.00 0.00 0.00 0.0% 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0% 0.00 0.00 0.00 0.00 0.00 0.00 Home Health 0.00 0.00 0.00 0.00 0.00 0.00 0.00 Ambulance 0.00 0.00 0.0% 0.00 0.00 0.00 DME/Prosthetics/Supplies 0.00 0.00 0.0% 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 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 OP Facility - Surgery 0.00 0.00 0.00 0.0% 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0% 0.00 0.00 0.00 OP Facility - Other 0.00 0.00 0.00 0.00 0.00 Professional 0.00 0.00 0.00 0.0% 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0% 0.00 0.00 0.00 0.00 0.00 0.00 0.00 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 Other Medicare Part B 0.00 0.00 Transportation (Non-Covered) 0.00 0.00% 0.0% 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00% 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 Vision (Non-Covered) 0.00 0.00 0.00 0.00% 0.00% 0.0% 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0% 0.00 0.00 0.00 0.00 0.00 0.00% 0.00% 0.00 0.00 0.00 0.00 Hearing (Non-Covered) 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 Other Non-Covered 0.00 0.00 0.00 0.00% 0.00% 0.0% 0.00 0.00 0.00 0.00 0.00 0.00 0.00

0.00%

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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:

COB/Subrg. (outside claim system)

Total Medical Expenses

0.0000

0.00

\$0.00

0.00

\$0.00

0.00

\$0.00

0.0000

	(c)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(I)	(m)	(n)	(o)	(p)	(q)	(r)
			Total B	enefits		% for	Cov. Svcs	State Medicaid	Actual cost sh.	Medicare Co	overed (w/Medica	id cost sh.)	A/B N	Mand Suppl (MS)	Benefits
		Reimb +	Plan Cost	Actual Cost	Plan		Cost	Required Bene.	for Medicare-	Allowed	Medicaid	Net	Net PMPM for	Reduction of	
	Service Category	Actual Cost Sh.	Sharing	Sharing	Reimb	Allowed	Sharing	cost sharing	covered svcs.	PMPM	Cost Sharing	PMPM	Add'l Svcs.	A/B Cost Sh.	Total
								1		•			Ī		
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
ĥ.	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
I.	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

 Contract Number: 		5. Organization Name:	9. Enrollee Type:		13. Region Name:	N/A	
2. Plan ID:		6. Plan Name:	10. MA Region:	N/A			
Segment ID:		7. Plan Type:	11. Act. Swap/Equiv Apply:				
4. Contract Year:	2013	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)	(I)	(m	,	(n)	(o)	(p)	(q)	(r)
			Total Ben	efits				///////	//////	//	Me	edicare Covered			Mand Suppl (MS)	Benefits
			X////X/		Net			///////					Net	Net PMPM for	Reduction of	
	Service Category		<u> </u>		PMPM			<u> </u>	<u> </u>	<u> </u>	<u>///X/</u>		PMPM	Add'l Svcs.	A/B Cost Sh.	Total
							 	 	 	 						
