

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

Note: See bid instructions for ESRD and hospice exclusions.

MA-2014.beta  
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:	2014	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

1. Time Period Definition	Incurred from: 01/01/2012	2. Member Months	Total 0	Non-DE#	DE# 0	5. Plans In Base	Contract-Plan ID	Member Months	Contract-Plan ID	Member Months
	Incurred to: 12/31/2012	3. Risk Score			0.0000					
	Paid through:	4. Completion Factor								
6. Describe the source of the base period experience data										

**III. Base Period Data (at Plan's Risk Factor) for 1/1/2012-12/31/2012**

**IV. Projection Assumptions**

Service Category	Utilizers	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	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	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**

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**VI. Base Period Summary for 1/1/2012-12/31/2012 (excludes Optional Supplemental)**

	ESRD	Hospice	All Other	Total				
1. CMS Revenue				\$0	Non-Benefit Expenses:		8. Gain/(Loss) Margin	\$0
2. Premium Revenue				\$0	7a. Sales & Marketing		Percentage of Revenue:	
3. Total Revenue	\$0	\$0	\$0	\$0	7b. Direct Administration		9a. Net Medical Expenses	0.0%
4. Net Medical Expenses				\$0	7c. Indirect Administration		9b. Non-Benefit Expenses	0.0%
5. Member Months			0	0	7d. Net Cost of Private Reinsurance		9c. Gain/(Loss) Margin	0.0%
PMPMs:					7e. Total Non-Benefit Expenses	\$0	10a. NBE Quality Initiatives	
6a. Revenue PMPM	\$0.00	\$0.00	\$0.00	\$0.00			10b. Taxes and Fees	
6b. Net Medical PMPM	\$0.00	\$0.00	\$0.00	\$0.00			10c. Insurer Fees (subset of Taxes & Fees)	
6c. Non-Benefit PMPM				\$0.00			11a. Medicaid Revenue	
6d. Gain/(Loss) Margin PMPM				\$0.00			11b. Medicaid Cost	\$0
							11b1. Benefit expenses	
							11b2. Non-benefit expenses	
							11c. Adjusted GLM	\$0

CMS - 10142 (4/30/2013)

**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: 2014	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)	
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.	<b>Total Medical Expenses</b>			<b>\$0.00</b>				<b>\$0.00</b>	<b>0%</b>		<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>		
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														

CMS Guideline Credibility



**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: 2014	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) 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			
	(f) Allowed PMPM	(g) Plan Cost Sharing	(g) Actual Cost Sharing		(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	\$0.00			0.0%	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
b. Skilled Nursing Facility	0.00	0.00	0.00	0.00			0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
c. Home Health	0.00	0.00	0.00	0.00			0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
d. Ambulance	0.00	0.00	0.00	0.00			0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
e. DME/Prosthetics/Supplies	0.00	0.00	0.00	0.00			0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
f. OP Facility - Emergency	0.00	0.00	0.00	0.00			0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
g. OP Facility - Surgery	0.00	0.00	0.00	0.00			0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
h. OP Facility - Other	0.00	0.00	0.00	0.00			0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
i. Professional	0.00	0.00	0.00	0.00			0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
j. Part B Rx	0.00	0.00	0.00	0.00			0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
k. Other Medicare Part B	0.00	0.00	0.00	0.00			0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
l. Transportation (Non-Covered)	0.00	0.00	0.00	0.00	0.00%	0.00%	0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
m. Dental (Non-Covered)	0.00	0.00	0.00	0.00	0.00%	0.00%	0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
n. Vision (Non-Covered)	0.00	0.00	0.00	0.00	0.00%	0.00%	0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
o. Hearing (Non-Covered)	0.00	0.00	0.00	0.00	0.00%	0.00%	0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
p. Health & Education (Non-Covered)	0.00	0.00	0.00	0.00	0.00%	0.00%	0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
q. Other Non-Covered	0.00	0.00	0.00	0.00	0.00%	0.00%	0.0%	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%	0.0%	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	\$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) Service Category	(e) Total Benefits			(h) Plan Reimb	(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			
	(f) Reimb + Actual Cost Sh.	(g) Plan Cost Sharing	(g) Actual Cost Sharing		(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	\$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	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	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	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	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	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	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	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	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	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	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	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	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	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	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	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
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	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	\$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: 2014	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) Service Category	(f) Total Benefits				(h) Net PMPM	(i)	(j)	(k)	(l)	(m)	(n) Medicare Covered		(p) A/B Mand Suppl (MS) Benefits		
	(e)	(g)	(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. Sales & Marketing						z1. NBE Quality Initiatives									
2. Direct Administration						z2. Taxes and Fees					\$0.00			\$0.00	
3. Indirect Administration						z3. Insurer Fees (subset of Taxes & Fees)					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						z4. Overall Gain/(Loss) Margin Level			CONTRACT		\$0.00	0.00	0.00	\$0.00	
x. Total Revenue Requirement				\$0.00							\$0.00	0.00	0.00	\$0.00	
y1. Net Medical Expense % of Revenue				0.0%		y4. Adjusted MLR*		0.0%			0.0%			0.0%	
y2. Non-Benefit % of Revenue				0.0%		* Adjusted MLR based on bid projection, Numerator includes					0.0%			0.0%	
y3. Gain/(Loss) Margin % of Revenue				0.0%		Quality Initiatives and denominator excludes Taxes and Fees.					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	0		
Basic benefits (user entries must be reported as "per ESRD member per month")		Supplemental Benefits	
CY Revenue		Non-ESRD CY cost sharing reductions	\$0.00
- CMS capitation		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		ESRD CY additional benefits	
CY Margin Requirement for Basic Services	\$0.00	Incremental CY cost of cost sharing reductions	\$0.00
CY Gain/(Loss) Margin for Basic Services	\$0.00	Incremental CY cost of additional benefits	\$0.00
Cost for CY basic benefits allocated to plan members	\$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)	
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**V. Projected Medicaid Data**

