

WORKSHEET 1 - MA BASE PERIOD EXPERIENCE AND PROJECTION ASSUMPTIONS

Note: See bid instructions for ESRD and hospice exclusions.

MA-2019.1

OMB Approved # 0938-0944 (Expires: TBD)

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/Equip Apply:			
4. Contract Year:	2019	8. MA-PD:		12. SNP:		14. SNP Type:	N/A
						15. VBID:	N

II. Base Period Background Information

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

1. Time Period Definition	Incurred from:	01/01/2017	2. Member Months	Total	0	Non-DE#		DE#	0	5. Bids In Base	Contr-Plan-Seg ID	Member Months	Contr-Plan-Seg ID	Member Months
	Incurred to:	12/31/2017		Risk Score				0.0000						
	Paid through:			4. Completion Factor										

III. Base Period Data (at Plan's Risk Factor) for 1/1/2017-12/31/2017

IV. Projection Assumptions

Service Category	(b) Utilizers	(c) Net PMPM	(d) Cost Sharing	(e) Util Type	(g) Total Benefits			(j) Util. Adjustments to Contract Period				(n) Unit Cost Adjustment		(p) Additive Adjustments	
					(h) Annualized Util/1000	(h) Avg Cost per Unit	(i) Allowed PMPM	(k) Util/1000 Trend	(k) Benefit Plan Change	(l) Population Change	(m) Other Factor	(o) Provider Payment Change	(o) Other Factor	(p) Util/1000	(q) 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/Diabetes			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. Suppl. Ben. Chpt 4 (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. Base Period Summary for 1/1/2017-12/31/2017 (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			
PMPMs:					7f. Total Non-Benefit Expenses	\$0	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				

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:		15. VBID: N
4. Contract Year: 2019	8. MA-PD:	12. SNP:	14. SNP Type:	N/A

II. Projected Allowed Costs

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

Contract Year Allowed Costs at Plan's Risk Factor:											Total	Non-DE#	DE#		
											1. Projected member months	0	0	0	
											2. Projected risk factor	0.0000	0.0000	0.0000	
(c)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(l)	(m)	(n)	(o)	(p)	(q)	(r)	
Service Category	Util Type	Projected Experience Rate			Manual Rate			Credibility	Blended Rate			% of svcs provided OON			
		Annual Util/1000	Avg Cost per Unit	Allowed PMPM	Annual Util/1000	Avg Cost per Unit	Allowed PMPM		Annual Util/1000	Avg Cost per Unit	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/Diabetes		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. Suppl. Ben. Chpt 4 (Non-Covered)		0	0.00	0.00		0.00			0	0.00	0.00				
q. Other Non-Covered		0	0.00	0.00		0.00			0	0.00	0.00				
r. COB/Subrg. (outside claim system)				0.00							0.00				
s. Total Medical Expenses				\$0.00			\$0.00	0%			\$0.00	\$0.00	\$0.00		
								0%	CMS Guideline Credibility						
t. Subtotal Medicare-covered service categories				\$0.00			\$0.00	0%			\$0.00	\$0.00	\$0.00		

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 Apply:		15. VBID: N
4. Contract Year: 2019	8. MA-PD:	12. SNP:	14. SNP Type:	N/A

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
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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 Deductible PMPM*	(g) In-Network Cost Sharing After Deductible				(i) Effective Copay / Coin Before OOP Max	(j) **Effective Copay / Coin After OOP Max	(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)
				(g) In-Network Util/1000 or PMPM	(h) Description of Cost Sharing / Add'l Days / Benefit Limits****	(g) Effective Copay / Coin Before OOP Max	(j) **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/Diabetes	DME								0.00	0.00			0.00
e.2.	DME/Prosthetics/Diabetes	Prosthetics/Diabetes								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.	Suppl. Ben. Chpt 4 (Non-Covered)									0.00	0.00			0.00
q.	Other Non-Covered									0.00	0.00			0.00
s.	Total		\$0.00							\$0.00	\$0.00		\$0.00	\$0.00

t. Actual combined plan deductible: *Actual in-network plan deductible: ***Actual OON plan deductible:

u. ** PMPM impact of in-network OOP max: ***PMPM impact of OON OOP max:

IV. Mapping of BPB service categories to BPT

BPB 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
18a	o1
18b	o2
19a	
19b	

****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:		15. VBID: N
4. Contract Year: 2019	8. MA-PD:	12. SNP:	14. SNP Type:	N/A