	tient Facility		<i>X/////X/</i>		\$0.00								\$0.00	\$0.00	\$0.00	\$0.00
	ed Nursing Facility				0.00								0.00	0.00	0.00	0.00
	e Health		X////X/		0.00			<i>X//////</i>					0.00	0.00	0.00	0.00
	ulance				0.00								0.00	0.00	0.00	0.00
	Prosthetics/Supplies				0.00								0.00	0.00	0.00	0.00
	Facility - Emergency				0.00								0.00	0.00	0.00	0.00
	Facility - Surgery				0.00			<u> </u>					0.00	0.00	0.00	0.00
	Facility - Other		<u> </u>		0.00			<i>X//////</i>	<u>//////</u>				0.00	0.00	0.00	0.00
	essional		<u> </u>		0.00			<u> </u>					0.00	0.00	0.00	0.00
j. Part F		<i>////////</i>	<u> </u>		0.00			<u> </u>	<u> </u>	<u>//////</u>			0.00	0.00	0.00	0.00
k. Othe	er Medicare Part B		<u> </u>		0.00			<u> </u>					0.00	0.00	0.00	0.00
	sportation (Non-Covered)		<u> </u>		0.00			<i>X//////</i>					0.00	0.00	0.00	0.00
m. Denta	al (Non-Covered)		<u> </u>		0.00				//////	//////			0.00	0.00	0.00	0.00
n. Visior	n (Non-Covered)		X////X/		0.00			<i>X//////</i>				///////	0.00	0.00	0.00	0.00
o. Heari	ring (Non-Covered)		<u> </u>		0.00			<i>X//////</i>	<u>//////</u>	//////			0.00	0.00	0.00	0.00
p. Healt	th & Education (Non-Covered)		X////X/		0.00			///////					0.00	0.00	0.00	0.00
q. Other	r Non-Covered		<i>/////////////////////////////////////</i>		0.00			///////	///////				0.00	0.00	0.00	0.00
r. ESRI	D				0.00								0.00	0.00	0.00	0.00
s. Addit	tional Benefits (employer bids only)	///////////////////////////////////////	<i>/////////////////////////////////////</i>		0.00			////////	///////	//////	/////		0.00	0.00	0.00	0.00
	S/Subrg. (outside claim system)				0.00					//////			0.00	0.00	0.00	0.00
u. Total	l Medical Expenses	77777777	X/////X/		\$0.00			////////	///////	//////	/////		\$0.00	\$0.00	\$0.00	\$0.00
v. Non-	Benefit Expense:															
1. Sal	les & Marketing												\$0.00			\$0.00
2. Dire	ect Administration						z1. Describe v	vhat's included	in Quality Initia	ives			0.00			0.00
3. Indi	lirect Administration												0.00			0.00
4. Net	t Cost of Private Reinsurance												0.00			0.00
5. Qua	ality Initiatives												0.00			0.00
	xes and Fees												0.00			0.00
	tal Non-Benefit Expense				\$0.00	<u> </u>							\$0.00	0.00	0.00	\$0.00
	/(Loss) Margin				1		z2. Overall Ga	in/(Loss) Marg	n Level				\$0.00	0.00	0.00	\$0.00
	Revenue Requirement				\$0.00			()					\$0.00	0.00	0.00	\$0.00
	t Medical Expense % of Revenue				0.0%		y4. Adjusted N	/ILR*	0.0%				0.0%	7.00		0.0%
	n-Benefit % of Revenue				0.0%			R based on bid		merator inclu	ıdes		0.0%	1		0.0%
	iin/(Loss) Margin % of Revenue				0.0%			es and denom					0.0%			0.0%

III. Development of Projected Contract Year ESRD "Subsidy" CY member months entered by county 0 CY ESRD member months 0 CY Out-of-Area (OOA) member months Basic benefits (user entries must be reported as "per ESRD member per month") Supplemental Benefits CY Revenue - CMS capitation Non-ESRD CY cost sharing reductions \$0.00 Non-ESRD CY additional benefits \$0.00 CY Medical Expenses for Basic Services ESRD CY cost sharing reductions CY Non-Benefit Expenses for Basic Services 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 plan members \$0.00 Incremental CY cost of additional benefits \$0.00 \$0.00 Total CY ESRD "subsidy" =

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

 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.

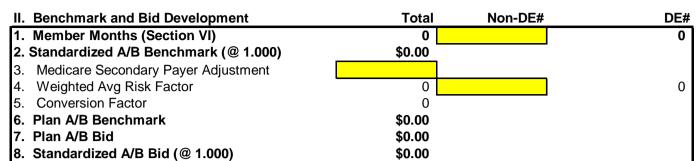
1. Savings

2. Rebate

3. Basic Member Premium

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					
Segment ID:	7. Plan Type:	11. Act. Swap/Equiv					
4. Contract Year: 2013	8. MA-PD:	12. SNP:	14. SNP Type:	N/A	15. EGWP:	N	



III. Savings/Basic Member Premium Development

\$0.00

\$0.00

\$0.00

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

IV. Standardized A/B Benchmark - Regional Plans Only

Statutory Component - Region N/A	74.0%	
 Statutory Component - Region N/A Plan Bid Component (from CMS)* Standardized A/B Benchmark 	26.0%	N/A
3. Standardized A/B Benchmark	100.0%	

٧.	Quality Rating		
1.	Quality Bonus Rating (per CMS)		
2.	New org/low enrollment indicator (per CMS)		
3.	Rebate %	58.3%	

VIII. Projected CY Member Month

VIII. Projected CY Member Months	
Member months entered by county (Sect. VI)	0
2. ESRD member months	
3. Hospice member months	
4. Out-of-Area (OOA) member months	
5. Total member months	0