Entries must be reported as "Per Member Per Month" (PMPM).

1. Medicaid Projected Revenue	
2. Medicaid Projected Cost (not in bid)	\$0.00
2a. Benefit expenses	
2b. Non-benefit expenses	
3. Adjusted GLM	\$0.00

**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: 2014	8. MA-PD:	12. SNP:	14. SNP Type:	N/A 15. EGWP: N

**II. Benchmark and Bid Development**

	Total	Non-DE#	DE#
1. Member Months (Section VI)	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

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

	Weighting	
1. Statutory Component - Region N/A	73.2%	
2. Plan Bid Component (from CMS)*	26.8%	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.

**VIII. Projected CY Member Months**

1. 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

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

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

**V. Quality Rating**

1. Quality Bonus Rating (per CMS)	
2. New org/low enrollment indicator (per CMS)	Not Applicable
3. Rebate %	50.0%

**VI. County Level Detail and Service Area Summary**

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	B only	Original Medicare cost sharing (c.s.)			FFS costs to weight Medicare c.s.			Metropolitan Statistical Area	
												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	51.077%	48.923%	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:
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: 2014	8. MA-PD:	12. SNP:	14. SNP Type: N/A 15. EGWP: N

**II. Other Information**

<b>A. Part B Information</b>	<b>B. Rebate Allocation for Part B Premium</b>	<b>C. Rebate Allocations</b>
1. Maximum Pt B premium buydown amt., per CMS \$104.90	1. PMPM rebate allocation for Part B premium (maximum value=\$104.90) [Redacted] 2. Part B Rebate Allocation, rounded to one decimal (see instructions) \$0.00	1. Reduce A/B Cost Sharing (max. value=\$0.00) [Redacted] 2. Other A/B Mand Suppl Benefits (max. value=\$0.00) [Redacted]

