

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

Note: See bid instructions for ESRD and hospice exclusions.

MA-2016.1

OMB Approved # 0938-0944

**I. General Information**

1. Contract Number:		5. Organization Name		9. Enrollee Type:		13. Region Name:	N/A
2. Plan ID:		6. Plan Name:		10. MA Region:	N/A		
3. Segment ID:		7. Plan Type:		11. Act. Swap/Equiv Apply:			
4. Contract Year:	2016	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		2. Member Months	Total	Non-DE#	DE#	5. Plans In Base	Contract-Plan ID	Member Months	Contract-Plan ID	Member Months
Incurring from:	01/01/2014	3. Risk Score	0		0					
Incurring to:	12/31/2014	4. Completion Factor			0.0000					
Paid through:										
6. Describe the source of the base period experience data										

**III. Base Period Data (at Plan's Risk Factor) for 1/1/2014-12/31/2014**

**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 1/1/2014-12/31/2014 (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%
					7e. Insurer Fees			
					7f. Total Non-Benefit Expenses	\$0		
PMPMs:							10a. Medicaid Revenue	
6a. Revenue PMPM	\$0.00	\$0.00	\$0.00	\$0.00			10b. Medicaid Cost	\$0
6b. Net Medical PMPM	\$0.00	\$0.00	\$0.00	\$0.00			10b1. Benefit expenses	
6c. Non-Benefit PMPM				\$0.00			10b2. Non-benefit expenses	
6d. Gain/(Loss) Margin PMPM				\$0.00			10c. Adjusted GLM	\$0

**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: 2016	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	0	0
										2. Projected risk factor	0.0000	0.0000	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					0.00				
<b>s. Total Medical Expenses</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%	CMS Guideline Credibility			\$0.00	\$0.00	\$0.00	
u. Briefly describe the source for the manual rate, including what trend assumptions were used, if applicable															

**WORKSHEET 3 - MA PROJECTED COST SHARING PMPM**

Note: See bid instructions for ESRD and hospice exclusions.

**I. General Information**

1. Contract No:	5. Org Name:	9. Enrollee Type:	13. Region Name:	N/A
2. Plan ID:	6. Plan Name:	10. MA Region: N/A		
3. Segment ID:	7. Plan Type:	11. Act. Swap/Equiv		
4. Contract Year: 2016	8. MA-PD:	12. SNP:	14. SNP Type: N/A	15. EGWP: N

**II. Maximum Cost Sharing Per Member Per Year**

Is there a plan-level OOP maximum? (Yes/No, then enter amount)	1. In Network	NO	2. Out of Network	NO	3. Combined	NO
4. Briefly explain the methodology for reflecting the impact of maximum cost sharing in Section III						

