WORKSHEET 1 - MA BAS	SE PERIOD	EXPERIEN	CE AND PRO	JECTION A	SSUMPTIONS							N	lote: See bid instru	uctions for ESRD an	d hospice exclusions
I. General Information														OMB	MA-2014.bet Approved # 0938-094
Contract Number:			Organization N	lame			9. Enrollee Type:				13. Region	n Name:	N/A		
2. Plan ID:			6. Plan Name:				10. MA Region:		N/A						
Segment ID: Contract Year:		2014	7. Plan Type: 8. MA-PD:				 Act. Swap/Equ SNP: 	iv Apply:			14. SNP T	vne·	N/A	15. EGWP:	N
Common roan		2011	O. 1111/11 D.						ı) _F			
II. Done Devied Deckground Info	atlan				Note: DE# refere to Du	al Elizible Benefi	ininging without full	Madiaara aaa	t abasina liabilit						
II. Base Period Background Info	rmation				Note: DE# refers to Du	ai Eligible Bener	Total	Non-DE#	DE#	у					
Time Period Definition					2. Member Months		C) THOM BE	0	5. Plar	ns In Base	Contract-Plan ID	Member Months	Contract-Plan ID	Member Months
	Incurred from:		01/01/2012		3. Risk Score				0.0000						
	Incurred to: Paid through:		12/31/2012		Completion Factor										
6. Describe the source of the base															
Base Period Data (at Plan's Risk (b)	Factor) for 1/ (c)	1/2012-12/31/201 (d)	12 (e)	(f)	(g)	(h)	(i)	IV. Projectio	n Assumptions (k)	(1)	(m)	(n)	(0)	(p)	(q)
(5)	(6)	(u)	(e)	(1)		Total Benefits	(1)	Util. Adjust	ments to Contra	(-)	(111)	Unit Cost A		Addit	
		Net	Cost	Util	Annualized		Allowed	Util/1000	Benefit Plan	Population		Provider Payment	Other	Adjus	stments
rvice Category	Utilizers	PMPM	Sharing	Туре	Util/1000	Avg Cost	PMPM	Trend	Change	Change	Factor	Change	Factor	Util/1000	PMPM
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 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 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) Health & Education (Non-Covered)		0.00			0.00									
Other Non-Covered	1		0.00			0.00									
COB/Subrg. (outside claim system	1)	0.00	0.00												
Total Medical Expenses		\$0.00	\$0.00				\$0.00	-							
Subtotal Medicare-covered service	e categories						\$0.00	1							
						•									
V. Description of Other Utilizatio	n Adiustment	Easter Other I	Init Cost Adjusts	ont Factor on	d Additive Adjustments										
v. Description of Other Offization	n Aujustment	ractor, Other C	Jilit Cost Adjustii	ient ractor, and	u Additive Adjustinents										
Base Period Summary for 1/1/201	12-12/31/2012	(excludes Ontio	nal Sunnlements	al)											
Dase I criou duminary for 17 17201	12 12/01/2012	ESRD	Hospice	All Other	<u>Total</u>										
CMS Revenue					\$0		enefit Expenses:			8.	Gain/(Loss) Margin	\$0		
Premium Revenue		\$0	\$0	\$0	\$0		Sales & Marketing	_		D					
. Total Revenue		\$0	\$0	\$0	\$0		Direct Administration Indirect Administration				centage of R Net Medica		0.0%		
Net Medical Expenses					\$0		Net Cost of Private				Non-Benef		0.0%		
·					-	_				9c.	Gain/(Loss) Margin	0.0%		
. Member Months				()		Total Non-Benefit E	vnonoca	\$0						
PMs:						7 e.	TOTAL INON-Denenit E	xpenses	Φ0	10a	NBE Quali	ty Initiatives	I		1
Revenue PMPM		\$0.00	\$0.00	\$0.00	\$0.00)					Taxes and				
Net Medical PMPM		\$0.00	\$0.00	\$0.00	\$0.00)				10c.	Insurer Fe	es (subset of Taxes &	Fees)		
Non-Benefit PMPM Gain/(Loss) Margin PMPM					\$0.00 \$0.00					110	Medicaid F	Pevenue	i		Ī
. Gail (LUSS) IVIAI GITI PIVIPIVI					φ0.00	,					. Medicaid C			\$0	I
CMS - 10142 (4/30/2013)										11b1.	Benefit ex	penses	ĺ	ΨΟ	
										11b2.	Non-bene	fit expenses			
										11c.	Adjusted G	LM		\$0	

Contract Number:	Organization Name:	Enrollee Type:	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: 2014	8. MA-PD:	12. SNP:	14. SNP Type:	N/A	15. EGWP:N

											Total		DE#	
Contract Year Allowed Costs at Plan's Ris	sk Factor:								Projected m Projected ris	ember months	0.0000	•	0.0000	
(c)	(e)	(f)	(g)	(h)	(i)	(i)	(k)	(1)	(m)	(n)	(0)	(q)	(a)	(r)
(0)	(0)		ected Experienc		(1)	Manual Ra		Exper.	(111)	(11)	Blended Rate		(4)	% of sv
	Util	Annual		Allowed	Annual		Allowed	Cred.	Annual		Total Allowed	Non-DE#	DE#	provide
Service Category	Туре	Util/1000	Avg Cost	PMPM	Util/1000	Avg Cost	PMPM	%	Util/1000	Avg Cost	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		4	
Total Medical Expenses			L	\$0.00]		\$0.00	0%			\$0.00	\$0.00	\$0.00	
			г		1	Г			CMS Guideline	e Credibility	***			
Subtotal Medicare-covered service categor				\$0.00			\$0.00	0%			\$0.00	\$0.00	\$0.00	