**III. Plan A/B Bid Summary**

<b>A. Overview</b>	<b>B. MA Rebate Allocation</b>	<b>C. Development of Estimated Plan Premium</b>																																																																																																																												
<table border="1"> <thead> <tr> <th></th> <th>Medicare-covered</th> <th>A/B Mandatory Supplemental</th> </tr> </thead> <tbody> <tr> <td>1. Net medical cost</td> <td>\$0.00</td> <td>\$0.00</td> </tr> <tr> <td>2. Non-benefit expense</td> <td>\$0.00</td> <td>\$0.00</td> </tr> <tr> <td>3. Gain / loss margin</td> <td>0.00</td> <td>0.00</td> </tr> <tr> <td>4. Total revenue requirement</td> <td>\$0.00</td> <td>\$0.00</td> </tr> <tr> <td>5. Standardized A/B Benchmark</td> <td>\$0.00</td> <td></td> </tr> <tr> <td>6. Plan A/B Benchmark</td> <td>\$0.00</td> <td></td> </tr> <tr> <td>7. Risk Factor</td> <td>0.0000</td> <td></td> </tr> <tr> <td>8. Conversion Factor</td> <td>0.0000</td> <td></td> </tr> </tbody> </table>		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		<table border="1"> <thead> <tr> <th rowspan="2"></th> <th colspan="3">Rebate PMPM Allocation</th> <th rowspan="2">Total</th> <th rowspan="2">Maximum Value</th> </tr> <tr> <th>Medical</th> <th>Non-Benefit</th> <th>Gain / (Loss)</th> </tr> </thead> <tbody> <tr> <td>1. MA Rebate</td> <td>n/a</td> <td>n/a</td> <td>n/a</td> <td>\$0.00</td> <td></td> </tr> <tr> <td>2. Reduce A/B Cost Sharing</td> <td>\$0.00</td> <td>\$0.00</td> <td>\$0.00</td> <td>\$0.00</td> <td>\$0.00</td> </tr> <tr> <td>3. Other A/B Mand Suppl Benefits</td> <td>0.00</td> <td>0.00</td> <td>0.00</td> <td>0.00</td> <td>0.00</td> </tr> <tr> <td>4. Pt B Premium Buydown</td> <td>0.00</td> <td>n/a</td> <td>n/a</td> <td>0.00</td> <td>104.90</td> </tr> <tr> <td>5. Pt D Premium Buydown Basic</td> <td>0.00</td> <td>n/a</td> <td>n/a</td> <td>0.00</td> <td>0.00</td> </tr> <tr> <td>6. Pt D Premium Buydown Suppl</td> <td>0.00</td> <td>n/a</td> <td>n/a</td> <td>0.00</td> <td>0.00</td> </tr> <tr> <td>7. 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A/B Mandatory Supplemental premium</td> <td>0.00</td> </tr> <tr> <td>4. Basic MA premium</td> <td>0.00</td> </tr> <tr> <td>5. Total MA Enrollee Premium (excl. Opt. Suppl.)</td> <td>0.00</td> </tr> <tr> <td><b>6. Rounded MA Premium (excl. Opt. Suppl.)</b></td> <td><b>\$0.00</b></td> </tr> <tr> <td>7. Part D Basic Premium</td> <td></td> </tr> <tr> <td>    7a. Prior to rebates (rounded value from Rx BPT)</td> <td>[Redacted]</td> </tr> <tr> <td>    7b. A/B rebates allocated to Part D Basic Premium</td> <td>[Redacted]</td> </tr> <tr> <td>    7c. A/B rebates for Part D Basic Premium (rounded)</td> <td>\$0.00</td> </tr> <tr> <td><b>7d. Part D Basic Premium*</b></td> <td><b>\$0.00</b></td> </tr> <tr> <td>8. Part D Supplemental Premium</td> <td></td> </tr> <tr> <td>    8a. Prior to rebates (rounded value from Rx BPT)</td> <td>[Redacted]</td> </tr> <tr> <td>    8b. A/B rebates allocated to Part D Suppl Premium</td> <td>[Redacted]</td> </tr> <tr> <td>    8c. 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Prior to rebates (rounded value from Rx BPT)	[Redacted]	8b. A/B rebates allocated to Part D Suppl Premium	[Redacted]	8c. A/B rebates for Part D Suppl Premium (rounded)	\$0.00	<b>8d. Part D Supplemental Premium</b>	<b>\$0.00</b>	<b>9. Total estimated plan premium*</b>	<b>\$0.00</b>	<b>10. Plan Intention for target PD basic premium</b>	[Redacted]
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**IV. Contact Information**