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

(c) Service Category	(d) Description	(e) Measurement Unit Code	(f) In-Network Effective Plan-Level Deduct PMPM*	(g) In-Network Cost Sharing After Plan-Level Deductible				(k) In-Network PMPM	(l) Total In-Network Cost Share PMPM	(m) Out-of-Network Description of Cost Sharing / . . . Benefit Limits****	(n) Out-of-Network Cost Sharing PMPM***	(o) Grand Total Cost Share PMPM (INN+OON)
				In-Network Util/1000 or PMPM	Description of Cost Sharing / Add'l Days / Benefit Limits****	Effective Copay / Coin Before OOP Max	**Effective Copay / Coin After OOP Max					
a.1.	Inpatient Facility	Acute						\$0.00	\$0.00			\$0.00
a.2.	Inpatient Facility	Mental Health						0.00	0.00			0.00
b.	Skilled Nursing Facility							0.00	0.00			0.00
c.	Home Health							0.00	0.00			0.00
d.	Ambulance							0.00	0.00			0.00
e.1.	DME/Prosthetics/Supplies	DME						0.00	0.00			0.00
e.2.	DME/Prosthetics/Supplies	Prosthetics/Supplies						0.00	0.00			0.00
f.	OP Facility - Emergency							0.00	0.00			0.00
g.	OP Facility - Surgery							0.00	0.00			0.00
h.1.	OP Facility - Other	Lab						0.00	0.00			0.00
h.2.	OP Facility - Other	Radiology						0.00	0.00			0.00
h.3.	OP Facility - Other	Mental Health						0.00	0.00			0.00
h.4.	OP Facility - Other	Renal Dialysis						0.00	0.00			0.00
h.5.	OP Facility - Other	Other						0.00	0.00			0.00
i.1.	Professional	PCP						0.00	0.00			0.00
i.2.	Professional	Specialist excl. MH						0.00	0.00			0.00
i.3.	Professional	Mental Health (MH)						0.00	0.00			0.00
i.4.	Professional	Therapy (PT/OT/ST)						0.00	0.00			0.00
i.5.	Professional	Radiology						0.00	0.00			0.00
i.6.	Professional	Other						0.00	0.00			0.00
j.	Part B Rx							0.00	0.00			0.00
k.	Other Medicare Part B							0.00	0.00			0.00
l.	Transportation (Non-Covered)							0.00	0.00			0.00
m.	Dental (Non-Covered)							0.00	0.00			0.00
n.1.	Vision (Non-Covered)	Professional						0.00	0.00			0.00
n.2.	Vision (Non-Covered)	Hardware						0.00	0.00			0.00
o.1.	Hearing (Non-Covered)	Professional						0.00	0.00			0.00
o.2.	Hearing (Non-Covered)	Hardware						0.00	0.00			0.00
p.	Health & Education (Non-Covered)							0.00	0.00			0.00
q.	Other Non-Covered							0.00	0.00			0.00
r1.								0.00	0.00			0.00
r2.								0.00	0.00			0.00
r3.								0.00	0.00			0.00
r4.								0.00	0.00			0.00
r5.								0.00	0.00			0.00
r6.								0.00	0.00			0.00
r7.								0.00	0.00			0.00
r8.								0.00	0.00			0.00
r9.								0.00	0.00			0.00
r10.								0.00	0.00			0.00
s.	<b>Total</b>		\$0.00					\$0.00	\$0.00		\$0.00	\$0.00

t.	Actual combined plan level deductible:		*Actual in-network plan level deductible:		***Actual OON plan level deductible:	
u.	Does combined ded apply to Pt B only?		Does in-network ded apply to Pt B only?		Does OON ded apply to Pt B only?	
v.			** PMPM impact of in-network OOP max:		***PMPM impact of OON OOP max:	

**IV. Mapping of PBP service categories to BPT**

PBP line	BPT category
1a	a1
1b	a2
2	b
3	h5
4a	f
4b	f
4c	f
5	h5
6	c
7a	i1, i5
7b	i6
7c	i4
7d	i2, i6
7e	i3
7f	i6
7g	i6
7h	i3
7i	i4
8a	h1
8b	h2
9a	h5, g
9b	g
9c	h5
9d	k
10a	d
10b	l
11a	e1
11b	e2
11c	e2
12	h4
13a	q
13b	q
13c	q
13d, 13e, 13f	q
13g, 13h	q
14a	i1
14b	i1
14c	p
14d	i6
14e	i6
15	j
16a	m
16b	m
17a	n1
17b	n2
17c	o1
18a	o1
18b	o2

\*\*\*\*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.



