WORKSHEET 1 - MA BASE PERIOD EXPERIENCE AND PROJECTION ASSUMPTIONS

Note: See bid instructions for ESRD and hospice exclusions.

MA-2020.1

OMB Approved # 0938-0944 (Expires: 2/28/2021)

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:	2020	8. MA-PD:		12. SNP:		14. SNP Type:	N/A

II. Base Period Background Information

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

			Total	Non-DE#	DE#
1. Time Period Definition		2. Member Months	0		0
Incurred from:	01/01/2018	3. Risk Score			0.0000
Incurred to:	12/31/2018	4. Completion Factor			
Paid through:					

5. Bids In Base

Contr-Plan-Seg ID	Member Months	Contr-Plan-Seg ID	Member Months

III. Base Period Data (at Plan's Risk Factor) for 1/1/2018-12/31/2018

IV. Projection Assumptions

	(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(l)	(m)	(n)	(o)	(p)	(q)
						Total Benefits			Util. Adjustments to Contract Period				Unit Cost Adjustment		Additive Adjustments	
	Service Category	Utilizers	Net PMPM	Cost Sharing	Util Type	Annualized Util/1000	Avg Cost per Unit	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/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 1/1/2018-12/31/2018 (excludes Optional Supplemental)

	ESRD	Hospice	All Other	Total
1. CMS Revenue				$0
2. Premium Revenue				$0
3. Total Revenue	$0	$0	$0	$0
4. Net Medical Expenses				$0
5. Member Months			0	0
PMPMs:				
6a. Revenue PMPM	$0.00	$0.00	$0.00	$0.00
6b. Net Medical PMPM	$0.00	$0.00	$0.00	$0.00
6c. Non-Benefit PMPM				$0.00
6d. Gain/(Loss) Margin PMPM				$0.00

Non-Benefit Expenses:		8. Gain/(Loss) Margin	$0
7a. Sales & Marketing			
7b. Direct Administration		Percentage of Revenue:	
7c. Indirect Administration		9a. Net Medical Expenses	0.0%
7d. Net Cost of Private Reinsurance		9b. Non-Benefit Expenses	0.0%
7e. Insurer Fees		9c. Gain/(Loss) Margin	0.0%
7f. Total Non-Benefit Expenses	$0		
		10a. Medicaid Revenue	
		10b. Medicaid Cost	$0
		10b1. Benefit expenses	
		10b2. Non-benefit expenses	

PRA Disclosure Statement *According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0944. The time required to complete this information collection is estimated to average 30 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.*

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:	2020	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)
		Projected Experience Rate			Manual Rate				Blended Rate					
Service Category	Util Type	Annual Util/1000	Avg Cost per Unit	Allowed PMPM	Annual Util/1000	Avg Cost per Unit	Allowed PMPM	Credibility	Annual Util/1000	Avg Cost per Unit	Total Allowed PMPM	Non-DE# Allowed PMPM	DE# Allowed PMPM	% of svcs provided 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/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:	2020	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		

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

	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(l)	(m)	(n)	(o)
					In-Network Cost Sharing After Deductible								
	Service Category	Description	Measure-ment Unit Code	In-Network Effective Deductible PMPM*	In-Network Util/1000 or PMPM	Description of Cost Sharing / Add'l Days / Benefit Limits****	Effective Copay / Coin Before OOP Max	**Effective Copay / Coin After OOP Max	In-Network PMPM	Total In-Network Cost Share PMPM	Out-of-Network Description of Cost Sharing / . . . Benefit Limits****	Out-of-Network Cost Sharing PMPM***	Grand Total Cost Share PMPM (INN+OON)
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
									0.00	0.00			0.00
									0.00	0.00			0.00
									0.00	0.00			0.00
									0.00	0.00			0.00
									0.00	0.00			0.00
									0.00	0.00			0.00
									0.00	0.00			0.00
									0.00	0.00			0.00
									0.00	0.00			0.00
s.	**Total**			$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:

****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
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	

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:	2020	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)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(l)	(m)	(n)	(o)	(p)	(q)	(r)
	Total Benefits				**% for Cov. Svcs**		FFS Medicare	Plan cost sh.	**Medicare Covered (w/AE cost sh.)**			**A/B Mand Suppl (MS) Benefits**		
Service Category	Allowed PMPM	Plan Cost Sharing		Net PMPM	Allowed	Cost Sharing	Actl. Equiv. cost sharing	for Medicare-covered svcs.	Allowed PMPM	FFS AE Cost Sharing	Net PMPM	Net PMPM for Add'l Svcs.	Reduction of 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/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**	**$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)	(l)	(m)	(n)	(o)	(p)	(q)	(r)
	Total Benefits				**% for Cov. Svcs**		State Medicaid	Actual cost sh.	**Medicare Covered (w/Medicaid cost sh.)**			**A/B Mand Suppl (MS) Benefits**		
Service Category	Reimb + Actual Cost Sh.	Plan Cost Sharing	Actual Cost Sharing	Plan Reimb	Allowed	Cost Sharing	Required Bene. cost sharing	for Medicare-covered svcs.	Allowed PMPM	Medicaid Cost Sharing	Net PMPM	Net PMPM for Add'l Svcs.	Reduction of 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
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**	**$0.00**

C. All Beneficiaries

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

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

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:	2020	8. MA-PD:		12. SNP:		14. SNP Type:	N/A

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	$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		$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	**$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%**

z1. Corporate Margin Requirement % of Rev.
z2. Corporate Margin Basis
z3. Overall Gain/(Loss) Margin Level
z4. Is this bid part of a valid product pairing?
z5. Bids in Product Pairing

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		
		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. 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 5 - MA BENCHMARK PMPM

Note: See bid instructions for ESRD and hospice exclusions.

I. General Information

1. Contract Number:		5. Organization Name:		9. Enrollee Type:		13. Region Name:	N/A
2. Plan ID:		6. Plan Name:		10. MA Region:	N/A		
3. Segment ID:		7. Plan Type:		11. Act. Swap/Equiv Apply:		15. VBID:	N
4. Contract Year:	2020	8. MA-PD:		12. SNP:		14. SNP Type:	N/A

II. Benchmark and Bid Development

	Total	Non-DE#	DE#
1. Member Months (Section VI)	**0**		**0**
2. Standardized A/B Benchmark (@ 1.000)	**$0.00**		
3. Medicare Secondary Payer Adjustment			
4. Weighted Avg Risk Factor	0		0
5. Conversion Factor	0		
6. Plan A/B Benchmark	**$0.00**		
7. Plan A/B Bid	**$0.00**		
8. Standardized A/B Bid (@ 1.000)	**$0.00**		

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

III. Savings/Basic Member Premium Development

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

IV. Standardized A/B Benchmark - Regional Plans Only

	Weighting	
1. Statutory Component - Region N/A	64.7%	
2. Plan Bid Component (from CMS)*	35.3%	N/A
3. Standardized A/B Benchmark	100.0%	