VI: County Level D	etail and	Service Area Summar	у									VII: Other Me	edicare Inf	ormation					
1. Use of plan-pro	vided ISAF	R factors? (Regional Pla	ns only - enter Ye	s or No)															
(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(I)	(m)	(n)	(o)	(p)	(q)	(r) (s)		(t)	(u)
State/County			Proj Member	Proj Risk	Plan Provided	MA Risk Ratebook	MA Risk Ratebook	ISAR	ISAR-Adjusted	Risk Paym	nent Rate	Original Med	licare cost	sharing (c.s.)	FFS costs to	o weight Medicare o	.s.	Metropolita	an Statistical Area
Code	State	County Name	Months	Factors	ISAR factors	Unadjusted	Risk-Adjusted	scale	Bid	A only	B only	Inpatient	SNF	Pt B (excl HH)	Inpatient	SNF Pt B (excl	HH)	MM	MSA name
Total or Weight County Level December 2.	_	e for Service Area:	0	0	0.00	\$0.00	\$0.00	0	\$0.00	52.532%	47.468%	0.0%	0.0%	0.0%	n/a	n/a	n/a	0 n/ 0% pre	'a edominant MSA

Attachment D-1, CY2013_MA_BPT.xlsm 12/14/2011 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:	2013	8. MA-PD:	12. SNP:	14. SNP Type:	N/A	15. EGWP: N

II. Other Information

A. Part B Information		B. Rebate Allocation for Part B Premium		C. Rebate Allocations	
		PMPM rebate allocation for Part B premium (maximum value=\$99.90)		1. Reduce A/B Cost Sharing (max. value=\$0.00)	
1. Maximum Pt B premium buydown amt., per CMS	\$99.90	Part B Rebate Allocation, rounded to one decimal (see instructions)	\$0.00	Other A/B Mand Suppl Benefits (max. value=\$0.00)	

III. Plan A/B Bid Summary

8. Conversion Factor

III. Plan A/B Bld Summary										
A. Overview			B.	MA Rebate Allocation						C.
					ı	Rebate PMPM AI	location		Maximum	ĺ
					Medical	Non-Benefit	Gain / (Loss)	Total	Value	1.
	Medicare-	A/B Mandatory	1.	MA Rebate	n/a	n/a	n/a	\$0.00		2.
	covered	Supplemental								:
Net medical cost	\$0.00	\$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	i
Non-benefit expense	\$0.00	\$0.00	4.	Pt B Premium Buydown	0.00	n/a	n/a	0.00	99.90	3.
3. Gain / loss margin	0.00	0.00	5.	Pt D Premium Buydown Basic	0.00	n/a	n/a	0.00	0.00	ĺ
4. Total revenue requirement	\$0.00	\$0.00	6.	Pt D Premium Buydown Suppl	0.00	n/a	n/a	0.00	0.00	4.
			7.	Total	\$0.00	\$0.00	\$0.00	\$0.00		5.
5. Standardized A/B Benchmark	\$0.00						Unalloc. rebate	\$0.00		6.
6. Plan A/B Benchmark	\$0.00								'	ĺ
7. Risk Factor	0.0000									7.

V	Working	Model	Tove	Roy

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	

0.0000

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.

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.