II. Development of Projected Revenue Requirement

A. Non-DE# (Non-Dual Eligible Beneficiaries AND Dual Eligible Beneficiaries with full Medicare cost sharing liability)

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

(c) Service Category	(e) Total Benefits			(g) % for Cov. Svcs		(k) FFS Medicare Act. Equiv. cost sharing	(l) Plan cost sh. for Medicare-covered svcs.	(m) Medicare Covered (w/AE cost sh.)			(p) A/B Mand Suppl (MS) Benefits		
	(e) Allowed PMPM	(f) Plan Cost Sharing	(g) Net PMPM	(h) Allowed	(i) Cost Sharing			(m) Allowed PMPM	(n) FFS AE Cost Sharing	(o) Net PMPM	(p) Net PMPM for Add'l Svcs.	(q) Reduction of A/B Cost Sh.	(r) Total
a. Inpatient Facility	\$0.00	\$0.00	\$0.00			0.0%	\$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/Diabetes	0.00	0.00	0.00			0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00
f. OP Facility - Emergency	0.00	0.00	0.00			0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00
g. OP Facility - Surgery	0.00	0.00	0.00			0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00
h. OP Facility - Other	0.00	0.00	0.00			0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00
i. Professional	0.00	0.00	0.00			0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00
j. Part B Rx	0.00	0.00	0.00			0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00
k. Other Medicare Part B	0.00	0.00	0.00			0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00
l. Transportation (Non-Covered)	0.00	0.00	0.00	0.00%	0.00%	0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00
m. Dental (Non-Covered)	0.00	0.00	0.00	0.00%	0.00%	0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00
n. Vision (Non-Covered)	0.00	0.00	0.00	0.00%	0.00%	0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00
o. Hearing (Non-Covered)	0.00	0.00	0.00	0.00%	0.00%	0.0%	0.00	0.00	0.00	0.00	0.00	0.00	0.00
p. Suppl. Ben. Chpt 4 (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

B. DE# (Dual Eligible Beneficiaries without full Medicare cost sharing liability)

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

(c) Service Category	(e) Total Benefits			(g) % for Cov. Svcs		(k) State Medicaid Required Bene. cost sharing	(l) Actual cost sh. for Medicare-covered svcs.	(m) Medicare Covered (w/Medicaid cost sh.)			(p) A/B Mand Suppl (MS) Benefits		
	(e) Reimb + Actual Cost Sh.	(f) Plan Cost Sharing	(g) Actual Cost Sharing	(h) Plan Reimb	(i) Allowed			(j) Cost Sharing	(m) Allowed PMPM	(n) Medicaid Cost Sharing	(o) Net PMPM	(p) Net PMPM for Add'l Svcs.	(q) Reduction of A/B Cost Sh.
a. Inpatient Facility	\$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
c. Home Health	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
e. DME/Prosthetics/Diabetes	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
g. OP Facility - Surgery	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
i. Professional	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
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
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
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
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
o. Hearing (Non-Covered)	0.00	0.00	0.00		0.00%	0.00%	0.00	0.00	0.00	0.00	0.00	0.00	0.00
p. Suppl. Ben. Chpt 4 (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
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
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
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

C. All Beneficiaries

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

(c) Service Category	(e) Total Benefits			(h) Net PMPM	(i)	(j)	(k)	(l)	(m) Medicare Covered		(p) A/B Mand Suppl (MS) Benefits		
	(e)	(f)	(g)						(m)	(n)	(p)	(q)	(r)

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:		15. VBID: N
4. Contract Year: 2019	8. MA-PD:	12. SNP:	14. SNP Type:	N/A