** See instructions - if Line 2 is not filled in, then Line 8 of Section II will be used.*

V. Quality Rating

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

VIII. Projected CY Member Months

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

VI: County Level Detail and Service Area Summary

VII: Other Medicare Information

1. Use of plan-provided ISAR factors? (Regional Plans only - enter Yes or No)

(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(l)	(m)	(n)	(o)	(p)	(q)	(r)	(s)	(t)	(u)
State/County Code	State	County Name	Proj Member Months	Proj Risk Factors	Plan Provided ISAR factors	MA Risk Ratebook Unadjusted	MA Risk Ratebook Risk-Adjusted	ISAR scale	ISAR-Adjusted Bid	Risk Payment Rate A only	Risk Payment Rate B only	Original Medicare cost sharing (c.s.) Inpatient	Original Medicare cost sharing (c.s.) SNF	Original Medicare cost sharing (c.s.) Pt B (excl HH)	FFS costs to weight Medicare c.s. Inpatient	FFS costs to weight Medicare c.s. SNF	FFS costs to weight Medicare c.s. Pt B (excl HH)	Metropolitan Statistical Area MM	Metropolitan Statistical Area MSA name
2. Total or Weighted Average for Service Area:			0	0	0.00	$0.00	$0.00	0	$0.00	43.790%	56.210%	0.0%	0.0%	0.0%	n/a	n/a	n/a	0	n/a
3. County Level Detail:																		0%	predominant MSA
Out of Area																			

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:	2020	8. MA-PD:		12. SNP:		14. SNP Type:	N/A

II. Other Information

A. Part B Information

1. Maximum Pt B premium buydown amt., per CMS	$131.00

B. Rebate Allocation for Part B Premium

1. PMPM Rebate Allocation for Part B premium (maximum value=$131.00)	
2. Part B Rebate Allocation, rounded to one decimal (see instructions)	$0.00

C. Rebate Allocations

1. Reduce A/B Cost Sharing (max. value=$0.00)	
2. Other A/B Mand Suppl Benefits (max. value=$0.00)	

III. Plan A/B Bid Summary

A. Overview

	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	

B. MA Rebate Allocation

	Rebate PMPM Allocation				Maximum
	Medical	Non-Benefit	Gain / (Loss)	Total	Value
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	131.00
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	

C. Development of Estimated Plan Premium

1. A/B Mandatory Supplemental revenue requirements	$0.00
2. Less rebate allocations:	
2a. Reduce A/B Cost Sharing	0.00
2b. Other A/B Mand Supplemental Benefits	0.00
3. A/B Mandatory Supplemental premium	0.00
4. Basic MA premium	0.00
5. Total MA Enrollee Premium (excl. Opt. Suppl.)	0.00
6. Rounded MA Premium (excl. Opt. Suppl.)	**$0.00**
7. Part D Basic Premium	
7a. Prior to rebates (rounded value from Rx BPT)	
7b. A/B rebates allocated to Part D Basic Premium	
7c. A/B rebates for Part D Basic Premium (rounded)	$0.00
7d. Part D Basic Premium*	**$0.00**
8. Part D Supplemental Premium	
8a. Prior to rebates (rounded value from Rx BPT)	
8b. A/B rebates allocated to Part D Suppl Premium	
8c. A/B rebates for Part D Suppl Premium (rounded)	$0.00
8d. Part D Supplemental Premium	**$0.00**
9. Total estimated plan premium*	**$0.00**
10. Plan Intention for target PD basic premium	

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

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

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 Actuarial 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.

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:	2020	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

III. Base Period Summary for 1/1/2018-12/31/2018 (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-2020.1

OMB Approved # 0938-0944 (Expires: 2/28/2021)

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:	2020	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
Incurred from:	01/01/2018	3. Risk Score			a.	
Incurred to:	12/31/2018	4. Completion Factor			b.	
Paid through:					c.	
					d.	

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

IV. Projection Assumptions

	(c)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(l)	(m)	(n)	(o)	(p)
				Total Benefits			Util. Adjustments to Contract Period						
	Service Category	Utilizers	Util Type	Annualized Util/1000	Avg Cost per Unit	Allowed PMPM	Util/1000 Trend	Benefit Plan Change	Population Change	Other Factor	Unit Cost/ Intensity Trend	Additive Adjustments Util/1000	Additive Adjustments PMPM
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**							

PRA Disclosure Statement *According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0944. The time required to complete this information collection is estimated to average 30 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.*

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:	2020	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)
		Projected Experience Rate			Manual Rate			Exper.	Contract Year Rate			% of svcs
Service Category	Util Type	Annual Util/1000	Avg Cost per Unit	Allowed PMPM	Annual Util/1000	Avg Cost per Unit	Allowed PMPM	Cred. %	Annual Util/1000	Avg Cost per Unit	Allowed PMPM	provided 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/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 3 - MSA BENCHMARK PMPM

Note: See bid instructions for ESRD and hospice exclusions.