<b>MA Plan Bid Contact:</b>	
Name, Position	[Redacted]
Phone Number	[Redacted]
Email Address	[Redacted]
<b>MA Certifying Actuary:</b>	
Name, Credentials	[Redacted]
Phone Number	[Redacted]
Email Address	[Redacted]
<b>MA Additional BPT Contact:</b>	
Name, Position	[Redacted]
Phone Number	[Redacted]
Email Address	[Redacted]
<b>Date Prepared</b>	[Redacted]

**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.

[Redacted]

**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: 2014	8. MA-PD:	12. SNP:	14. SNP Type:	N/A
				15. EGWP N

**II. Optional Supplemental Packages**

Package ID	Service category	Benefit category or pricing component	Allowed medical expense			Enrollee cost sharing				Net PMPM value	Non-Benefit Expense	Gain/(Loss) Margin	Premium	Projected Member Months
			Util. type	Annual Util / 1000	Average cost	PMPM	Measurement unit code	Util/1000 or PMPM	Average cost shr					
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	<b>Package Total</b>					<b>\$0.00</b>			<b>\$0.00</b>	<b>\$0.00</b>			<b>\$0.00</b>	
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						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	<b>Package Total</b>					<b>\$0.00</b>			<b>\$0.00</b>	<b>\$0.00</b>			<b>\$0.00</b>	



**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: 2014	8. MA-PD:	12. SNP:	14. SNP Type: N/A	15. EGWP N

**II. Optional Supplemental Packages**

Package ID	Service category	Benefit category or pricing component	Allowed medical expense				Enrollee cost sharing				Net PMPM value	Non-Benefit Expense	Gain/(Loss) Margin	Premium	Projected Member Months
			Util. type	Annual Util / 1000	Average cost	PMPM	Measurement unit code	Util/1000 or PMPM	Average cost shr	PMPM					
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	<b>Package Total</b>					<b>\$0.00</b>				<b>\$0.00</b>	<b>\$0.00</b>			<b>\$0.00</b>	
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	<b>Package Total</b>					<b>\$0.00</b>				<b>\$0.00</b>	<b>\$0.00</b>			<b>\$0.00</b>	

**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: 2014	8. MA-PD:	12. SNP:	14. SNP Type: N/A	15. EGWP N

**II. Optional Supplemental Packages**

Package ID	Service category	Benefit category or pricing component	Allowed medical expense			Enrollee cost sharing				Net PMPM value	Non-Benefit Expense	Gain/(Loss) Margin	Premium	Projected Member Months
			Util. type	Annual Util / 1000	Average cost	PMPM	Measurement unit code	Util/1000 or PMPM	Average cost shr					
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						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**

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**IV. Base Period Summary for 1/1/2012-12/31/2012 (Note: This section must be reported at the contract level.)**

1. Total \$: for all OSB packages combined	Net Medical Expenses	Non-Benefit Expenses	Gain/(Loss) Margin	Premium	Member Months
2. PMPM (based on OSB membership)	\$0.00	\$0.00	\$0.00	\$0.00	

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

Note: See bid instructions for ESRD and hospice exclusions.

MSA-2014.beta  
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:	MSA		
4. Contract Year:	2014	8. Deductible Amount:			

**II. Base Period Background Information**

1. Time Period Definition	2. Member Months	5. Plans In Base	Contract-Plan ID	% of MMs
Incurred from: 01/01/2012			a.	
Incurred to: 12/31/2012	3. Risk Score		b.	
Paid through:	4. Completion Factor		c.	
			d.	
6. Describe the source of the base period experience data				

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

**IV. Projection Assumptions**

Service Category	Utilizers	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)													
<b>m. Total Medicare Covered Medical Expenses</b>					<b>\$0.00</b>								

**V. Description of Other Utilization Factor and Additive Values**

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CMS - 10142 (4/30/2013)

**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:	MSA	
4. Contract Year: 2014	8. Deductible Amount:		

**II. Projected Allowed Costs**

Contract Year Allowed Costs at Plan's Risk Factor:												
(c) Service Category	(e) Util Type	(f) Projected Experience Rate			(i) Manual Rate			(l) Exper. Cred. %	(m) Contract Year Rate			(p) % of svcs provided OON
		(g) Annual Util/1000	(g) Avg Cost	(h) Allowed PMPM	(i) Annual Util/1000	(j) Avg Cost	(k) Allowed PMPM		(m) Annual Util/1000	(n) Avg Cost	(o) Allowed PMPM	
a. Inpatient Facility		0	\$0.00	\$0.00		\$0.00			0	\$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	
<b>m. Total Medicare Covered Medical Expenses</b>				<b>\$0.00</b>				<b>\$0.00</b>	<b>0%</b>		<b>\$0.00</b>	
									0%	CMS Guideline Credibility		
n. Briefly describe the source for the manual rate, including what trend assumptions were used, if applicable												

