

WORKSHEET 1 - MA BASE PERIOD EXPERIENCE AND PROJECTION ASSUMPTIONS

Note: See bid instructions for ESRD and hospice exclusions.

MA-2025.1

OMB Approved # 0938-0944 (Expires: 8/31/2025)

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:	2025	8. MA-PD:		12. SNP:		14. SNP Type:	N/A
						15. VBID-C:	N
						16. VBID-H:	N

II. Base Period Background Information

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

1. Time Period Definition		Total	Non-DE#	DE#	5. Bids In Base	Contr-Plan-Seg ID	Member Months	Contr-Plan-Seg ID	Member Months
Incurred from:	01/01/2023		0	0					
Incurred to:	12/31/2023			0.0000					
Paid through:									

III. Base Period Data (at Plan's Risk Factor) for 1/1/2023-12/31/2023

IV. Projection Assumptions

Service Category	Net PMPM	Cost Sharing	Util Type	Total Benefits			Util. Adjustments to Contract Period				Unit Cost Adjustment		Additive Adjustments				
				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			
															(b)	(c)	(d)
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															
t. Subtotal Medicare-covered service categories																	

V. Base Period Summary for 1/1/2023-12/31/2023 (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			
3. Total Revenue	\$0	\$0	\$0	\$0	7b. Direct Administration		Percentage of Revenue:	
4. Net Medical Expenses				\$0	7c. Indirect Administration		9a. Net Medical Expenses	0.0%
5. Member Months			0	0	7d. Net Cost of Private Reinsurance		9b. Non-Benefit Expenses	0.0%
					7e. Total Non-Benefit Expenses	\$0	9c. Gain/(Loss) Margin	0.0%
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				

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-C: N
4. Contract Year: 2025	8. MA-PD:	12. SNP:	14. SNP Type: N/A	16. VBID-H: 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			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			
t. Subtotal Medicare-covered service categories				\$0.00				\$0.00	0%	CMS Guideline Credibility	\$0.00	\$0.00	\$0.00			

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-C: N
4. Contract Year: 2025	8. MA-PD:	12. SNP:	14. SNP Type:	N/A 16. VBID-H: N

II. Maximum Cost Sharing Per Member Per Year

Is there a plan-level OOP maximum? (Yes/No, then enter amount)	1. In Network		2. Out of Network		3. Combined	
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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) (h) (i) (j) (k) (l) In-Network Cost Sharing After Deductible					(m) Total In-Network Cost Share PMPM	(n) Out-of-Network Description of Cost Sharing / ... Benefit Limits****	(o) Out-of-Network Cost Sharing PMPM***	(p) Grand Total Cost Share PMPM (INN+OON)
				(g) In-Network Util/1000 or PMPM	(h) Description of Cost Sharing / Add'l Days / Benefit Limits****	(i) Effective Copay / Coin Before OOP Max	(j) **Effective Copay / Coin After OOP Max	(k) In-Network PMPM				
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:

****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	h3, h5
6	c
7a	i1
7b	i2, i6
7c	i4
7d	i2, i5, i6
7e	i3
7f	i2, i6
7g	i2, i6
7h	i3
7i	i4
7j	i1
7k	i2
8a	h1
8b	h2
9a	h5, g
9b	g
9c	h5
9d	h5, k
10a	d
10b	i
11a	e1
11b	e2
11c	e2
12	h4
13a	q
13b	q
13c	q
13d, 13e, 13f	q
13g, 13h	q
14a	k, i1, i2, i6
14b	i1, i2, i6
14c	p
14d	i1, i2, i6
14e	i1, i2, i6
15	j
16a	i2, i6
16b	m
16c	m
17a	n1
17b	n2
18a	o1
18b	o2
V/T	
19a	
19b	
19c	

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-C: N
4. Contract Year: 2025	8. MA-PD:	12. SNP:	14. SNP Type:	N/A 16. VBID-H: N