 Contract No: 		Org Name:	9. Enrollee Type:	Region Name:	N/A	
Plan ID:		Plan Name	10. MA Region: N/A			
Segment ID:		Plan Type:	11. Act. Swap/Equiv			
Contract Year:	2014	8. MA-PD:	12. SNP:	SNP Type:	N/A	15. EGWP: N

II.	Maximum	Cost	Sharing	Per	Member	Per \	ear/
-----	---------	------	---------	-----	--------	-------	------

Is there a plan-level OOP maximum? (Yes/No, then enter amount)	In Network	NO	2. C	Out of Network	NO	3. Combined	NO	
Briefly explain the methodology for reflecting the impact of maximur	n cost sharing in Se	ction III						

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

	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(1)	(m)	(n)	(o)
			Measure-	In-Network		In-Network Cost Sharing				Total	Out-of-Network		Grand Tota
			ment	Effective	In-Network	Description of Cost	Effective	**Effective		In-Network	Description of	Out-of-Network	Cost Share
			Unit	Plan-Level	Util/1000	Sharing / Add'l Days /	Copay / Coin	Copay / Coin	In-Network	Cost Share	Cost Sharing /	Cost Sharing	PMPM
	Service Category	Description	Code	Deduct PMPM*	or PMPM	Benefit Limits****	Before OOP Max	After OOP Max	PMPM	PMPM	Benefit Limits****	PMPM***	(INN+OON)
		I .		1	1								
1.	Inpatient Facility	Acute							\$0.00	\$0.00			\$0.00
2.	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			0.00
1.	DME/Prosthetics/Supplies	DME							0.00	0.00			0.0
2.	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
1.	OP Facility - Other	Lab							0.00	0.00			0.00
2.	OP Facility - Other	Radiology							0.00	0.00			0.0
3.	OP Facility - Other	Mental Health							0.00	0.00			0.00
4.	OP Facility - Other	Renal Dialysis							0.00	0.00			0.00
5.	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			0.0
	Professional	Mental Health (MH)							0.00	0.00			0.0
l.	Professional	Therapy (PT/OT/ST)							0.00	0.00			0.0
j.	Professional	Radiology							0.00	0.00			0.0
ò.	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-Covere	ed)							0.00	0.00			0.0
	Dental (Non-Covered)	ľ							0.00	0.00			0.0
1.	Vision (Non-Covered)	Professional							0.00	0.00			0.0
2.	Vision (Non-Covered)	Hardware							0.00	0.00			0.0
1.	Hearing (Non-Covered)	Professional							0.00	0.00			0.0
2.	Hearing (Non-Covered)	Hardware							0.00	0.00			0.0
	Health & Education (Non-Co								0.00	0.00			0.0
	Other Non-Covered	1							0.00	0.00			0.0
									0.00	0.00			0.0
									0.00	0.00			0.0
									0.00	0.00			0.0
									0.00	0.00			0.0
									0.00	0.00			0.0
									0.00	0.00			0.0
									0.00	0.00			0.0
									0.00	0.00			0.0
									0.00	0.00			0.0
									0.00	0.00			0.0
	Total			\$0.00					\$0.00	\$0.00		\$0.00	\$0.0
	1 Ottal			Actual combined plan	level deductible:		*Actual in-natural	k plan level deductible:	φυ.00		N plan level deductible:	φυ.00	\$0.0
				oes combined ded at				ded apply to Pt B only?			ded apply to Pt B only?		
			D	oco combined ded ap	opiy to i t b offiy?			f in-network OOP max:			pact of OON OOP max:		

^{****}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.

IV. Mapping of PBP service categories to BPT

PBP line BPT category 10a 10b 11a 11b 11c 13a 13b 13c 13d, 13e, 13f 13g, 13h 14a 14b 14c 14d 14e 16a 16b 17a 17b 18a * new line 4c

CY2014_MA_BPT.xlsm 12/06/2012

 Contract Number: 		Organization Name:	Enrollee Type:	Region Name:	N/A		
2. Plan ID:		6. Plan Name:	10. MA Region: N/A				
Segment ID:		7. Plan Type:	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)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(I)	(m)	(n)	(o)	(p)	(q)	(r)
			Total E	Benefits		% for 0	Cov. Svcs	FFS Medicare	Plan cost sh.	Medica	are Covered (w/AE co	st sh.)	A/B N	Mand Suppl (MS)	Benefits
		Allowed	Plan Cost		Net		Cost	Actl. Equiv.	for Medicare-	Allowed	FFS AE	Net	Net PMPM for	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
a.	Inpatient Facility	\$0.00	\$0.00		\$0.00			0.0%	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
b.	Skilled Nursing Facility	0.00	0.00		0.00			0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00
c.	Home Health	0.00	0.00		0.00			0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00
d.	Ambulance	0.00	0.00		0.00			0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00
e.	DME/Prosthetics/Supplies	0.00	0.00		0.00			0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00
f.	OP Facility - Emergency	0.00	0.00		0.00			0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00
g.	OP Facility - Surgery	0.00	0.00		0.00			0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00
h.	OP Facility - Other	0.00	0.00		0.00			0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00
i.	Professional	0.00	0.00		0.00			0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00
j.	Part B Rx	0.00	0.00		0.00			0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00
k.	Other Medicare Part B	0.00	0.00		0.00			0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00
l.	Transportation (Non-Covered)	0.00	0.00		0.00	0.00%	0.00%	0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00
m.	Dental (Non-Covered)	0.00	0.00		0.00	0.00%	0.00%	0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00
n.	Vision (Non-Covered)	0.00	0.00		0.00	0.00%	0.00%	0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00
0.	Hearing (Non-Covered)	0.00	0.00		0.00	0.00%	0.00%	0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00
p.	Health & Education (Non-Covered)	0.00	0.00		0.00	0.00%	0.00%	0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00
q.	Other Non-Covered	0.00	0.00		0.00	0.00%	0.00%	0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00
r.	COB/Subrg. (outside claim system)	0.00	0.00		0.00		0.00%	0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00
s.	Total Medical Expenses	\$0.00	\$0.00		\$0.00			\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00