**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: 2016	8. MA-PD:	12. SNP:	14. SNP Type:	N/A
			15. EGWP:	N

**II. Development of Projected Revenue Requirement**

Service Category	PMPM	PMPM	Add'l Svcs.	A/B Cost Sh.	Total
a. Inpatient Facility	\$0.00		\$0.00	\$0.00	\$0.00
b. Skilled Nursing Facility	0.00		0.00	0.00	0.00
c. Home Health	0.00		0.00	0.00	0.00
d. Ambulance	0.00		0.00	0.00	0.00
e. DME/Prosthetics/Supplies	0.00		0.00	0.00	0.00
f. OP Facility - Emergency	0.00		0.00	0.00	0.00
g. OP Facility - Surgery	0.00		0.00	0.00	0.00
h. OP Facility - Other	0.00		0.00	0.00	0.00
i. Professional	0.00		0.00	0.00	0.00
j. Part B Rx	0.00		0.00	0.00	0.00
k. Other Medicare Part B	0.00		0.00	0.00	0.00
l. Transportation (Non-Covered)	0.00		0.00	0.00	0.00
m. Dental (Non-Covered)	0.00		0.00	0.00	0.00
n. Vision (Non-Covered)	0.00		0.00	0.00	0.00
o. Hearing (Non-Covered)	0.00		0.00	0.00	0.00
p. Health & Education (Non-Covered)	0.00		0.00	0.00	0.00
q. Other Non-Covered	0.00		0.00	0.00	0.00
r. ESRD	0.00		0.00	0.00	0.00
s. Additional Benefits (employer bids only)	0.00		0.00	0.00	0.00
t. COB/Subrg. (outside claim system)	0.00		0.00	0.00	0.00
u. Total Medical Expenses	\$0.00		\$0.00	\$0.00	\$0.00
v. Non-Benefit Expense:					
1. Sales & Marketing			\$0.00		\$0.00
2. Direct Administration			0.00		0.00
3. Indirect Administration			0.00		0.00
4. Net Cost of Private Reinsurance			0.00		0.00
5. Insurer Fees			0.00		0.00
6. Total Non-Benefit Expense	\$0.00		\$0.00	0.00	\$0.00
w. Gain/(Loss) Margin			\$0.00	0.00	\$0.00
x. Total Revenue Requirement	\$0.00		\$0.00	0.00	\$0.00
y1. Net Medical Expense % of Revenue	0.0%		0.0%		0.0%
y2. Non-Benefit % of Revenue	0.0%		0.0%		0.0%
y3. Gain/(Loss) Margin % of Revenue	0.0%		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		
<b>Basic benefits (user entries must be reported as "per ESRD member per month")</b>		<b>Supplemental Benefits</b>	
CY Revenue			
- CMS capitation		Non-ESRD CY cost sharing reductions	\$0.00
		Non-ESRD CY additional benefits	\$0.00
CY Medical Expenses for Basic Services		ESRD CY cost sharing reductions	
CY Non-Benefit Expenses for Basic Services		ESRD CY additional benefits	
CY Margin Requirement for Basic Services	\$0.00		
CY Gain/(Loss) Margin for Basic Services	\$0.00		
Cost for CY basic benefits allocated to plan members	\$0.00	Incremental CY cost of cost sharing reductions	\$0.00
		Incremental CY cost of additional benefits	\$0.00
		<b>Total CY ESRD "subsidy" =</b>	<b>\$0.00</b>

**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	



**WORKSHEET 6 - MA BID SUMMARY**

Note: See bid instructions for ESRD and hospice exclusions.

**I. General Information**

1. Contract Number:	5. Organization Name:	9. Enrollee Type:	13. Region Name:	N/A
2. Plan ID:	6. Plan Name:	10. MA Region:	N/A	
3. Segment ID:	7. Plan Type:	11. Act. Swap/Equiv Apply:		
4. Contract Year:	2016	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. Max. Pt B premium buydown amt., per CMS	\$104.90	1. PMPM Rebate Allocation for Part B premium (maximum value=\$104.90)		1. Reduce A/B Cost Sharing (max. value=\$0.00)	
		2. Part B Rebate Allocation, rounded to one decimal (see instructions)	\$0.00	2. Other A/B Mand Suppl Benefits (max. value=\$0.00)	

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

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

**IV. Contact Information**

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

**V. Working Model Text Box**

<p>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.</p>
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\* The premiums shown in lines 7 and 9 are estimates. Actual plan premiums will be calculated by CMS when the Part D National Average is determined by CMS. The premiums shown in lines 7 and 9 may not be final.

Note: Premiums are rounded to one decimal (i.e., to the nearest dime) to comply with premium withhold system requirements. See instructions for more information.

**WORKSHEET 7 - OPTIONAL SUPPLEMENTAL BENEFITS**

Note: See bid instructions for ESRD and hospice exclusions.