II. Development of Projected Revenue Requirement

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/Diabetes		0.00				0.00	0.00	0.00	0.00
f. OP Facility - Emergency		0.00				0.00	0.00	0.00	0.00
g. OP Facility - Surgery		0.00				0.00	0.00	0.00	0.00
h. OP Facility - Other		0.00				0.00	0.00	0.00	0.00
i. Professional		0.00				0.00	0.00	0.00	0.00
j. Part B Rx		0.00				0.00	0.00	0.00	0.00
k. Other Medicare Part B		0.00				0.00	0.00	0.00	0.00
l. Transportation (Non-Covered)		0.00				0.00	0.00	0.00	0.00
m. Dental (Non-Covered)		0.00				0.00	0.00	0.00	0.00
n. Vision (Non-Covered)		0.00				0.00	0.00	0.00	0.00
o. Hearing (Non-Covered)		0.00				0.00	0.00	0.00	0.00
p. Suppl. Ben. Chpt 4 (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.									
t. COB/Subrg. (outside claim system)		0.00				0.00	0.00	0.00	0.00
u. Total Medical Expenses		\$0.00				\$0.00	\$0.00	\$0.00	\$0.00
v. Non-Benefit Expense:									
1. Sales & Marketing			z1. Corporate Margin Requirement % of Rev.			\$0.00			\$0.00
2. Direct Administration			z2. Corporate Margin Basis			0.00			0.00
3. Indirect Administration			z3. Overall Gain/(Loss) Margin Level			0.00			0.00
4. Net Cost of Private Reinsurance						0.00			0.00
5. Insurer Fees			z4. Is this bid part of a valid product pairing?			0.00			0.00
6. Total Non-Benefit Expense		\$0.00	z5. Bids in Product Pairing			\$0.00	0.00	0.00	\$0.00
w. Gain/(Loss) Margin						\$0.00	0.00	0.00	\$0.00
x. Total Revenue Requirement		\$0.00				\$0.00	0.00	0.00	\$0.00
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		
Basic benefits (user entries must be reported as "per ESRD member per month")		Supplemental Benefits	
CY Revenue			
- CMS capitation		Non-ESRD CY cost sharing reductions	\$0.00
		Non-ESRD CY additional benefits	\$0.00
CY Medical Expenses for Basic Services			
CY Non-Benefit Expenses for Basic Services		ESRD CY cost sharing reductions	
CY Margin Requirement for Basic Services	\$0.00	ESRD CY additional benefits	
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
		Total CY ESRD "subsidy" =	\$0.00

IV. 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:	15. VBID:	N	
4. Contract Year:	2019	8. MA-PD:	12. SNP:	14. SNP Type:	N/A

II. Other Information

A. Part B Information	B. Rebate Allocation for Part B Premium	C. Rebate Allocations
1. Maximum Pt B premium buydown amt., per CMS \$131.00	1. PMPM Rebate Allocation for Part B premium (maximum value=\$131.00) [Redacted]	1. Reduce A/B Cost Sharing (max. value=\$0.00) [Redacted]
	2. Part B Rebate Allocation, rounded to one decimal (see instructions) \$0.00	2. Other A/B Mand Suppl Benefits (max. value=\$0.00) [Redacted]

III. Plan A/B Bid Summary

A. Overview	B. MA Rebate Allocation	C. Development of Estimated Plan Premium																																																																																																																													
<table border="1"> <thead> <tr> <th></th> <th>Medicare-covered</th> <th>A/B Mandatory Supplemental</th> </tr> </thead> <tbody> <tr> <td>1. Net medical cost</td> <td>\$0.00</td> <td>\$0.00</td> </tr> <tr> <td>2. Non-benefit expense</td> <td>\$0.00</td> <td>\$0.00</td> </tr> <tr> <td>3. Gain / loss margin</td> <td>0.00</td> <td>0.00</td> </tr> <tr> <td>4. Total revenue requirement</td> <td>\$0.00</td> <td>\$0.00</td> </tr> <tr> <td>5. Standardized A/B Benchmark</td> <td>\$0.00</td> <td></td> </tr> <tr> <td>6. Plan A/B Benchmark</td> <td>\$0.00</td> <td></td> </tr> <tr> <td>7. Risk Factor</td> <td>0.0000</td> <td></td> </tr> <tr> <td>8. Conversion Factor</td> <td>0.0000</td> <td></td> </tr> </tbody> </table>		Medicare-covered	A/B Mandatory Supplemental	1. Net medical cost	\$0.00	\$0.00	2. Non-benefit expense	\$0.00	\$0.00	3. Gain / loss margin	0.00	0.00	4. Total revenue requirement	\$0.00	\$0.00	5. Standardized A/B Benchmark	\$0.00		6. Plan A/B Benchmark	\$0.00		7. Risk Factor	0.0000		8. Conversion Factor	0.0000		<table border="1"> <thead> <tr> <th rowspan="2"></th> <th colspan="4">Rebate PMPM Allocation</th> <th rowspan="2">Maximum Value</th> </tr> <tr> <th>Medical</th> <th>Non-Benefit</th> <th>Gain / (Loss)</th> <th>Total</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>131.00</td> </tr> <tr> <td>5. Pt D Premium Buydown Basic</td> <td>0.00</td> <td>n/a</td> <td>n/a</td> <td>0.00</td> <td>0.00</td> </tr> <tr> <td>6. Pt D Premium Buydown Suppl</td> <td>0.00</td> <td>n/a</td> <td>n/a</td> <td>0.00</td> <td>0.00</td> </tr> <tr> <td>7. 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A/B rebates allocated to Part D Suppl Premium	[Redacted]	8c. A/B rebates for Part D Suppl Premium (rounded)	\$0.00	8d. Part D Supplemental Premium	\$0.00	9. Total estimated plan premium*	\$0.00	10. Plan Intention for target PD basic premium	[Redacted]
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IV. Contact Information