**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: MSA	
4. Contract Year: 2014	8. Deductible Amount:	

**II. Contact Information**

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

**IV. Quality Bonus Rating**

1. Quality Bonus Rating	
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**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 - MSA 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: MSA	
4. Contract Year: 2014	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	
	<b>Total</b>		<b>0.00%</b>	<b>\$0.00</b>	<b>\$0.00</b>

**III. Development of Summary Information (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. 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 Quality Initiatives and denominator excludes Taxes and Fees.			
j. NBE Quality Initiatives			
k. Taxes and Fees			
l. Insurer Fees (subset of Taxes and Fees)			

**WORKSHEET 5 - MSA 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:	MSA	
4. Contract Year:	2014	8. Deductible Amount	

**II. Optional Supplemental Packages**

Package ID	Service category	Benefit category or pricing component	Allowed medical expense			Enrollee cost sharing				Net PMPM value	Non-Benefit expense	Gain/(Loss) Margin	Premium	Projected Member Months	
			Util. type	Annual Util / 1000	Average cost	PMPM	Measurement unit code	Util/1000 or PMPM	Average cost shr						PMPM
Description															
1										\$0.00	\$0.00	n/a	n/a	n/a	n/a
1										0.00	0.00	n/a	n/a	n/a	n/a
1										0.00	0.00	n/a	n/a	n/a	n/a
1										0.00	0.00	n/a	n/a	n/a	n/a
1										0.00	0.00	n/a	n/a	n/a	n/a
1										0.00	0.00	n/a	n/a	n/a	n/a
1										0.00	0.00	n/a	n/a	n/a	n/a
1										0.00	0.00	n/a	n/a	n/a	n/a
1										0.00	0.00	n/a	n/a	n/a	n/a
1										0.00	0.00	n/a	n/a	n/a	n/a
1										0.00	0.00	n/a	n/a	n/a	n/a
1										0.00	0.00	n/a	n/a	n/a	n/a
1										0.00	0.00	n/a	n/a	n/a	n/a
1										0.00	0.00	n/a	n/a	n/a	n/a
1										0.00	0.00	n/a	n/a	n/a	n/a
1										0.00	0.00	n/a	n/a	n/a	n/a
1										0.00	0.00	n/a	n/a	n/a	n/a
<b>1</b>	<b>Package Total</b>									<b>\$0.00</b>	<b>\$0.00</b>			<b>\$0.00</b>	
Description															
2										\$0.00	\$0.00	n/a	n/a	n/a	n/a
2										0.00	0.00	n/a	n/a	n/a	n/a
2										0.00	0.00	n/a	n/a	n/a	n/a
2										0.00	0.00	n/a	n/a	n/a	n/a
2										0.00	0.00	n/a	n/a	n/a	n/a
2										0.00	0.00	n/a	n/a	n/a	n/a
2										0.00	0.00	n/a	n/a	n/a	n/a
2										0.00	0.00	n/a	n/a	n/a	n/a
2										0.00	0.00	n/a	n/a	n/a	n/a
2										0.00	0.00	n/a	n/a	n/a	n/a
2										0.00	0.00	n/a	n/a	n/a	n/a
2										0.00	0.00	n/a	n/a	n/a	n/a
2										0.00	0.00	n/a	n/a	n/a	n/a
2										0.00	0.00	n/a	n/a	n/a	n/a
2										0.00	0.00	n/a	n/a	n/a	n/a
2										0.00	0.00	n/a	n/a	n/a	n/a
2										0.00	0.00	n/a	n/a	n/a	n/a
2										0.00	0.00	n/a	n/a	n/a	n/a
2										0.00	0.00	n/a	n/a	n/a	n/a
<b>2</b>	<b>Package Total</b>									<b>\$0.00</b>	<b>\$0.00</b>			<b>\$0.00</b>	