B. DE# (Dual Eligible Beneficiaries without full Medicare cost sharing liability) Cost and Required Revenue PMPM at Plan's Risk Factor:

0.0000

	(c)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(1)	(m)	(n)	(0)	(p)	(q)	(r)
			Total B	enefits		% for	Cov. Svcs	State Medicaid	Actual cost sh.	Medicare	Covered (w/Medicaid	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
a.	Inpatient Facility	\$0.00	\$0.00	\$0.00	\$0.00				\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
b.	Skilled Nursing Facility	0.00	0.00	0.00	0.00				0.00	0.00	0.00	0.00	0.00	0.00	0.00
C.	Home Health	0.00	0.00	0.00	0.00				0.00	0.00	0.00	0.00	0.00	0.00	0.00
d.	Ambulance	0.00	0.00	0.00	0.00				0.00	0.00	0.00	0.00	0.00	0.00	0.00
e.	DME/Prosthetics/Supplies	0.00	0.00	0.00	0.00				0.00	0.00	0.00	0.00	0.00	0.00	0.00
f.	OP Facility - Emergency	0.00	0.00	0.00	0.00				0.00	0.00	0.00	0.00	0.00	0.00	0.00
g.	OP Facility - Surgery	0.00	0.00	0.00	0.00				0.00	0.00	0.00	0.00	0.00	0.00	0.00
h.	OP Facility - Other	0.00	0.00	0.00	0.00				0.00	0.00	0.00	0.00	0.00	0.00	0.00
i.	Professional	0.00	0.00	0.00	0.00				0.00	0.00	0.00	0.00	0.00	0.00	0.00
j.	Part B Rx	0.00	0.00	0.00	0.00				0.00	0.00	0.00	0.00	0.00	0.00	0.00
k.	Other Medicare Part B	0.00	0.00	0.00	0.00				0.00	0.00	0.00	0.00	0.00	0.00	0.00
l.	Transportation (Non-Covered)	0.00	0.00	0.00	0.00	0.00%	0.00%		0.00	0.00	0.00	0.00	0.00	0.00	0.00
m.	Dental (Non-Covered)	0.00	0.00	0.00	0.00	0.00%	0.00%		0.00	0.00	0.00	0.00	0.00	0.00	0.00
n.	Vision (Non-Covered)	0.00	0.00	0.00	0.00	0.00%	0.00%		0.00	0.00	0.00	0.00	0.00	0.00	0.00
ο.	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

CY2014_MA_BPT.xlsm 12/06/2012

 Contract Number: 		Organization Name:	Enrollee Type:	Region Name:	N/A	
2. Plan ID:		6. Plan Name:	10. MA Region: N/A			
Segment ID:		7. Plan Type:	Act. Swap/Equiv Apply:			
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)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(1)	(m)	(n)	(o)	(p)	(q)	(r)
			Total B	enefits							Medicare Covered			/Iand Suppl (MS)	Benefits
					Net							Net	Net PMPM for	Reduction of	
	Service Category				PMPM							PMPM	Add'l Svcs.	A/B Cost Sh.	Total
a.	Inpatient Facility				\$0.00							\$0.00	\$0.00	\$0.00	\$0.00
b.	Skilled Nursing Facility				0.00							0.00	0.00	0.00	0.00
c.	Home Health				0.00							0.00	0.00	0.00	0.00
d.	Ambulance				0.00							0.00	0.00	0.00	0.00
e.	DME/Prosthetics/Supplies				0.00							0.00	0.00	0.00	0.00
f.	OP Facility - Emergency				0.00							0.00	0.00	0.00	0.00
g.	OP Facility - Surgery				0.00							0.00	0.00	0.00	0.00
h.	OP Facility - Other				0.00							0.00	0.00	0.00	0.00
i.	Professional				0.00							0.00	0.00	0.00	0.00
j.	Part B Rx				0.00							0.00	0.00	0.00	0.00
k.	Other Medicare Part B				0.00							0.00	0.00	0.00	0.00
l.	Transportation (Non-Covered)				0.00							0.00	0.00	0.00	0.00
m.	Dental (Non-Covered)				0.00							0.00	0.00	0.00	0.00
n.	Vision (Non-Covered)				0.00							0.00	0.00	0.00	0.00
ο.	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
٧.	Non-Benefit Expense:			_		_	z1. NBE Qua								
1.	Sales & Marketing						z2. Taxes an					\$0.00			\$0.00
2.	Direct Administration						z3. Insurer Fe	ees (subset of Taxes	& Fees)			0.00			0.00
3.	Indirect Administration											0.00			0.00
4.	Net Cost of Private Reinsurance			[0.00			0.00
5.	Total Non-Benefit Expense			Ī	\$0.00							\$0.00	0.00	0.00	\$0.00
w.	Gain/(Loss) Margin			Ī			z4. Overall Ga	ain/(Loss) Margin Le	vel	CONTRACT		\$0.00	0.00	0.00	\$0.00
x.	Total Revenue Requirement				\$0.00			<u></u>			·	\$0.00	0.00	0.00	\$0.00
y1.	Net Medical Expense % of Revenue				0.0%		y4. Adjusted I		0.0%			0.0%			0.0%
y2.	Non-Benefit % of Revenue			Ī	0.0%			R based on bid proj				0.0%			0.0%
у3.	Gain/(Loss) Margin % of Revenue				0.0%	,	Quality Initiation	ves and denominato	r excludes Ta	xes 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 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 CY Non-Benefit Expenses for Basic Services ESRD CY cost sharing reductions ESRD CY additional benefits CY Margin Requirement for Basic Services \$0.00 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 Total CY ESRD "subsidy" = \$0.00