**I. General Information**

1. Contract	5. Organization Name	9. Enrollee Type:	13. Region Name: N/A
2. Plan ID:	6. Plan Name:	10. MA Region: N/A	
3. Segment	7. Plan Type:	11. Act. Swap/Equi	
4. Contract 2016	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)
Package ID	Description	Allowed Medical Expense PMPM	Enrollee Cost Sharing PMPM	Net PMPM value	Non-Benefit Expense	Gain/(Loss) Margin	Premium	Projected Member Months
1				\$0.00			\$0.00	
2				\$0.00			\$0.00	
3				\$0.00			\$0.00	
4				\$0.00			\$0.00	
5				\$0.00			\$0.00	
	Weighted Avg. Total	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	0

**III. Comments**

**IV. Base Period Summary for 1/1/2014-12/31/2014 (Note: This section must be reported at the contract level.)**

	Net Medical Expenses	Non-Benefit Expenses	Gain/(Loss) Margin	Premium	Member Months
1. 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-2016.1  
OMB Approved # 0938-0944

**I. General Information**

1. Contract Number:		5. Organization Name:		9. Enrollee Type:	A/B
2. Plan ID:		6. Plan Name:			
3. Segment ID:		7. Plan Type:	MSA		
4. Contract Year:	2016	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:	01/01/2014	3. Risk Score				a.	
Incurred to:	12/31/2014	4. Completion Factor				b.	
Paid through:						c.	
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	Additive Adjustments		
			Annualized Util/1000	Avg Cost	Allowed PMPM	Util/1000 Trend	Benefit Plan Change	Population Change	Other Factor		Util/1000	PMPM	
													(c)
a. Inpatient Facility				\$0.00									
b. Skilled Nursing Facility				0.00									
c. Home Health				0.00									
d. Ambulance				0.00									
e. DME/Prosthetics/Supplies				0.00									
f. OP Facility - Emergency				0.00									
g. OP Facility - Surgery				0.00									
h. OP Facility - Other				0.00									
i. Professional				0.00									
j. Part B Rx				0.00									
k. Other Medicare Part B				0.00									
l. COB/Subrg. (outside claim system)													
m. Total Medicare Covered Medical Expenses						\$0.00							

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

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**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: 2016	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			(j) Manual Rate			(l) Exper. Cred. %	(n) 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			
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		
<b>n.</b>	Briefly describe the source for the manual rate, including what trend assumptions were used, if applicable											



**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: 2016	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. Insurer Fees			
6. 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. Corporate Margin Requirement % of Rev.			
j. Corporate Margin Basis	NON-MEDICARE		
k. Overall Gain/(Loss) Margin Level	CONTRACT		

**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:	8. Deductible Amount		

**II. Optional Supplemental Packages**

(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)
Package ID	Description	Allowed Medical Expense PMPM	Enrollee Cost Sharing PMPM	Net PMPM value	Non-Benefit Expense	Gain/(Loss) Margin	Premium	Projected Member Months
1				\$0.00			\$0.00	
2				\$0.00			\$0.00	
3				\$0.00			\$0.00	
4				\$0.00			\$0.00	
5				\$0.00			\$0.00	
	Weighted Avg. Total	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	0

**III. Comments**

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**IV. Base Period Summary for 1/1/2014-12/31/2014 (Note: This section must be reported at the contract level.)**

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

**WORKSHEET 1**

**ESRD Plan Bid Submission**

**Enrollment and PMPM Revenue Projection**

ESRD-2016.1

OMB Approved # 0938-0944

CMS - 10142 (2/28/2015)

**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")	0.215

**I. General Information**

1. Contract Year:	2016	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 reductions	\$0.00
4. Plan intention for target Part D basic Premium	0
5. Quality Bonus Rating (per CMS)	
6. New/low indicator (per CMS)	Not applicable

**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. 2016	Proj. Risk Score	CY 2016 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 PMPM**

<b>I. General Information</b>			
1. Contract Year:	2016	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		