II. Development of Projected Revenue Requirement

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

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

(c) Service Category	(e) Total Benefits			(h) Net PMPM		(i) % for Cov. Svcs		(k) FFS Medicare Actl. Equiv. cost sharing	(l) Plan cost sh. for Medicare-covered svcs.	(m) Medicare Covered (w/AE cost sh.)			(p) A/B Mand Suppl (MS) Benefits		
	Allowed PMPM	Plan Cost Sharing		Allowed	Cost Sharing	Allowed	Cost Sharing			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) Service Category	(e) Total Benefits			(h) Plan Reimb		(i) % for Cov. Svcs		(k) State Medicaid Required Bene. cost sharing	(l) Actual cost sh. for Medicare-covered svcs.	(m) Medicare Covered (w/Medicaid cost sh.)			(p) A/B Mand Suppl (MS) Benefits		
	Reimb + Actual Cost Sh.	Plan Cost Sharing	Actual Cost Sharing	Allowed	Cost Sharing	Allowed	Cost Sharing			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) Service Category	(e) Total Benefits			(h) Net	(i)	(j)	(k)	(l)	(m)	(n) Medicare Covered	(o) Net	(p) Net PMPM for	(q) Reduction of	(r) Total
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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. VBIID-C: N
4. Contract Year: 2025	8. MA-PD:	12. SNP:	14. SNP Type: N/A	16. VBIID-H: 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/Diabetes	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. Suppl. Ben. Chpt 4 (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.					
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. 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%

z1. Related-Party Allowed Cost PMPM
z2. Related-Party Non-Benefit Expense PMPM

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		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		
		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	

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. VBIID-C: N
4. Contract Year: 2025	8. MA-PD:	12. SNP:	14. SNP Type: N/A	16. VBIID-H: N

II. Benchmark and Bid Development

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

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

IV. Standardized A/B Benchmark - Regional Plans Only

	Weighting	
1. Statutory Component - Region N/A	53.3%	
2. Plan Bid Component (from CMS)*	46.7%	N/A
3. Standardized A/B Benchmark	100.0%	

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

VIII. Projected CY Member Months

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

III. Savings/Basic Member Premium Development

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

V. Quality Rating

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

VI: County Level Detail and Service Area Summary

VI: County Level Detail and Service Area Summary												VII: Other Medicare Information								
1. Use of plan-provided ISAR factors? (Regional Plans only - enter Yes or No)																				
(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(l)		(m)	(n)	(o)	(p)	(q)	(r)	(s)	(t)	(u)
State/County Code	State	County Name	Proj Member Months	Proj Risk Factors	Plan Provided ISAR factors	MA Risk Ratebook Unadjusted	MA Risk Ratebook Risk-Adjusted	ISAR scale	ISAR-Adjusted Bid	Risk Payment Rate			Original Medicare cost sharing (c.s.)			FFS costs to weight Medicare c.s.			Metropolitan Statistical Area	
											A only	B only	Inpatient	SNF	Pt B (excl HH)	Inpatient	SNF	Pt B (excl HH)	MM	MSA name
2. Total or Weighted Average for Service Area:			0	0	0.00	\$0.00	\$0.00	0	\$0.00	41.260%	58.740%		0.0%	0.0%	0.0%	n/a	n/a	n/a	0	n/a
3. County Level Detail:																				
Out of Area																				0% predominant MSA

WORKSHEET 6 - MA BID SUMMARY

Note: See bid instructions for ESRD and hospice exclusions.

I. General Information

1. Contract Number:	5. Organization Name:	9. Enrollee Type:	13. Region Name:	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-C: N
4. Contract Year: 2025	8. MA-PD:	12. SNP:	14. SNP Type: N/A	16. VBID-H: N

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	\$174.80	1. PMPM Rebate Allocation for Part B premium (maximum value=\$170.10)		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