**WORKSHEET 5 - MSA 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: MSA		
4. Contract Year: 2014	8. Deductible Amount		

**II. Optional Supplemental Packages**

Package ID	Service category	Benefit category or pricing component	Allowed medical expense			Enrollee cost sharing				Net PMPM value	Non-Benefit expense	Gain/(Loss) Margin	Premium	Projected Member Months	
			Util. type	Annual Util / 1000	Average cost	PMPM	Measurement unit code	Util/1000 or PMPM	Average cost shr						PMPM
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	<b>Package Total</b>					\$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	<b>Package Total</b>					\$0.00			\$0.00	\$0.00			\$0.00		



**WORKSHEET 5 - MSA 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:	MSA	
4. Contract Year:	2014	8. Deductible Amount	

**II. Optional Supplemental Packages**

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

**III. Comments**

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**IV. Base Period Summary for 1/1/2012-12/31/2012 (Note: This section must be reported at the contract level.)**

1 Total \$: for all OSB packages combined	Net Medical Expenses	Non-Benefit Expenses	Gain/(Loss) Margin	Premium	Member Months
2 PMPM (based on OSB membership)	\$0.00	\$0.00	\$0	\$0.00	

**WORKSHEET 1**  
**ESRD Plan Bid Submission**  
**Enrollment and PMPM Revenue Projection**

ESRD-2014.beta  
 OMB Approved # 0938-0944  
 CMS - 10142 (4/30/2013)

**III. ESRD MSP Adjustment Factors for CY (from April Rate Announcement)**

1. Functioning Graft (i.e., postgraft) "F"	0.173
2. Dialysis / transplant ("D" / "T")	0.189

**I. General Information**

1. Contract Year:	2014	6. Contract #:	
2. Contract-Plan-Segment:		7. Plan ID:	
3. Organization Name:		8. Segment ID:	
4. Service Area:			
5. Plan type:	ESRD SNP		

**IV. Summary Data**

1. Part C Mandatory Monthly Enrollee Premium	\$0.00
2. Part C Monthly Plan Revenue	\$0.00
3. Part D Premium (basic + supplemental) net of MA "rebates"	\$0.00
4. Plan intention for target Part D basic Premium	0
5. Quality Bonus Rating (per CMS)	
6. New/low indicator (per CMS)	

**II. Service Area Summary**

(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)
State/County Code	State	County Name (Func Graft)	ESRD Status D / T / F	Projected Member Months Jan.- Dec. 2014	Proj. Risk Score	CY 2014 State or County Rate	Percentage of MSP Mem. Months	Projected CMS Monthly Capitation
1. Total or Weighted Average for Service Area:				-	-	\$0.00	n/a	\$0.00
						-		

**WORKSHEET 2**

**ESRD Plan Bid Submission**

**Projection of benefit cost, non-benefit expenses, and gain/loss margin PPM**

<b>I. General Information</b>		6. Contract #:	0
1. Contract Year:	2014	7. Plan ID:	0
2. Contract-Plan-Segment:	0_0_0	8. Segment ID:	0
3. Organization Name:	0		
4. Service Area:	0		
5. Plan type:	ESRD SNP		

