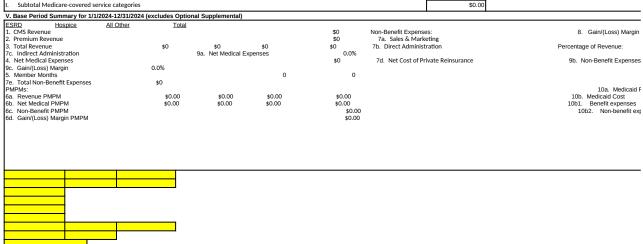
I. General Information

Contract Number:			5. Organization Name 6. Plan Name:				Enrollee T	ype:		
Plan ID: Segment ID:			6. Plan Name: 7. Plan Type:				 MA Region Act. Swap 	n: VEquiv Apply:	N/A	
							12. SNP:	"Equiv Apply.		
Contract Year:	2	2026 8. M.	A-PD:							
II. Base Period Bac	kground Inform	ation		Not	te: DE# refers to Dual Eli	gible Beneficiaries				
							Total	Non-DE#	DE#	
Time Period Definition					2 Member Months			U	0	6.
	Incu		01/01/2024		3 Risk Score				0.0000	
	Incu		12/31/2024		4 Completion Factor					
		Paid through:			•			•		
				5. Level of	significance					
		k Factor) for 1/1/2024-1								jection Assum
(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(i)	(k)	(1)

	Net PMPM	Cost Sharing	Util		Total Benefits		Util. Adjustments	to Contract Perio	od
Service Category			Туре	Annualize d	Avg Cost per Unit	Allowed PMPM	Util/1000 Trend	Benefit Plan Change	Population Change
		•							
. Inpatient Facility . Skilled Nursing Facility		\$0.00			\$0.00				
Skilled Nursing Facility Home Health		0.00			0.00				
Ambulance		0.00			0.00				
DME/Prosthetics/Diabetes		0.00			0.00				
OP Facility - Emergency OP Facility - Surgery		0.00	•		0.00				
OP Facility - Surgery OP Facility - Other		0.00			0.00				
Professional		0.00			0.00				
Part B Rx		0.00			0.00				
Other Medicare Part B Transportation (Non-Covered)		0.00			0.00				
. Dental (Non-Covered)		0.00			0.00				
Vision (Non-Covered)		0.00			0.00				
Hearing (Non-Covered) Suppl. Ben. Chpt 4 (Non-Covered)		0.00			0.00				
Other Non-Covered		0.00			0.00				
COB/Subrg. (outside claim system)		0.00			0.00				
. 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			
		•					1		
Subtotal Medicare-covered service categ	ories					\$0.00	1		



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 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 commer Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS - 10142

CM3 - 10142			
Contract Number:	5. Organization Name:	9. Enrollee	1
		Type:	
2. Plan ID:	6. Plan Name:	10. MA N/A	

 3. Segment ID:
 7. Plan Type:
 11. Act.

 4. Contract Year:
 2026
 8. MA-PD:
 Swap/Equiv
 1

II. Projected Allowed Costs Note: DE# re

(c)	(e)	(f)	(g)	(h)	(i)	(j)	(k)
	Util	Pi	ojected Experi	ence Rate		Manual Rate	
Service Category	Туре	Annual Util/1000	Avg Cost per Unit	Allowed PMPM	Annual Util/1000	Avg Cost per Unit	Allowed PMPM
Inpatient Facility		ol		\$0.00		\$0.00	
Skilled Nursing Facility		0	+	0.00		0.00	
Home Health Ambulance		0	+	0.00		0.00	
DME/Prosthetics/Diabetes		0	+	0.00		0.00	
OP Facility - Emergency OP Facility - Surgery		0		0.00		0.00	
OP Facility - Surgery OP Facility - Other		0		0.00		0.00	
Professional		0		0.00		0.00	
Part B Rx Other Medicare Part B		0		0.00		0.00	
Transportation (Non-Covered)		0		0.00		0.00	
Dental (Non-Covered) Vision (Non-Covered)		0		0.00		0.00	
Hearing (Non-Covered)		0		0.00		0.00	
Suppl. Ben. Chpt 4 (Non-Covered) Other Non-Covered		0		0.00		0.00	
Other Non-Covered		0		0.00		0.00	
		0		0.00		0.00	
		0		0.00		0.00	
		0		0.00		0.00	
		0		0.00		0.00	
COB/Subrg. (outside claim system) Total Medical Expenses			-	0.00 \$0.00			
, , , , , , , , , , , , , , , , , , ,			L	\$0.00		l	
Subtotal Medicare-covered service categories				\$0.00			
Contract No:	5	i. Org Name:			9.	Enrollee Type:	
Plan ID:		6. Plan Name:			10. MA	A Region:	N/A
Segment ID: Contract Year: 2026		'. Plan Type: B. MA-PD:					11. Act. Swan/