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

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

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

Note: See bid instructions for ESRD and hospice exclusions.

I. General Information						
Contract Number	Organization Name:	Enrollee Type:	13. Region Name:	N/A		
2. Plan ID:	6. Plan Name:	MA Region: N/A				
Segment ID:	7. Plan Type:	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			
Weighted Avg Risk Factor	0		0
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	
Statutory Component - Region N/A	73.2%	
Plan Bid Component (from CMS)*	26.8%	N/A
Standardized A/B Benchmark	100.0%	

VIII. Projected CY Member Months	
1. Member months entered by county (Sect. VI)	0
ESRD member months	
Hospice member months	
Out-of-Area (OOA) member months	
5. Total member menths	۸

III. Savings/Basic Member Premium Development

Г	1. Savings	\$0.00
ŀ	2. Rebate	\$0.00
ı:	Basic Member Premium	\$0.00

V. Quality Rating

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

VI: County Level Detail and Service Area Summary

VII: Other Medicare Information

	n oounty zoron z	ctan ana	OCI VICE AICE OUIIIIIE	,									VIII. Othici Mic	alcuic III	TOTTILATION					
	 Use of plan-prov 	ided ISAI	R factors? (Regional Pla	ans only - enter Ye	es or No)															
L	(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	ent Rate	Original Medi	icare cost	sharing (c.s.)	FFS costs to	o weight N	Medicare c.s.	Metropol	itan 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
2	Total or Weighte	d Averag	e 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 De	tail:																	0% p	predominant MSA

CY2014_MA_BPT.xlsm

WORKSHEET 6 - MA BID SUMMARY Note: See bid instructions for ESRD and hospice exclusions.

I. General Information

 Contract Number: 		Organization Name:	Enrollee Type:	Region Name:	N/A		
Plan ID:		6. Plan Name:	10. MA Region: N/A	A			
 Plan ID: Segment ID: 		7. Plan Type:	Act. Swap/Equiv Apply:				
Contract Year:	2014	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			
		Reduce A/B Cost Sharing (max. value=\$0.00) Other A/B Mand Suppl Benefits (max. value=\$0.00)			

III. Plan A/B Bid Summary

A. Overview			B. MA Rebate Allocation						C. Development of Estimated Plan Premium	
				F	Rebate PMPM All	ocation		Maximum	· ·	
				Medical	Non-Benefit	Gain / (Loss)	Total	Value	A/B Mandatory Supplemental revenue requirements	
	Medicare-	A/B Mandatory	MA Rebate	n/a	n/a	n/a	\$0.00		Less rebate allocations:	
	covered	Supplemental							2a. Reduce A/B Cost Sharing	
 Net medical cost 	\$0.00	\$0.00	Reduce A/B Cost Sharing	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	2b. Other A/B Mand Supplemental Benefits	
			Other A/B Mand Suppl Benefits	0.00	0.00	0.00	0.00	0.00		
Non-benefit expense	\$0.00	\$0.00	 Pt B Premium Buydown 	0.00	n/a	n/a	0.00	104.90	A/B Mandatory Supplemental premium	
Gain / loss margin	0.00	0.00	Pt D Premium Buydown Basic	0.00	n/a	n/a	0.00	0.00		
Total revenue requirement	\$0.00	\$0.00	Pt D Premium Buydown Suppl	0.00	n/a	n/a	0.00	0.00	4. Basic MA premium	
	·		7. Total	\$0.00	\$0.00	\$0.00	\$0.00	_	5. Total MA Enrollee Premium (excl. Opt. Suppl.)	
Standardized A/B Benchmar	k \$0.00					Unalloc. rebate	\$0.00		6. Rounded MA Premium (excl. Opt. Suppl.)	
Plan A/B Benchmark	\$0.00				•			='		
Risk Factor	0.0000								7. Part D Basic Premium	
Conversion Factor	0.0000								7a. Prior to rebates (rounded value from Rx BPT)	
			_						7b. A/B rebates allocated to Part D Basic Premium	

IV. Contact Information

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

V. Working Model Text Box

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

3. A/B Mandatory Supplemental premium	0.00							
 Basic MA premium Total MA Enrollee Premium (excl. Opt. Suppl.) Rounded MA Premium (excl. Opt. Suppl.) 	0.00 0.00 \$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) 7d. Part D Basic Premium*	\$0.00 \$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) 8d. Part D Supplemental Premium	\$0.00 \$0.00							
9. Total estimated plan premium*	\$0.00							
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.	retermined by CiviS. The premiums							

\$0.00 0.00

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.