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:	2013	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)	(I)	(m)	(n)	(o)	(p)	(p)
					medical expe	ense		Enrollee co	st sharing		Net	Non-	Gain/		Projected
Package	Service	Benefit category or	Util.	Annual	Average		Measurment	Util/1000 or	Average			Benefit	(Loss)		Member
ID	category	pricing component	type	Util / 1000	cost	PMPM	unit code	PMPM	cost shr	PMPM	value	Expense	Margin	Premium	Months
Description						_									
1						\$0.00				\$0.00	\$0.00	n/a		n/a	n/a
1						0.00				0.00	0.00	n/a			n/a
1						0.00				0.00	0.00	n/a			n/a
1						0.00				0.00	0.00	n/a		n/a	n/a
1						0.00				0.00	0.00	n/a		n/a	n/a
1						0.00				0.00	0.00	n/a		n/a	n/a
1						0.00				0.00	0.00	n/a		n/a	n/a
1						0.00				0.00	0.00	n/a		n/a	n/a
1						0.00				0.00	0.00	n/a		n/a	n/a
1						0.00				0.00	0.00	n/a		n/a	n/a
1						0.00				0.00	0.00	n/a		n/a	n/a
1						0.00				0.00	0.00	n/a		n/a	n/a
1						0.00				0.00	0.00	n/a		n/a	n/a
1						0.00				0.00	0.00	n/a		n/a	n/a
1						0.00				0.00	0.00	n/a		n/a	n/a
1						0.00 0.00				0.00	0.00 0.00	n/a		n/a	n/a
1										0.00		n/a		n/a	n/a
1						0.00 0.00				0.00 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
I						0.00				0.00	0.00	11/6	II/a	II/a	11/6
	Package Total					\$0.00				\$0.00	\$0.00			\$0.00	
Description												,	,	,	,
2						\$0.00				\$0.00	\$0.00	n/a			n/a
2						0.00				0.00	0.00	n/a			n/a
2						0.00				0.00	0.00	n/a		n/a	n/a
2 2						0.00				0.00	0.00	n/a		n/a	n/a
2						0.00 0.00				0.00 0.00	0.00 0.00	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				
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
2						0.00				0.00	0.00	n/a		n/a	n/a
2						0.00				0.00	0.00	n/a			n/a
2						0.00				0.00	0.00	n/a			n/a
2						0.00				0.00	0.00	n/a			n/a
2						0.00				0.00	0.00	n/a		n/a	n/a
2						0.00				0.00	0.00	n/a		n/a	n/a
2						0.00				0.00	0.00	n/a		n/a	n/a
2						0.00				0.00	0.00	n/a		n/a	n/a
2						0.00				0.00	0.00	n/a		n/a	n/a
2						0.00				0.00	0.00	n/a			n/a
												1	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:	2013	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)	(I)	(m)	(n)	(o)	(p)	(q)
				medical expe			Enrollee co	st sharing		Net	Non-	Gain/		Projected
Package	Service	Benefit category or	Util. Annual	Average		Measurment	Util/1000 or	Average		PMPM	Benefit	(Loss)		Member
ID	category	pricing component	type Util / 1000	cost	PMPM	unit code	PMPM	cost shr	PMPM	value	Expense	Margin	Premium	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 Description	Package Total	<u> </u>			\$0.00				\$0.00	\$0.00			\$0.00	
Description					ድር ዕር				የ ስ ስስ	የ በ	2/2	2/2	2/0	2/0
4					\$0.00 0.00				\$0.00 0.00	\$0.00	n/a	n/a	n/a	n/a
4					0.00				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	n/a n/a	n/a n/a
4					0.00				0.00	0.00		n/a	n/a	n/a
4					0.00				0.00	0.00	n/a	n/a n/a	n/a	n/a
4					0.00				0.00	0.00	n/a n/a	n/a n/a	n/a	n/a
4									0.00	0.00				
4					0.00 0.00				0.00	0.00	n/a n/a	n/a n/a	n/a	n/a n/a
4					0.00				0.00	0.00	n/a	n/a n/a	n/a	n/a
4					0.00				0.00	0.00	n/a n/a	n/a n/a	n/a n/a	n/a n/a
4					0.00				0.00	0.00	n/a n/a	n/a n/a	n/a n/a	n/a n/a
4					0.00				0.00	0.00	n/a n/a	n/a n/a	n/a n/a	n/a n/a
4					0.00				0.00	0.00		n/a n/a	n/a n/a	n/a n/a
4					0.00				0.00	0.00	n/a			n/a n/a
4											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	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 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	
4	i ackaye iblal				φυ.υυ				φυ.υυ	Ψ 0.00			Φ υ.υυ	

WORKSHEET 7 - OPTIONAL SUPPLEMENTAL BENEFITS

Note: See bid instructions for ESRD and hospice exclusions.