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> </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	<table border="1"> <thead> <tr> <th colspan="4">Rebate PMPM Allocation</th> <th>Maximum Value</th> </tr> <tr> <th>Medical</th> <th>Non-Benefit</th> <th>Gain / (Loss)</th> <th>Total</th> <th></th> </tr> </thead> <tbody> <tr> <td>n/a</td> <td>n/a</td> <td>n/a</td> <td>\$0.00</td> <td></td> </tr> <tr> <td>\$0.00</td> <td>\$0.00</td> <td>\$0.00</td> <td>\$0.00</td> <td>\$0.00</td> </tr> <tr> <td>0.00</td> <td>0.00</td> <td>0.00</td> <td>0.00</td> <td>0.00</td> </tr> <tr> <td>0.00</td> <td>n/a</td> <td>n/a</td> <td>0.00</td> <td>170.10</td> </tr> <tr> <td>0.00</td> <td>n/a</td> <td>n/a</td> <td>0.00</td> <td>0.00</td> </tr> <tr> <td>0.00</td> <td>n/a</td> <td>n/a</td> <td>0.00</td> <td>0.00</td> </tr> <tr> <td>\$0.00</td> <td>\$0.00</td> <td>\$0.00</td> <td>\$0.00</td> <td>\$0.00</td> </tr> <tr> <td colspan="3"></td> <td>Unalloc. rebate</td> <td>\$0.00</td> </tr> </tbody> </table>		Rebate PMPM Allocation				Maximum Value	Medical	Non-Benefit	Gain / (Loss)	Total		n/a	n/a	n/a	\$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/a	n/a	0.00	170.10	0.00	n/a	n/a	0.00	0.00	0.00	n/a	n/a	0.00	0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00				Unalloc. rebate	\$0.00	<table border="1"> <tbody> <tr> <td>1. A/B Mandatory Supplemental revenue requirements</td> <td>\$0.00</td> </tr> <tr> <td>2. Less rebate allocations:</td> <td></td> </tr> <tr> <td> 2a. Reduce A/B Cost Sharing</td> <td>0.00</td> </tr> <tr> <td> 2b. Other A/B Mand Supplemental Benefits</td> <td>0.00</td> </tr> <tr> <td>3. A/B Mandatory Supplemental premium</td> <td>0.00</td> </tr> <tr> <td>4. Basic MA premium</td> <td>0.00</td> </tr> <tr> <td>5. Total MA Enrollee Premium (excl. Opt. Suppl.)</td> <td>0.00</td> </tr> <tr> <td>6. Rounded MA Premium (excl. Opt. Suppl.)</td> <td>\$0.00</td> </tr> <tr> <td>7. Part D Basic Premium</td> <td></td> </tr> <tr> <td> 7a. Prior to rebates (rounded value from Part D BPT)</td> <td></td> </tr> <tr> <td> 7b. A/B rebates allocated to Part D Basic Premium</td> <td></td> </tr> <tr> <td> 7c. A/B rebates for Part D Basic Premium (rounded)</td> <td>\$0.00</td> </tr> <tr> <td>7d. Part D Basic Premium*</td> <td>\$0.00</td> </tr> <tr> <td>8. Part D Supplemental Premium</td> <td></td> </tr> <tr> <td> 8a. Prior to rebates (rounded value from Rx BPT)</td> <td></td> </tr> <tr> <td> 8b. A/B rebates allocated to Part D Suppl Premium</td> <td></td> </tr> <tr> <td> 8c. A/B rebates for Part D Suppl Premium (rounded)</td> <td>\$0.00</td> </tr> <tr> <td>8d. Part D Supplemental Premium</td> <td>\$0.00</td> </tr> <tr> <td>9. Total estimated plan premium*</td> <td>\$0.00</td> </tr> <tr> <td>10. Plan Intention for target PD basic premium</td> <td></td> </tr> </tbody> </table>		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 Part D 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	
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7. Risk Factor	0.0000																																																																																																												
8. Conversion Factor	0.0000																																																																																																												

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.

* 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-C:	N
4. Contract Year: 2025	8. MA-PD:	12. SNP:	14. SNP Type:	N/A
			16. VBID-H:	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. Base Period Summary for 1/1/2023-12/31/2023 (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-2025.1

OMB Approved # 0938-0944 (Expires: 8/31/2025)

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:	2025	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: 01/01/2023			a.	
Incurred to: 12/31/2023	3. Risk Score		b.	
Paid through:	4. Completion Factor		c.	
			d.	