CY2014_MA_BPT.xlsm 12/06/2012

Contract Number:		Organization Name	Enrollee Type:	13. Region Name:	N/A		
2. Plan ID:		6. Plan Name:	10. MA Region: N/A				
Segment ID:		7. Plan Type:	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

(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(I)	(m)	(n)	(o)	(p)	(p)
					medical expe	nse		Enrollee co				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	n/a
1						0.00 0.00				0.00	0.00 0.00	n/a		n/a	n/a n/a
1 1						0.00				0.00 0.00	0.00	n/a n/a		n/a n/a	n/a n/a
1 1						0.00				0.00	0.00	n/a		n/a	n/a
1 1						0.00				0.00	0.00	n/a		n/a	n/a
1 1						0.00				0.00	0.00	n/a		n/a	n/a
1 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	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	n/a
1	Package Total					\$0.00				\$0.00	\$0.00			\$0.00	
Description	rackage rotal					φυ.υυ				\$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	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	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
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	n/a
2						0.00				0.00	0.00	n/a		n/a	n/a
2 2						0.00				0.00 0.00	0.00 0.00	n/a		n/a	n/a n/a
						0.00					0.00	n/a		n/a	
2 2						0.00 0.00				0.00 0.00	0.00	n/a n/a		n/a n/a	n/a n/a
						0.00				0.00	0.00	11/2	l IVa	1Va	II/a
2	Package Total					\$0.00				\$0.00	\$0.00			\$0.00	

Contract Number:		Organization Name	Enrollee Type:	13. Region Name:	N/A		
2. Plan ID:		6. Plan Name:	10. MA Region: N/A				
Segment ID:		7. Plan Type:	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

(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(I)	(m)	(n)	(o)	(p)	(q)
					medical expe	nse		Enrollee co				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												,	,	,	,
3						\$0.00				\$0.00	\$0.00	n/a		n/a	n/a
3						0.00				0.00	0.00	n/a		n/a	n/a
3						0.00 0.00				0.00 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	n/a n/a
3						0.00				0.00	0.00	n/a		n/a	n/a
3						0.00				0.00	0.00	n/a		n/a	n/a
3						0.00				0.00	0.00	n/a		n/a	n/a
3						0.00				0.00	0.00	n/a		n/a	n/a
3						0.00				0.00	0.00	n/a		n/a	n/a
3						0.00				0.00	0.00	n/a		n/a	n/a
3						0.00				0.00	0.00	n/a		n/a	n/a
3						0.00				0.00	0.00	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
3						0.00				0.00	0.00	n/a	n/a	n/a	n/a
						**				***	***			** **	
3 Description	Package Total					\$0.00				\$0.00	\$0.00			\$0.00	
Description						\$0.00				\$0.00	\$0.00	n/a	n/a	n/a	n/o
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
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
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
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
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
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
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
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
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	

Note: See bid instructions for ESRD and hospice exclusions.

I. General Information

i. General information							
 Contract Number: 		Organization Name	Enrollee Type:	Region Name:	N/A		
2. Plan ID:		6. Plan Name:	10. MA Region: N/A				
Segment ID:		7. Plan Type:	Act. Swap/Equiv Apply:				
Contract Year:	2014	8. MA-PD:	12. SNP:	14. SNP Type:	N/A	15. EGWPN	

II. Optional Supplemental Packages

(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(1)	(m)	(n)	(o)	(p)	(q)
					nedical expe	nse		Enrollee co			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
5						0.00				0.00	0.00	n/a			n/a
5						0.00				0.00	0.00	n/a			n/a
5						0.00				0.00	0.00	n/a			n/a
5						0.00				0.00	0.00	n/a			n/a
5						0.00				0.00	0.00	n/a			n/a
5						0.00				0.00	0.00	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	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	

Ш	C	٦m	ım	۵r	١t٥
		ווט		СI	ш

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

	Net Medical	Non-Benefit	Gain/(Loss)		Member
	Expenses	Expenses	Margin	Premium	Months
Total \$: for all OSB packages combined			\$0		
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	3-0944

I	. General Information							
1	 Contract Number: 		Organization Name:		9.	Enrollee Type:	A/B	
2	2. Plan ID:		6. Plan Name:				•	- '
3	B. Segment ID:		7. Plan Type:	MSA				
4	Contract Year:	2014	8. Deductible Amount					

II. Base Period Background Information

Time Period Definition Incurred from: Incurred to: Paid through: Obscribe the source of the base	01/01/2012 12/31/2012 period experience data	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 Risk Factor)

IV. Projection Assumptions

	(c)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(I)	(m)	(n)	(o)	(p)
				Total B	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	Type	Util/1000	Avg Cost	PMPM	Trend	Change	Change	Factor	Trend	Util/1000	PMPM
a.	Inpatient Facility				\$0.00								
b.	Skilled Nursing Facility				0.00								
c.	Home Health				0.00								
d.	Ambulance				0.00								
e.	DME/Prosthetics/Supplies				0.00								
f.	OP Facility - Emergency				0.00								
g.	OP Facility - Surgery				0.00								
h.	OP Facility - Other				0.00								
i.	Professional				0.00								
j.	Part B Rx				0.00								
k.	Other Medicare Part B				0.00								
I.	COB/Subrg. (outside claim syst	tem)											
m.	Total Medicare Covered Med	ical Expenses				\$0.00							
		•											