I. General Information

1. Contrac	t Number:		5. Organization Name	9. Enrollee Type:	13. Region Name:	N/A		
2. Plan ID			6. Plan Name:	10. MA Region: N/A				
Segmer	nt ID:		7. Plan Type:	11. Act. Swap/Equiv Apply:				
4. Contrac	t Year:	2013	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)	(I)	(m)	(n)	(o)	(p)	(p)
				Allowed r	nedical expe	nse		Enrollee co	st sharing		Net	Non-	Gain/		Projected
Package	Service	Benefit category or	Util.	Annual	Average		Measurment	Util/1000 or	Average		PMPM	Benefit	(Loss)		Member
ID	category	pricing component	type	Util / 1000	cost	PMPM	unit code	PMPM	cost shr	PMPM	value	Expense	Margin	Premium	Months
Description															
5						\$0.00				\$0.00	\$0.00	n/a		n/a	n/
5						0.00				0.00	0.00	n/a		n/a	n/
5						0.00				0.00	0.00	n/a			n/
5						0.00				0.00	0.00	n/a	n/a	n/a	n/
5						0.00				0.00	0.00	n/a	n/a	n/a	n/
5						0.00				0.00	0.00	n/a	n/a	n/a	n/
5						0.00				0.00	0.00	n/a	n/a	n/a	n/
5						0.00				0.00	0.00	n/a	n/a	n/a	n/
5						0.00				0.00	0.00	n/a	n/a	n/a	n/
5						0.00				0.00	0.00	n/a	n/a	n/a	n/
5						0.00				0.00	0.00	n/a	n/a	n/a	n/
5						0.00				0.00	0.00	n/a	n/a	n/a	n/s
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/s
5						0.00				0.00	0.00	n/a	n/a	n/a	n/s
5						0.00				0.00	0.00	n/a	n/a	n/a	n/s
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/
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 I	Package Total					\$0.00				\$0.00	\$0.00			\$0.00	

III.	Con	nme	nts
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WORKSHEET 1 - MSA BASE PERIOD EXPERIENCE AND PROJECTION ASSUMPTIONS

Note: See bid instructions for ESRD and hospice exclusions.

MSA-2013.1
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:	2013	8. Deductible Amount				

Time Period Definition Incurred from: Incurred to: Paid through: Describe the source of the base.	01/01/2011 12/31/2011 se period experience da	Member Months Risk Score Completion Factor	5. Plans In Base	Contract-Plan ID a. b. c. d.	% of MMs	

III. Base Period Data (at Plan's F	Period Data (at Plan's Risk Factor)						n Assumptions	s				
(c)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(I)	(m)	(n)	(o)	(p)
			Total E	Benefits		Util. Adjus	tments to Cont	ract Period		Unit Cost/	Additiv	е
		Util	Annualized		Allowed	Util/1000	Benefit Plan	Population	Other	Intensity	Adjustme	nts
Service Category	Utilizers	Туре	Util/1000	Avg Cost	PMPM	Trend	Change	Change	Factor	Trend	Util/1000	PMPM
. Inpatient Facility				\$0.00								
. Skilled Nursing Facility				0.00								
. Home Health				0.00								
. Ambulance				0.00								
. DME/Prosthetics/Supplies				0.00								
OP Facility - Emergency				0.00								
. OP Facility - Surgery				0.00								
. OP Facility - Other				0.00								
Professional				0.00								
Part B Rx				0.00								
Other Medicare Part B				0.00								
COB/Subrg. (outside claim sy				_								
m. Total Medicare Covered Medical Expenses					\$0.00							
				•								

escription of Other Utilization Factor and Additive Values											

CMS - 10142 (3/31/2012)

WORKSHEET 2 - MSA TOTAL PROJECTED ALLOWED COSTS PMPM

Note: See bid instructions for ESRD and hospice exclusions.

I. General Information

1. C	ontract Number:	5. Organization Name:	9.	Enrollee Type:	A/B
2. Pl	lan ID:	6. Plan Name:			
3. S	egment ID:	7. Plan Type:			
4. C	ontract Year: 2013	8. Deductible Amount:			

II. Projected Allowed Costs

(c)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(I)	(m)	(n)	(o)	(p)
		Projecte	ed Experienc	e Rate	IV	lanual Rate		Exper.	Cor	ntract Year Ra	te	% of svc
	Util	Annual		Allowed	Annual		Allowed	Cred.	Annual		Allowed	provided
Service Category	Туре	Util/1000	Avg Cost	PMPM	Util/1000	Avg Cost	PMPM	%	Util/1000	Avg Cost	PMPM	OON
Inpatient Facility		0	\$0.00	\$0.00		\$0.00			0	\$0.00	\$0.00	
Skilled Nursing Facility		0	0.00	0.00		0.00			0	0.00	0.00	
Home Health		0	0.00	0.00		0.00			0	0.00	0.00	
Ambulance		0	0.00	0.00		0.00			0	0.00	0.00	
DME/Prosthetics/Supplies		0	0.00	0.00		0.00			0	0.00	0.00	
OP Facility - Emergency		0	0.00	0.00		0.00			0	0.00	0.00	
OP Facility - Surgery		0	0.00	0.00		0.00			0	0.00	0.00	
OP Facility - Other		0	0.00	0.00		0.00			0	0.00	0.00	
Professional		0	0.00	0.00		0.00			0	0.00	0.00	
Part B Rx		0	0.00	0.00		0.00			0	0.00	0.00	
Other Medicare Part B		0	0.00	0.00		0.00			0	0.00	0.00	
COB/Subrg. (outside claim system)				0.00							0.00	
Total Medicare Covered Medical Ex	kpenses			\$0.00			\$0.00	0%			\$0.00	

WORKSHEET 3 - MSA BENCHMARK PMPM

Note: See bid instructions for ESRD and hospice exclusions.