Benefit category	Projection of Plan Costs			Supplemental Benefits		
	Allowed cost	Enrollee cost sharing	Net cost	Medicare AE cost sharing proportion	Medicare AE cost sharing value	Total cost sharing enhancements
Inpatient hospital			\$0.00	6.2%	\$0.00	\$0.00
Skilled nursing facility			\$0.00	18.7%	0.00	0.00
Home health			\$0.00	0.0%	0.00	0.00
Outpatient hospital / ASC			\$0.00	19.9%	0.00	0.00
Emergency Room			\$0.00	19.9%	0.00	0.00
Dialysis			\$0.00	19.9%	0.00	0.00
Primary care physician			\$0.00	19.9%	0.00	0.00
Nephrologist			\$0.00	19.9%	0.00	0.00
Physician specialist (o/t nephrologist)			\$0.00	19.9%	0.00	0.00
Other professional			\$0.00	19.9%	0.00	0.00
Radiology / pathology			\$0.00	19.9%	0.00	0.00
Ambulance / transportation			\$0.00	19.9%	0.00	0.00
DME / supplies			\$0.00	19.9%	0.00	0.00
Part B Rx: Medicare-covered			\$0.00	19.9%	0.00	0.00
Other Part B services			\$0.00	19.9%	0.00	0.00
Coordination of benefits 1/			\$0.00			0.00
Sub-total: Medicare-covered	\$0.00	\$0.00	\$0.00	n/a	\$0.00	\$0.00
Other: Part B premium reduction			0.00			0.00
Other: Part D Basic premium reduction			0.00			0.00
Other: Part D Supp premium reduction			0.00			0.00
Additional services 2/			0.00			0.00
Sub-total: additional services			\$0.00			\$0.00
<b>Total benefit cost</b>			<b>\$0.00</b>			<b>\$0.00</b>
<b>Non-benefit components</b>				Adjusted MLR*	0.00%	
Sales & Marketing				* Adjusted MLR based on bid projection, Numerator includes Quality Initiatives and denominator excludes Taxes and Fees.		
Direct Administration						
Indirect Administration						
Net Cost of Private Reinsurance						
Gain / loss margin						
Total NBE+GLM			\$0.00			
Total plan cost			\$0.00			
CMS capitation			\$0.00			
Part C mandatory enrollee premium			\$0.00			
	Benefit Cost	NBE+GLM	Total Cost	NBE Quality Initiatives		
Medicare-covered benefits	\$0.00	\$0.00	\$0.00	Taxes and Fees		
Cost sharing enhancements	\$0.00	\$0.00	\$0.00	Insurer Fees (subset of Taxes and Fees)		
Additional services	\$0.00	\$0.00	\$0.00			
Part B premium reduction	\$0.00	\$0.00	\$0.00			
Part D Basic premium reduction	\$0.00	\$0.00	\$0.00			
Part D Supp premium reduction	\$0.00	\$0.00	\$0.00			
Total Supplemental benefits	\$0.00	\$0.00	\$0.00			
<b>Total</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>			

1/ Coordination of benefits and reinsurance recoveries are to be entered as negative figures

2/ Additional services includes preventative services that are not covered by Medicare and covered benefits that exceed Medicare limits (such as inpatient coverage beyond lifetime reserve days)

**WORKSHEET 2**

**ESRD Plan Bid Submission**

**Projection of benefit cost, non-benefit expenses, and gain/loss margin PMPM**

<b>I. General Information</b>		6. Contract #:	0
1. Contract Year:	2014	7. Plan ID:	0
2. Contract-Plan-Segment:	0_0_0	8. Segment ID:	0
3. Organization Name:	0		
4. Service Area:	0		
5. Plan type:	ESRD SNP		

<b>Development of "Rebate" Allocations and Estimated Plan Premium</b>	
<u>Rebate Allocation for Part B Premium</u>	
1. PMPM rebate allocation for Part B premium	
2. Part B Rebate Allocation, rounded to one decimal (see instructions)	\$0.00
3. Total MA Enrollee Premium (excl. Opt. Suppl.)	0.00
<b>4. Rounded MA Premium (excl. Opt. Suppl.)</b>	<b>\$0.00</b>
5. Part D Basic Premium	
5a. Prior to rebates (rounded value from Rx BPT)	
5b. A/B rebates allocated to Part D Basic Premium	
5c. A/B rebates for Part D Basic Premium (rounded)	\$0.00
<b>5d. Part D Basic Premium*</b>	<b>\$0.00</b>
6. Part D Supplemental Premium	
6a. Prior to rebates (rounded value from Rx BPT)	
6b. A/B rebates allocated to Part D Suppl Premium	
6c. A/B rebates for Part D Suppl Premium (rounded)	\$0.00
<b>6d. Part D Supplemental Premium</b>	<b>\$0.00</b>
<b>7. Total estimated plan premium*</b>	<b>\$0.00</b>
<b>8. Plan Intention for target PD basic premium</b>	
* The premiums shown in lines 5 and 7 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 5 and 7 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 3**  
**ESRD Plan Bid Submission**  
**Program Experience for Calendar Year 2012**