	٧.	Description	of C	Other	Utilization	Factor	and	Additive	Values
--	----	-------------	------	-------	-------------	--------	-----	----------	--------

CMS - 10142 (4/30/2013)

CY2014_MSA_BPT.xlsm 12/06/2012

WORKSHEET 2 - MSA TOTAL PROJECTED ALLOWED COSTS 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:			
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 Ris	sk Factor:											
	(c)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(1)	(m)	(n)	(o)	(p)
			Projecte	ed Experienc	e Rate	N	/lanual Rate		Exper.	Coi	ntract Year Ra	ite	% of svcs
		Util	Annual		Allowed	Annual		Allowed	Cred.	Annual		Allowed	provided
	Service Category	Type	Util/1000	Avg Cost	PMPM	Util/1000	Avg Cost	PMPM	%	Util/1000	Avg Cost	PMPM	OON
a.	Inpatient Facility		0	\$0.00	\$0.00		\$0.00			0	\$0.00	\$0.00	
b.	Skilled Nursing Facility		0	0.00	0.00		0.00			0	0.00	0.00	
c.	Home Health		0	0.00	0.00		0.00			0	0.00	0.00	
d.	Ambulance		0	0.00	0.00		0.00			0	0.00	0.00	
e.	DME/Prosthetics/Supplies		0	0.00	0.00		0.00			0	0.00	0.00	
f.	OP Facility - Emergency		0	0.00	0.00		0.00			0	0.00	0.00	
g.	OP Facility - Surgery		0	0.00	0.00		0.00			0	0.00	0.00	
h.	OP Facility - Other		0	0.00	0.00		0.00			0	0.00	0.00	
i.	Professional		0	0.00	0.00		0.00			0	0.00	0.00	
j.	Part B Rx		0	0.00	0.00		0.00			0	0.00	0.00	
k.	Other Medicare Part B		0	0.00	0.00		0.00			0	0.00	0.00	
I.	COB/Subrg. (outside claim system)				0.00							0.00	
m.	Total Medicare Covered Medical Exper	nses			\$0.00			\$0.00	0%			\$0.00	·
				•			•		0%	CMS Guideli	ne Credibility		

. Briefly describe the source for the manual rate, including what trend assumptions were used, if applicable

CY2014_MSA_BPT.xlsm 12/06/2012

WORKSHEET 3 - MSA BENCHMARK PMPM

Note: See bid instructions for ESRD and hospice exclusions.

. General Inf	nrm	ation

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

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	

IV. Quality Bonus Rating 1. Quality Bonus Rating

III: County Level Detail and Service Area Summary

(b) State/County Code 1. Total or Weighte 2. County Level De	(c) State d Average for Service Area tail:	(d) County Name	(e) Projected Member Months	(f) Projected Risk Factors	(g) MA Risk Ratebook Unadjusted \$0.00	Plan Benchmark

WORKSHEET 4 - MSA ENROLLEE DEPOSIT AND PLAN PAYMENT PMPM

Note: See bid instructions for ESRD and hospice exclusions.

I.	General	Information
	Ochici ai	miormanon

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	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)

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	İ	
	Gain/(Loss) Margin	\$0.00		
	Total Plan Revenue Requirement	\$0.00		
	Projected Plan Benchmark	-		
	•	\$0.00	£0.00	¢0.00
	Projected Monthly Enrollee Deposit	\$0.00	\$0.00	\$0.00
g.	Percent of Plan Revenue		1	
	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. A	Adjusted MLR*	0.00%		
* A	djusted MLR based on bid projection, Num	erator includes		
	ality Initiatives and denominator excludes T			

j. NBE Quality Initiatives

k. Taxes and Fees

I. Insurer Fees (subset of Taxes and Fees)



 Contract Number: 		Organization Name:		9.	Enrollee Type:	A/B
2. Plan ID:		Plan Name:				
Segment ID:		Plan Type:	MSA			
4. Contract Year:	2014	8. Deductible Amount				

II. Optional Supplemental Packages

(b)	(c)	(d)		(f)		(h)	(i)	(j)	(k)	(I)	(m)	(n)	(o)	(p)	(p)
		Benefit category		Allowed medic				Enrollee cost s					Gain/		Projected
Package	Service	or pricing	Util.	Annual	Average	DIADIA	Measurment	Util/1000 or	Average	DMDM		Benefit	(Loss)		Member
ID Description	category	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	n/a
1 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	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
						0.00 0.00				0.00 0.00	0.00 0.00	n/a n/a		n/a	n/a n/a
1 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 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	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	n/a
1	Package Total					\$0.00				\$0.00	\$0.00			\$0.00	
Description															
2						\$0.00				\$0.00	\$0.00	n/a	n/a	n/a	n/a
2						0.00				0.00	0.00	n/a		n/a	n/a
2						0.00				0.00	0.00	n/a		n/a	n/a
2 2						0.00 0.00				0.00 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	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	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 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	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
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	Package Total		1			\$0.00				\$0.00	\$0.00			\$0.00	

 Contract Number: 		5. Organization Name:	9. Enrollee Type:	A/B
2. Plan ID:		6. Plan Name:	• •	
Segment ID:		7. Plan Type: MSA		
4 Contract Year:	2014	Deductible Amount		