MA Plan Bid Contact:
 Name, Position [Redacted]
 Phone Number [Redacted]
 Email Address [Redacted]

MA Certifying Actuary:
 Name, Credentials [Redacted]
 Phone Number [Redacted]
 Email Address [Redacted]

MA Additional BPT Actuarial Contact:
 Name, Position [Redacted]
 Phone Number [Redacted]
 Email Address [Redacted]

Date Prepared [Redacted]

V. Working Model Text Box

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

[Redacted]

* 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 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:		15. VBID: N
4. Contract Year: 2019	8. MA-PD:	12. SNP:	14. SNP Type:	N/A

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

IV. Base Period Summary for 1/1/2017-12/31/2017 (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-2019.1

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:	2019	8. Deductible Amount:			

II. Base Period Background Information

1. Time Period Definition	2. Member Months	5. Bids In Base	Contr-Plan-Seg ID	% of MMs
Incurring from: 01/01/2017			a.	
Incurring to: 12/31/2017			b.	
Paid through:			c.	
			d.	
6. Describe the source of the base period experience data				

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

IV. Projection Assumptions

Service Category	Utilizers	Util Type	Total Benefits			Util. Adjustments to Contract Period				Unit Cost/ Intensity Trend	Additive Adjustments			
			Annualized Util/1000	Avg Cost per Unit	Allowed PMPM	Util/1000 Trend	Benefit Plan Change	Population Change	Other Factor		Util/1000	PMPM		
													(c)	(e)
a. Inpatient Facility				\$0.00										
b. Skilled Nursing Facility				0.00										
c. Home Health				0.00										
d. Ambulance				0.00										
e. DME/Prosthetics/Diabetes				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									

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: 2019	8. Deductible Amount:		

II. Projected Allowed Costs

Contract Year Allowed Costs at Plan's Risk Factor:												
(c)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(l)	(m)	(n)	(o)	(p)
Service Category	Util Type	Projected Experience Rate			Manual Rate			Exper. Cred. %	Contract Year Rate			% of svcs provided OON
		Annual Util/1000	Avg Cost per Unit	Allowed PMPM	Annual Util/1000	Avg Cost per Unit	Allowed PMPM		Annual Util/1000	Avg Cost per Unit	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/Diabetes		0	0.00	0.00		0.00			0	0.00	0.00	
f. OP Facility - Emergency		0	0.00	0.00		0.00			0	0.00	0.00	
g. OP Facility - Surgery		0	0.00	0.00		0.00			0	0.00	0.00	
h. OP Facility - Other		0	0.00	0.00		0.00			0	0.00	0.00	
i. Professional		0	0.00	0.00		0.00			0	0.00	0.00	
j. Part B Rx		0	0.00	0.00		0.00			0	0.00	0.00	
k. Other Medicare Part B		0	0.00	0.00		0.00			0	0.00	0.00	
l. COB/Subrg. (outside claim system)				0.00							0.00	
m. Total Medicare Covered Medical Expenses				\$0.00			\$0.00	0%			\$0.00	
								0%	CMS Guideline Credibility			

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: 2019	8. Deductible Amount:	

II. Development of Claim Information Intervals (Plan's Risk Factor and Exclude Services Covered Within the Deductible)

	(c)	(d)	(e)	(f)	(g)
	Annual Projected Claim Interval	Annual Average Claim Amount	Percentage of Member Months (Only Use Highest Claim Interval)	Gross Claims (PMPM)	Gross Claims Over Deductible (PMPM)
1.	\$0-\$250			\$0.00	
2.	\$251-\$2,000			0.00	
3.	\$2001-\$4,000			0.00	
4.	\$4001-\$6,000			0.00	
5.	\$6001-\$8,000			0.00	
6.	\$8001-\$10,000			0.00	
7.	\$10,001-\$12,000			0.00	
8.	\$12,001-\$15,000			0.00	
9.	\$15,001-\$20,000			0.00	
10.	\$20,001-\$30,000			0.00	
11.	\$30,001-\$50,000			0.00	
12.	\$50,001-\$70,000			0.00	
13.	over \$70,000			0.00	
	Total		0.00%	\$0.00	\$0.00

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			
k. Overall Gain/(Loss) Margin Level			

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: 2019	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. Base Period Summary for 1/1/2017-12/31/2017 (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-2019.1
OMB Approved # 0938-0944
CMS - 10142 (4/30/2017)

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:	2019	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. 2019	Proj. Risk Score	CY 2019 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 Revenue Requirement PMPM