**I. General Information**

1. Contract Year:	2014	6. Contract #:	0
2. Contract-Plan-Segment:	0_0_0	7. Plan ID:	0
3. Organization Name:	0	8. Segment ID:	0
4. Service Area:	0		
5. Plan type:	ESRD SNP		

**II. Contact Information**

<b>ESRD-SNP Plan Contact Person:</b>	
Name, Position	
Phone Number	
Email Address	
<b>ESRD-SNP Certifying Actuary:</b>	
Name, Creden.	
Phone Number	
Email Address	

	Revenues	
	CY 2012	
	Enrollment	PMPM
Member months		n/a
CMS payments 1/	n/a	
Enrollee premium 1/	n/a	
Total revenue	n/a	\$0.00

Benefit category	Medical Benefits (PMPM) 2/			
	CY 2012			
	Claims incurred in period paid thru 03/31/2013	Claim reserve as of 03/31/2013	Incurred claims	Utilizers
Inpatient hospital			\$0.00	
Skilled nursing facility			0.00	
Home health			0.00	
Outpatient hospital / ASC			0.00	
Emergency Room			0.00	
Dialysis			0.00	
Primary care physician			0.00	
Nephrologist			0.00	
Physician specialist (o/t nephrologist)			0.00	
Other professional			0.00	
Radiology / pathology			0.00	
Ambulance / transportation			0.00	
DME / supplies			0.00	
Part B Rx: Medicare-covered			0.00	
Other Part B services			0.00	
Coordination of benefits 3/			0.00	
Sub-total: Medicare-covered	\$0.00	\$0.00	\$0.00	
Additional services			0.00	
Sub-total: additional services	\$0.00	\$0.00	\$0.00	
<b>Total benefit costs</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	
<b>Non-benefit components</b>				
Sales & Marketing				
Direct Administration				
Indirect Administration				
Net Cost of Private Reinsurance				
Gain / loss margin				
Total NBE+GLM			\$0.00	
Total plan cost			\$0.00	

1/ CMS payments and enrollee premium are to be reported in period in which they are due, not period of collection.  
 CMS payments for CY 2012 are to include an estimate of final risk adjustment settlement to be received in mid-2013.  
 2/ Medical benefits are to be reported net of enrollee cost-sharing.  
 3/ Coordination of benefits and reinsurance recoveries are to be entered as negative figures

**WORKSHEET 4**  
**ESRD Plan Bid Submission**

**OPTIONAL SUPPLEMENTAL BENEFITS**

<b>I. General Information</b>		6. Contract #:	0
1. Contract Year:	2014	7. Plan ID:	0
2. Contract-Plan-Segment:	—	8. Segment ID:	0
3. Organization Name:	0		
4. Service Area:	0		
5. Plan type:	ESRD SNP		

**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) Measurment 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
1						0.00				0.00	0.00	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
1						0.00				0.00	0.00	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
1						0.00				0.00	0.00	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
1						0.00				0.00	0.00	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
1						0.00				0.00	0.00	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
1						0.00				0.00	0.00	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
1						0.00				0.00	0.00	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
1						0.00				0.00	0.00	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
1						0.00				0.00	0.00	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
1						0.00				0.00	0.00	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
1						0.00				0.00	0.00	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
1						0.00				0.00	0.00	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
1						0.00				0.00	0.00	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
1	<b>Package Total</b>					<b>\$0.00</b>				<b>\$0.00</b>	<b>\$0.00</b>			<b>\$0.00</b>		
Description																
2						\$0.00				\$0.00	\$0.00	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
2						0.00				0.00	0.00	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
2						0.00				0.00	0.00	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
2						0.00				0.00	0.00	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
2						0.00				0.00	0.00	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
2						0.00				0.00	0.00	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
2						0.00				0.00	0.00	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
2						0.00				0.00	0.00	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
2						0.00				0.00	0.00	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
2						0.00				0.00	0.00	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
2						0.00				0.00	0.00	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
2						0.00				0.00	0.00	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
2						0.00				0.00	0.00	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
2						0.00				0.00	0.00	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
2						0.00				0.00	0.00	n/a	n/a	n/a	n/a	n/a
2	<b>Package Total</b>					<b>\$0.00</b>				<b>\$0.00</b>	<b>\$0.00</b>			<b>\$0.00</b>		