	_					
	Can	arai	Info	rm	コキェヘ	
-	GEI	CI AI	HILL		auv	

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: 2013	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) State/County Code	(c) State	(d) County Name	(e) Projected Member Months	(f) Projected Risk Factors	(g) MA Risk Ratebook Unadjusted	(h) MA Risk Ratebook Risk-Adjusted	
Total or Weighte County Level De	d Average for Service Area tail:	0	0	\$0.00		Plan Benchmark	

WORKSHEET 4 - ENROLLEE DEPOSIT AND PLAN PAYMENT PMPM

Note: See bid instructions for ESRD and hospice exclusions.

I. General Information	
------------------------	--

 Contract Number: 		5. Organization Name:	9. Enrollee Type: A/B
2. Plan ID:		6. Plan Name:	
Segment ID:		7. Plan Type:	
4. Contract Year:	2013	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	Annual	Percentage		
Projected		Average	of Member Months	Gross	Gross Claims
Claim		Claim	(Only Use Highest	Claims	Over Deductible
	Interval	Amount	Claim Interval)	(PMPM)	(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

III. Development of Summary Information (Plan's Risk Factor)

on (Plan's Risk Factor)			
a. Plan Medical Expenses	\$0.00	Part A	Part B
b. Non-Benefit Expense:			
1. Sales & Marketing			
2. Direct Administration			
3. Indirect Administration			
4. Net cost of private reinsurance			
5. Quality Initiatives			
6. Taxes and Fees			
7. 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. Adjusted MLR* 0.00% * Adjusted MLR based on bid projection, Numerator includes

j. Describe what's included in Quality Initiatives

Attachment D-1, CY2013_MA_BPT.xlsm 12/14/2011

Quality Initiatives and denominator excludes Taxes and Fees.

ſ	Contract Number:		5. Organization Name:	9. Enrollee Type:	A/B
	2. Plan ID:		6. Plan Name:		
	3. Segment ID:		7. Plan Type:		
ı	1 Contract Year:	2013	8 Deductible Amount		

II. Optional Supplemental Packages

(b)	(c)	(d)		(f)	(g)	(h)	(i)	(j)	(k)	(I)	(m)	(n)	(o)	(p)	(q)
		Benefit category		Allowed medica		_		Enrollee cost s			Net		Gain/		Projected
Package	Service	or pricing	Util.	Annual	Average		Measurment	Util/1000 or	Average		PMPM	Benefit	(Loss)		Member
ID	category	component	type	Util / 1000	cost	PMPM	unit code	PMPM	cost shr	PMPM	value	expense	Margin	Premium	Months
Description						#0.00				#0.00	#0.00	/-	/	/-	
1 1						\$0.00				\$0.00	\$0.00				n/a
1						0.00 0.00				0.00 0.00	0.00 0.00				n/a n/a
1 1						0.00				0.00	0.00				n/a
						0.00				0.00	0.00				n/a
'1						0.00				0.00	0.00				n/a
1						0.00				0.00	0.00				n/a
1						0.00				0.00	0.00				n/a
1						0.00				0.00	0.00				n/a
1						0.00				0.00	0.00				n/a
1						0.00				0.00	0.00				n/a
1						0.00				0.00	0.00			n/a	n/a
1						0.00				0.00	0.00			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
1						0.00				0.00	0.00		n/a	n/a	n/a
1						0.00				0.00	0.00			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						Ψ0.00				ψ0.00	ψ0.00			ψ0.00	
2						\$0.00				\$0.00	\$0.00	n/a	n/a	n/a	n/a
2						0.00				0.00	0.00				n/a
2						0.00				0.00	0.00				n/a
2						0.00				0.00	0.00				n/a
2						0.00				0.00	0.00				n/a
2						0.00				0.00	0.00				n/a
2						0.00				0.00	0.00				n/a
2						0.00				0.00	0.00		. /-	n/a	n/a
2						0.00				0.00	0.00		n/a	n/a	n/a
2						0.00				0.00	0.00		n/a	n/a	n/a
2						0.00				0.00	0.00		n/a	n/a	n/a
2						0.00				0.00	0.00				n/a
2						0.00				0.00	0.00				n/a
2						0.00				0.00	0.00				n/a
2						0.00				0.00	0.00				n/a
2						0.00				0.00	0.00				n/a
2						0.00				0.00	0.00				n/a
2						0.00				0.00	0.00				n/a
2						0.00				0.00	0.00				n/a
2						ባ ሰስ				0.00	0.00	n/a	n/a	n/a	n/a
						0.00				0.00	0.00	11/4		11/α	.,.