I. General Information

1. Contract Number:		5. Organization Name:		9. Enrollee Type:	A/B
2. Plan ID:		6. Plan Name:			
3. Segment ID:		7. Plan Type:	MSA		
4. Contract Year:	2020	8. Deductible Amount:			

II. Contact Information

MSA Plan Contact Person:
Name, Position
Phone Number
Email Address

MSA Certifying Actuary:
Name, Credentials
Phone Number
Email Address

MSA Additional BPT Actuarial Contact:
Name, Position
Phone Number
Email Address

Date Prepared (MM/DD/YYYY)

IV. Quality Bonus Rating

1. Quality Bonus Rating	
2. New/low indicator (per CMS)	Not applicable

III: County Level Detail and Service Area Summary

(b) State/County Code	(c) State	(d) County Name	(e) Projected Member Months	(f) Projected Risk Factors	(g) MA Risk Ratebook Unadjusted	(h) MA Risk Ratebook Risk-Adjusted	
1. Total or Weighted Average for Service Area:			0	0	$0.00	$0.00	Plan Benchmark
2. County Level Detail:							
Out of Area							

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:	2020	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)

		Part A	Part B
a. Plan Medical Expenses	**$0.00**		
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:	2020	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-2020.1

ESRD Plan Bid Submission OMB Approved # 0938-0944

Enrollment and PMPM Revenue Projection (Expires: 2/28/2021)

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:	2020	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) State/County Code	(b) State	(c) County Name (Func Graft)	(d) ESRD Status D / T / F	(e) Projected Member Months Jan.- Dec. 2020	(f) Proj. Risk Score	(g) CY 2020 State or County Rate	(h) Percentage of MSP Mem. Months	(i) 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			
1. Contract Year:	2020	6. Contract #:	0
2. Contract-Plan-Segment:	0_000_00	7. Plan ID:	
3. Organization Name:	0	8. Segment ID:	
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	6.2%	$0.00	$0.00
Skilled nursing facility			$0.00	19.8%	0.00	0.00
Home health			$0.00	0.0%	0.00	0.00
Outpatient hospital / ASC			$0.00	19.8%	0.00	0.00
Emergency Room			$0.00	19.8%	0.00	0.00
Dialysis			$0.00	19.8%	0.00	0.00
Primary care physician			$0.00	19.8%	0.00	0.00
Nephrologist			$0.00	19.8%	0.00	0.00
Physician specialist (o/t nephrologist)			$0.00	19.8%	0.00	0.00
Other professional			$0.00	19.8%	0.00	0.00
Radiology / pathology			$0.00	19.8%	0.00	0.00
Ambulance / transportation			$0.00	19.8%	0.00	0.00
DME / Diabetes			$0.00	19.8%	0.00	0.00
Part B Rx: Medicare-covered			$0.00	19.8%	0.00	0.00
Other Part B services			$0.00	19.8%	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 srvs 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		Net Medical % of Revenue	0.0%
Sub-total non-benefit expenses	$0.00	Non-Benefit Expense % of Revenue	0.0%
Gain / loss margin		Gain/ loss margin % of Revenue	0.0%
Total NBE + GLM	$0.00	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	Benefit Cost	NBE+GLM	Total
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 benefi	$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			
1. Contract Year:	2020	6. Contract #:	0
2. Contract-Plan-Segment:	0_000_00	7. Plan ID:	
3. Organization Name:	0	8. Segment ID:	
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**	
	CY2018	
	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)**				
	CY2018				
Service category	Claims incurred in period paid thru	Claim reserve as of	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 / 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			
1. Contract Year:	2020	6. Contract #:	0
2. Contract-Plan-Segment:	0_000_00	7. Plan ID:	
3. Organization Name:	0	8. Segment ID:	
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 1/1/2018-12/31/2018 (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	