II. Optional Supplemental Packages

(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(i)	(k)	(I)	(m)	(n)	(o)	(p)	(q)
	(3)	Benefit category		Allowed medic		· /		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		-													
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
3						0.00				0.00	0.00	n/a		n/a	n/a
3						0.00				0.00	0.00	n/a		n/a	n/a
3						0.00				0.00	0.00	n/a		n/a	n/a
3						0.00				0.00	0.00	n/a		n/a	n/a
3						0.00				0.00	0.00	n/a		n/a	n/a
3						0.00				0.00	0.00	n/a		n/a	n/a
3 3						0.00 0.00				0.00	0.00 0.00	n/a		n/a	n/a
3						0.00				0.00 0.00	0.00	n/a		n/a	n/a
3						0.00				0.00	0.00	n/a n/a		n/a n/a	n/a n/a
3						0.00				0.00	0.00	n/a		n/a	n/a
3						0.00				0.00	0.00	n/a		n/a	n/a
3						0.00				0.00	0.00	n/a		n/a	n/a
3						0.00				0.00	0.00	n/a		n/a	n/a
3						0.00				0.00	0.00	n/a		n/a	n/a
						0.00				0.00	0.00	.,,	.,,	.,,	., .
3	Package Total					\$0.00				\$0.00	\$0.00			\$0.00	
Description												,	,	,	,
4						\$0.00				\$0.00	\$0.00	n/a		n/a	n/a
4						0.00 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	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
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
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
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
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
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
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	Package Total					\$0.00				\$0.00	\$0.00			\$0.00	
	i ackage rotal		1			φυ.υυ	l .			φυ.00	φυ.υυ			φυ.00	

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)	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(1)	(m)	(n)	(o)	(p)	(q)
		Benefit category		Allowed medica	al 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	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
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	Package Total					\$0.00				\$0.00	\$0.00			\$0.00	

III. Comments

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

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

WORKSHEET 1 ESRD-2014.beta III. ESRD MSP Adjustment Factors for CY (from April Rate Announcement) 0.173 **ESRD Plan Bid Submission** OMB Approved # 0938-0944 1. Functioning Graft (i.e., postgraft) "F" **Enrollment and PMPM Revenue Projection** CMS - 10142 (4/30/2013) 2. Dialysis / transplant ("D" / "T") 0.189 I. General Information 6. Contract #: IV. Summary Data Part C Mandatory Monthly Enrollee Premium
 Part C Monthly Plan Revenue 2014 7. Plan ID: \$0.00 1. Contract Year: 2. Contract-Plan-Segment: 8. Segment ID: \$0.00 Part D Premium (basic + supplemental) net of MA "rebates"
 Plan intention for target Part D basic Premium 3. Organization Name: \$0.00 4. Service Area: 5. Plan type: ESRD SNP 5. Quality Bonus Rating (per CMS) 6. New/low indicator (per CMS) II. Service Area Summary (a) (b) (c) (d) (g) (h) ESRD Projected CY 2014 Percentage Projected Proj. Risk CMS Monthly State/County Member Months of MSP County Name Status State or Code State (Func Graft) D/T/F Jan.- Dec. 2014 Score County Rate Mem. Months Capitation \$0.00 1. Total or Weighted Average for Service Area: \$0.00 n/a

WORKSHEET 2 ESRD Plan Bid Submission

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

110,000.01.01.001.01.000., 1101.000.		· · · · · · · · · · · · · · · · · · ·	
I. General Information		Contract #:	0
Contract Year:	2014	7. Plan ID:	0
Contract-Plan-Segment:	0_0_0	Segment ID:	0
Organization Name:	0		
4. Service Area:	0		
5. Plan type:	ESRD SNP		

	Pro	jection of Plan Cos	ts		Supplemental Benefits	
				Medicare	Medicare	
		Enrollee		AE	AE	Total
Benefit	Allowed	cost	Net	cost sharing	cost sharing	cost sharing
category	cost	sharing	cost	proportion	value	enhancements
Inpatient hospital		J	\$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	19.970	0.00	
	\$0.00	\$0.00	\$0.00	2/0	\$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
						0.00
Other: Part D Basic premium reduction			0.00			
Other: Part D Supp premium reduction			0.00			0.00
Additional services 2/ Sub-total: additional services			0.00			0.00
Sub-total: additional services			\$0.00			\$0.00
Total benefit cost			\$0.00			\$0.00
Non-benefit components				Adjusted MLR*	0.00%	
Sales & Marketing					n bid projection, Numera	
Direct Administration				Quality Initiatives and de	nominator excludes Taxe	s and Fees.
Indirect Administration						
Net Cost of Private Reinsurance						
Gain / loss margin						
Total NBE+GLM			\$0.00			
Total plan cost			\$0.00			
CMS capitation			\$0.00	NBE Quality Initiatives		
Part C mandatory enrollee premium			\$0.00	Taxes and Fees		
	Benefit Cost	NBE+GLM	Total Cost	Insurer Fees (subset of 1	Taxes and Fees)	
Medicare-covered benefits	\$0.00	\$0.00	\$0.00			
Cost sharing enhancements	\$0.00	\$0.00	\$0.00			
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			
Total	\$0.00	\$0.00	\$0.00	1		
Total	ψ0.00	Ψ0.00	ψ0.00			

^{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)