Section II 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	21.0%	0.00	0.00
Home health			\$0.00	0.0%	0.00	0.00
Outpatient hospital / ASC			\$0.00	20.0%	0.00	0.00
Emergency Room			\$0.00	20.0%	0.00	0.00
Dialysis			\$0.00	20.0%	0.00	0.00
Primary care physician			\$0.00	20.0%	0.00	0.00
Nephrologist			\$0.00	20.0%	0.00	0.00
Physician specialist (o/t nephrologist)			\$0.00	20.0%	0.00	0.00
Other professional			\$0.00	20.0%	0.00	0.00
Radiology / pathology			\$0.00	20.0%	0.00	0.00
Ambulance / transportation			\$0.00	20.0%	0.00	0.00
DME / supplies			\$0.00	20.0%	0.00	0.00
Part B Rx: Medicare-covered			\$0.00	20.0%	0.00	0.00
Other Part B services			\$0.00	20.0%	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>						
Sales & Marketing				Corporate Margin Requirement % of Rev.		
Direct Administration				Corporate Margin Basis	NON-MEDICARE	
Indirect Administration				Overall Gain/(Loss) Margin Level	CONTRACT	
Net Cost of Private Reinsurance						
Insurer Fees						
Gain / loss margin						
Total NBE+GLM			\$0.00			
Total plan cost			\$0.00			
CMS capitation			\$0.00			
Part C mandatory enrollee premium			\$0.00			
Medicare-covered benefits	Benefit Cost	NBE+GLM	Total Cost			
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			
<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)

Section III Development of Estimated Plan Premium	
<b>Part B Premium Reduction</b>	
1. PMPM reduction for Part B premium	
2. Part B Premium Reduction, rounded to one decimal (see instructions)	\$0.00
3. Total MA Enrollee Premium (excl. Opt. Suppl.)	0.00
4. <b>Rounded MA Premium (excl. Opt. Suppl.)</b>	<b>\$0.00</b>
<b>5. Part D Basic Premium</b>	
5a. Prior to reductions (rounded value from Rx BPT)	
5b. Part D Basic Premium reduction	
5c. Part D Basic Premium reduction (rounded)	\$0.00
5d. <b>Part D Basic Premium*</b>	<b>\$0.00</b>
<b>6. Part D Supplemental Premium</b>	
6a. Prior to reductions (rounded value from Rx BPT)	
6b. Part D Suppl Premium reduction	
6c. Part D Suppl Premium reduction (rounded)	\$0.00
6d. <b>Part D Supplemental Premium</b>	<b>\$0.00</b>
7. <b>Total estimated plan premium*</b>	<b>\$0.00</b>
8. <b>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 2014**

<b>I. General Information</b>			
1. Contract Year:	2016	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		

<b>II. Contact Information</b>	
<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	
Date Prepared	

<b>Section III</b>	<b>Revenues</b>	
	CY 2014	
	Enrollment	PMPM
Member months		n/a
CMS payments 1/	n/a	
Enrollee premium 1/	n/a	
Total revenue	n/a	\$0.00

<b>Section IV</b>	<b>Medical Benefits (PMPM) 2/</b>			
	CY 2014			
	Claims incurred in period paid thru 03/31/2015	Claim reserve as of 03/31/2015	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	
Total benefit costs	\$0.00	\$0.00	\$0.00	
<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 2014 are to include an estimate of final risk adjustment settlement to be received in mid-2015.  
 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

I. General Information		6. Contract #:	0
1. Contract Year:	2016	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)	(e)	(f)	(g)	(h)	(i)	(j)
Package ID	Description	Allowed Medical Expense PMPM	Enrollee Cost Sharing PMPM	Net PMPM value	Non-Benefit Expense	Gain/(Loss) Margin	Premium	Projected Member Months
1				\$0.00			\$0.00	
2				\$0.00			\$0.00	
3				\$0.00			\$0.00	
4				\$0.00			\$0.00	
5				\$0.00			\$0.00	
	Weighted Avg. Total	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	0

III. Comments

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IV. Base Period Summary for 1/1/2014-12/31/2014 (Note: This section must be reported at the contract level.)

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