 Contract Number: 		Organization Name:	9. Enrollee Type:	A/B
2. Plan ID:		6. Plan Name:		
Segment ID:		7. Plan Type:		
4. Contract Year:	2013	8. Deductible Amount		

II. Optional Supplemental Packages

ID category component type Util / 1000 cost PMPM unit code PMPM co	Sing PMPM	Net PMPM value \$0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.	Benefit	Gain/ (Loss) Margin n/a n/a n/a n/a n/a n/a n/a	Premium n/a n/a n/a n/a n/a n/a n/a n/a n/a n/	Projected Member Months n/a n/a n/a n/a n/a n/a n/a n/a n/a n/
Category Component type Util / 1000 Cost PMPM unit code PMPM Co Description 3	\$0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	\$0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	n/a n/a n/a n/a n/a n/a n/a n/a	Margin n/a n/a n/a n/a n/a n/a n/a n/a n/a n	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
Description \$0.00	\$0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	\$0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	n/a n/a n/a n/a n/a n/a n/a n/a	n/a n/a n/a n/a n/a n/a n/a	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
\$0.00 0.00	0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	n/a n/a n/a n/a n/a n/a n/a	n/a n/a n/a n/a n/a n/a	n/a n/a n/a n/a n/a n/a	n/a n/a n/a n/a n/a n/a
3 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.	0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	n/a n/a n/a n/a n/a n/a n/a	n/a n/a n/a n/a n/a n/a	n/a n/a n/a n/a n/a n/a	n/a n/a n/a n/a n/a n/a
3 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.	0.00 0.00 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/a n/a n/a n/a n/a n/a n/a	n/a n/a n/a n/a n/a n/a	n/a n/a n/a n/a n/a	n/a n/a n/a n/a n/a
3 0.00 3 0.00	0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	0.00 0.00 0.00 0.00 0.00 0.00	n/a n/a n/a n/a n/a n/a	n/a n/a n/a n/a n/a	n/a n/a n/a n/a	n/a n/a n/a n/a
3 0.00 3 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	n/a n/a n/a n/a n/a	n/a n/a n/a n/a	n/a n/a n/a	n/a n/a n/a
3 0.00 3 0.00 3 0.00 3 0.00 3 0.00 3 0.00 3 0.00 3 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/a n/a n/a n/a	n/a n/a n/a	n/a n/a	n/a n/a
3 0.00 3 0.00 3 0.00 3 0.00 3 0.00 3 0.00 3 0.00	0.00 0.00 0.00 0.00 0.00	0.00 0.00 0.00 0.00	n/a n/a n/a	n/a n/a	n/a	n/a
3 0.00 3 0.00 3 0.00 3 0.00 3 0.00	0.00 0.00 0.00 0.00	0.00 0.00 0.00	n/a n/a	n/a		
3 0.00 3 0.00 3 0.00 3 0.00	0.00 0.00 0.00	0.00 0.00	n/a	_	11/a	11/a
3 0.00 3 0.00 3 0.00	0.00 0.00	0.00		II/a	n/a	n/a
3 3 0.00 0.00	0.00			n/a	n/a	n/a
3 0.00			n/a	n/a	n/a	n/a
		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
2 Poekara Total	\$0.00	¢0.00			¢0.00	
3 Package Total \$0.00 Description	\$0.00	\$0.00			\$0.00	
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
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
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	

1. Contract Number:		Organization Name:	9. Enrollee Type:	√ B
2. Plan ID:		6. Plan Name:		
Segment ID:		7. Plan Type:		
Contract Year:	2013	8. Deductible Amount		

II. Optional Supplemental Packages

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

Ш	Cc	mm	ents	•

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