ESRD Plan Bid Submission

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

I. General Information		6. Contract #:	0
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		

Development of "Rebate" Allocations and Estimated Plan Premium	
Rebate Allocation for Part B Premium	
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
4. Rounded MA Premium (excl. Opt. Suppl.)	\$0.00
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
5d. Part D Basic Premium*	\$0.00
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
6d. Part D Supplemental Premium	\$0.00
7. Total estimated plan premium*	\$0.00
8. Plan Intention for target PD basic premium	
* 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		6. Contract #: 0
Contract Year:	2014	7. Plan ID: 0
Contract-Plan-Segment:	0_0_0	8. Segment ID: 0
Organization Name:	0	
4. Service Area:	0	
Plan type:	ESRD SNP	

II. Contact Information					
ESRD-SNP Plan Contact Person:					
Name, Position					
Phone Number					
Email Address					
ESRD-SNP Certif	fying Actuary:				
Name, Creden.					
Phone Number					
Email Address					

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

	Medical	Benefits (PMPM) 2/			
			CY 201	2	
		Claims			
		incurred	Claim		
		in period	reserve		
Benefit		paid thru	as of	Incurred	
category		03/31/2013	03/31/2013	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	
Total benefit costs		\$0.00	\$0.00	\$0.00	
Non-benefit components					
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

ESRD Plan Bid Submission

OPTIONAL SUPPLEMENTAL BENEFITS

I.	General Information		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)	(c)	(d)			(g)	(h)		(j)	(k)	(l)	(m)	(n)	(o)	(p)	(q)
		Benefit category		Allowed medical				Enrollee cost sl				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															
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
	Package Total					\$0.00				\$0.00	\$0.00			\$0.00	
Description															
2						\$0.00				\$0.00	\$0.00	n/a	n/a	n/a	n/a
2						0.00				0.00	0.00	n/a	n/a	n/a	n/a
2						0.00				0.00	0.00	n/a	n/a	n/a	n/a
2						0.00				0.00	0.00	n/a	n/a	n/a	n/a
2						0.00				0.00	0.00	n/a	n/a	n/a	n/a
2						0.00				0.00	0.00	n/a	n/a	n/a	n/a
2						0.00				0.00	0.00	n/a	n/a	n/a	n/a
2						0.00				0.00	0.00	n/a	n/a	n/a	n/a
2						0.00				0.00	0.00	n/a	n/a	n/a	n/a
2						0.00				0.00	0.00	n/a	n/a	n/a	n/a
2						0.00				0.00	0.00	n/a	n/a	n/a	n/a
2						0.00				0.00	0.00	n/a	n/a	n/a	n/a
2						0.00				0.00	0.00	n/a	n/a	n/a	n/a
2						0.00				0.00	0.00	n/a	n/a	n/a	n/a
2						0.00				0.00	0.00	n/a	n/a	n/a	n/a
2						0.00				0.00	0.00	n/a	n/a	n/a	n/a
2						0.00				0.00	0.00	n/a	n/a	n/a	n/a
2						0.00				0.00	0.00	n/a	n/a	n/a	n/a
2						0.00				0.00	0.00	n/a	n/a	n/a	n/a
2						0.00				0.00	0.00	n/a	n/a	n/a	n/a
2	Package Total					\$0.00				\$0.00	\$0.00			\$0.00	

ESRD Plan Bid Submission

OPTIONAL SUPPLEMENTAL BENEFITS

1. 0	General Information		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)	(c)	(d)				(h)	(i)	(j)	(k)	(1)	(m)	(n)	(o)	(p)	(q)
		Benefit category		Allowed medical				Enrollee cost sl				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						60.00				\$0.00	¢0.00	,	,	,	,
3						\$0.00 0.00				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	n/a n/a
3						0.00				0.00	0.00	n/a		n/a	n/a
3						0.00				0.00	0.00	n/a		n/a	n/a
3						0.00				0.00	0.00	n/a		n/a	n/a
3						0.00				0.00	0.00	n/a		n/a	n/a
3						0.00				0.00	0.00	n/a		n/a	n/a
3						0.00				0.00	0.00	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
3						0.00				0.00	0.00	n/a		n/a	n/a
3						0.00				0.00	0.00	n/a		n/a	n/a
3						0.00				0.00	0.00	n/a		n/a	n/a
3						0.00				0.00	0.00	n/a		n/a	n/a
3						0.00				0.00	0.00	n/a	n/a	n/a	n/a
3	Package Total					\$0.00				\$0.00	\$0.00			\$0.00	
Description						•				• • • • • • • • • • • • • • • • • • • •	*****			*	
4						\$0.00				\$0.00	\$0.00	n/a	n/a	n/a	n/a
4						0.00				0.00	0.00	n/a	n/a	n/a	n/a
4						0.00				0.00	0.00	n/a	n/a	n/a	n/a
4						0.00				0.00	0.00	n/a	n/a	n/a	n/a
4						0.00				0.00	0.00	n/a		n/a	n/a
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
4						0.00				0.00	0.00	n/a		n/a	n/a
4						0.00 0.00				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
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
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
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
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
						-									
4	Package Total					\$0.00				\$0.00	\$0.00			\$0.00	

ESRD Plan Bid Submission

OPTIONAL SUPPLEMENTAL BENEFITS

I. General Information		6. Contract #:	0
1. Contract Year:	2014	7. Plan ID:	0
Contract-Plan-Segment:	_	8. Segment ID:	0
Organization Name:	0		
4. Service Area:	0		
5. Plan type:	ESRD SNP		

II. Optional Supplemental Packages

(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(1)	(m)	(n)	(o)	(p)	(q)
		Benefit category		Allowed medical	expense			Enrollee cost sl	haring		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	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

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

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