I. General Information		6. Contract #: 0
1. Contract Year:	2019	7. Plan ID:
2. Contract-Plan-Segment:	0_000_00	8. Segment ID:
3. Organization Name:	0	
4. Service Area:	0	
5. Plan type:	ESRD SNP	

Section II Projection of Revenue Requirement PMPM				Mandatory Supplemental Benefits		
Service category	Allowed cost	Enrollee cost sharing	Net PMPM	Medicare AE cost sharing proportion	Medicare AE cost sharing value	Cost sharing enhancements
Inpatient hospital			\$0.00	6.3%	\$0.00	\$0.00
Skilled nursing facility			\$0.00	19.2%	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 / Diabetes			\$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			\$0.00			0.00
Sub-total: Medicare-covered services	\$0.00	\$0.00	\$0.00	Sub-total cost sharing	\$0.00	\$0.00
Other: Part B premium reduction			0.00	Other: Part B premium reduction		0.00
Other: Part D Basic premium reduction			0.00	Other: Part D Basic premium reduction		0.00
Other: Part D Supp premium reduction			0.00	Other: Part D Supp premium reduction		0.00
Additional services			0.00	Additional services		0.00
Sub-total: premium reductions + add'l services net PMPM			\$0.00	Sub-total: prem reduct + add'l svcs net PMPM		\$0.00
Total benefit cost			\$0.00	Total benefit cost - mand. supplemental		\$0.00
Non-benefit Expenses (NBE) and Gain Loss Margin (GLM)						
Sales & Marketing				Corporate Margin Requirement % of Revenue		
Direct Administration				Corporate Margin Basis		
Indirect Administration				Overall Gain/(Loss) Margin Level		
Net Cost of Private Reinsurance						
Insurer Fees				Total Benefit Cost % of Revenue		0.0%
Sub-total non-benefit expenses			\$0.00	Total Non-Benefit Expense % of Revenue		0.0%
Gain / loss margin				Gain/ loss margin % of Revenue		0.0%
Total NBE + GLM			\$0.00	Total NBE + GLM % of Revenue		0.0%
Total Revenue Requirement			\$0.00			
CMS capitation			\$0.00			
Part C mandatory enrollee premium			\$0.00			
Summary of Total Revenue Requirement						
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			
Mandatory supplemental benefits	\$0.00	\$0.00	\$0.00			
Medicare covered and mand. supplemental benef	\$0.00	\$0.00	\$0.00			

Section III Development of Estimated Plan Premium	"Excess Funds"	\$0.00
Funds for Part B & Part D premium reductions		\$0.00
Part B Premium Reduction		
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. Rounded MA Premium (excl. Opt. Suppl.)		\$0.00
5. Part D Basic Premium		
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. Part D Basic Premium*		\$0.00
6. Part D Supplemental Premium		
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. 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 2017

I. General Information		6. Contract #:	0
1. Contract Year:	2019	7. Plan ID:	
2. Contract-Plan-Segment:	0_000_00	8. Segment ID:	
3. Organization Name:	0		
4. Service Area:	0		
5. Plan type:	ESRD SNP		

II. Contact Information	
ESRD-SNP Plan Contact Person:	
Name, Position	
Phone Number	
Email Address	
ESRD-SNP Certifying Actuary:	
Name, Creden.	
Phone Number	
Email Address	
Date Prepared	

Section III	Revenues	
	CY 2017	
	Enrollment	PMPM
Member months		n/a
CMS payments	n/a	
Enrollee premium	n/a	
Total revenue	n/a	\$0.00

Section IV	Components of Revenue (PMPM)			
	Service category	CY 2017		
		Claims incurred in period paid thru	Claim reserve as of	Incurred claims
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 / Diabetes			0.00	
Part B Rx: Medicare-covered			0.00	
Other Part B services			0.00	
Coordination of benefits			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 Expenses (NBE) and Gain Loss Margin (GLM)				
Sales & Marketing				
Direct Administration				
Indirect Administration				
Net Cost of Private Reinsurance				
Insurer Fee				
Sub-total non-benefit exp.			\$0.00	
Gain / loss margin				
Total NBE+GLM			\$0.00	
Total Revenue			\$0.00	

WORKSHEET 4

ESRD Plan Bid Submission

OPTIONAL SUPPLEMENTAL BENEFITS

I. General Information		6. Contract #:	0
1. Contract Year:	2019	7. Plan ID:	
2. Contract-Plan-Segment:	0_000_00	8. Segment ID:	
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. Base Period Summary for 1/1/2017-12/31/2017 (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	

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