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

IV. Projection Assumptions

Service Category	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)	(f)	(g)	(h)	(i)	(j)	(k)		(l)	(m)	(n)
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: 2025	8. Deductible Amount:		

II. Projected Allowed Costs

Contract Year Allowed Costs at Plan's Risk Factor:

(c) Service Category	(e) Util Type	(f) (g) (h) Projected Experience Rate			(i) (j) (k) Manual Rate			(l) Exper. Cred. %	(m) (n) (o) Contract Year Rate			(p) % 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	
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: 2025	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)	(c)	(d)	(e)	(f)	(g)	(h)
State/County Code	State	County Name	Projected Member Months	Projected Risk Factors	MA Risk Ratebook Unadjusted	MA Risk Ratebook Risk-Adjusted
1. Total or Weighted Average for Service Area:			0	0	\$0.00	\$0.00
2. County Level Detail:						
Out of Area						

Plan Benchmark

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: 2025	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
- b. Non-Benefit Expense:
 - 1. Sales & Marketing
 - 2. Direct Administration
 - 3. Indirect Administration
 - 4. Net cost of private reinsurance

\$0.00

Part A

Part B

- 5. Total Non-Benefit Expense
- c. Gain/(Loss) Margin
- d. Total Plan Revenue Requirement
- e. Projected Plan Benchmark
- f. Projected Monthly Enrollee Deposit
- g. Percent of Plan Revenue
 - 1. Medical Expenses
 - 2. Non-Benefit Expense
 - 3. Gain/(Loss) Margin
- h. Standardized Plan Benchmark

\$0.00
\$0.00
\$0.00
\$0.00
0.0%
0.0%
0.0%
\$0.00

\$0.00	\$0.00	\$0.00
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\$0.00	\$0.00	\$0.00
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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:	2025	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 1/1/2023-12/31/2023 (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-2025.1

OMB Approved # 0938-0944

(Expires: 8/31/2025)

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

1. Functioning Graft (i.e., postgraft) "F"	0.136
2. Dialysis / transplant ("D" / "T")	0.135

I. General Information

1. Contract Year:	2025	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. 2025	Proj. Risk Score	CY 2024 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:	2025	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	5.6%	\$0.00	\$0.00
Skilled nursing facility			\$0.00	16.6%	0.00	0.00
Home health			\$0.00	0.0%	0.00	0.00
Outpatient hospital / ASC			\$0.00	19.3%	0.00	0.00
Emergency Room			\$0.00	19.3%	0.00	0.00
Dialysis			\$0.00	19.3%	0.00	0.00
Primary care physician			\$0.00	19.3%	0.00	0.00
Nephrologist			\$0.00	19.3%	0.00	0.00
Physician specialist (o/t nephrologist)			\$0.00	19.3%	0.00	0.00
Other professional			\$0.00	19.3%	0.00	0.00
Radiology / pathology			\$0.00	19.3%	0.00	0.00
Ambulance / transportation			\$0.00	19.3%	0.00	0.00
DME / Diabetes			\$0.00	19.3%	0.00	0.00
Part B Rx: Medicare-covered			\$0.00	19.3%	0.00	0.00
Other Part B services			\$0.00	19.3%	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						
Direct Administration						
Indirect Administration						
Net Cost of Private Reinsurance						
Sub-total non-benefit expenses			\$0.00	Net Medical % of Revenue		0.0%
Gain / loss margin				Non-Benefit Expense % of Revenue		0.0%
				Gain/loss margin % of Revenue		0.0%
				NBE + GLM % of Revenue		0.0%
Total NBE + GLM			\$0.00			
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 benefits	\$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 2023

I. General Information		6. Contract #:	0
1. Contract Year:	2025	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 2023	
	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)		
	CY 2023		
	Claims incurred in period paid thru	Claim reserve as of	Incurred claims
Service category			
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			
Sub-total non-benefit exp.			\$0.00
Gain / loss margin			
Total NBE+GLM			\$0.00
Total Revenue			\$0.00

OPTIONAL SUPPLEMENTAL BENEFITS

I. General Information		6. Contract #:	0
1. Contract Year:	2025	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 1/1/2023-12/31/2023 (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	