IV. Mappi to BPT	ing of PB	P service catego	ri
PBP line	BPT cat	egory	
	1a 1b 2	a1	
1	3 a 4b 4c 5	a2	
	6	b	
	7d 7e 7f	h5	
79 711 7 3b 9a 9b 9	'i 7j 7k 8a 9c 9d 10a	f	
	a 11b 11c	f	
	12 13a	f	
	13b 13c	h3, h5	
13d	, 13e, 13f 13a 13h	С	
14a 14b	13g, 13h 14c 14d	i1	
	14e 15 16a	i2, i6	
16b 16d	: 17a 17b	i4	
18a 18l	b 18c V/T 19a	i2, i5, i6	
	19b	i3	
		i2, i6	
		i2, i6	
		i3	
		i4	
		i1	
		i2	
		h1	
		h2	
		h5, g	
		g	
		h5	
		h5, k	
		d	
		I	
		e1	
		e2	
		e2	
		h4	
		q	
		q	
		q	
		q	
		q	
		k, i1, i2, i6	
		i1, i2, i6	
		р	
		i1, i2, i6	
		i1, i2, i6	

i2, i6	
m	
m	
n1	
n2	
01	
02	
02	

III. Developmer	nt of Contract Year Co	st Sharing PMPN	l (Plan's Risk Facto	or)
(c)	(d)	(e)	(f)	(g)

	Measure- ment Unit Code	In-Network Effective	In-Network Cost Sharing After Deductible							
		Deductible PMPM*	Network	Description of Cost Sharing / Add'l Days / Benefit Limits****	Effective Copay / Coin Before OOP Max	**Effect Aft				

(h)

(i)

(k)

(j)

			Measure- ment	In-Network Effective	tive In-Network Cost Sharing After Deductible				
	Service Category	Description	Unit Code	Deductible PMPM*	In- Network Util/1000 or PMPM	Description of Cost Sharing / Add'l Days / Benefit Limits****	Effective Copay / Coin Before OOP Max	**Effective C After OC	
a.1.	Inpatient Facility	Acute							
ι.2.	Inpatient Facility	Mental Health DME							
١.	Skilled Nursing Facility	Prosthetics/Diabetes							
:.	Home Health	Lab Radiology Mental Health Renal Dialysis							
l.	Ambulance	Other							
.1.	DME/Prosthetics/Diabetes	PCP Specialist excl. MH							
.2.	DME/Prosthetics/Diabetes	Mental Health (MH)							
	OP Facility - Emergency	Therapy (PT/OT/ST)							
	OP Facility - Surgery	Radiology Other							
.1.	OP Facility - Other								
.2.	OP Facility - Other								
.3.	OP Facility - Other								
.4.	OP Facility - Other								
.5.	OP Facility - Other								
1.	Professional							+	
2.	Professional								
3.	Professional								
3. 4.	Professional								
4. 5.								+	
5. 6.	Professional								
0.	Professional								
	Part B Rx								
	Other Medicare Part B	I							
	Transportation (Non-Covered)								
٦.	Dental (Non-Covered)								
.1.	,	ssional							
.2.	Vision (Non-Covered) Hardy								
.1.	Hearing (Non-Covered) Profes	ssional							
.2.	Hearing (Non-Covered) Hardy	vare							
	Suppl. Ben. Chpt 4 (Non-Covered)								
	Other Non-Covered								
_	Total			\$0.00					

** PMPM impact of in-network OOP max:

0.0000

****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 in

I. General Information

Contract Number:		5. Organization	9.	
2. Plan ID:		6. Plan Name:	10. MA	N/A
Segment ID: Contract Year:	2026	7. Plan Type: 8. MA-PD:	11. Act.	

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:

(c)

(h) <u>(i)</u> (f)

			Total E	Benefits		% fo	r Cov. Svcs	FFS Medicare	Pla
	Service Category	Allowed PMPM	Plan Cost Sharing		Net PMPM	Allowed	Cost Sharing	Actl. Equiv. cost sharing	for cov
a.	Inpatient Facility	**	\$0.0	ю	\$0.00			0.0%	
b.	Skilled Nursing Facility Home Health	0.00	0.0	o				0.0%	
c. d.	Ambulance	0.00	0.0	o				0.0%	
e.	DME/Prosthetics/Diabetes	0.00	0.0	o[]				0.0%	

f.	OP Facility - Emergency OP Facility - Surgery	0.00	0.00			0.0%	
g. h.	OP Facility - Other	0.00	0.00			0.0%	
i.	Professional	0.00	0.00			0.0%	
j.	Part B Rx	0.00	0.00			0.0%	
I ^{K.}	Other Medicare Part B Transportation (Non-Covered)	0.00	0.00			0.0%	
m.	Dental (Non-Covered)	0.00	0.00			0.0%	
n.	Vision (Non-Covered)	0.00	0.00			0.0%	
0. p.	Hearing (Non-Covered) Suppl. Ben. Chpt 4 (Non-Covered)	0.00	0.00		0.00%	0.0%	
q.	Other Non-Covered	0.00	0.00		0.00%	0.0%	
r.	COB/Subrg. (outside claim system)	0.00	0.00		0.00%	0.0%	
S.	Total Medical Expenses	0.00	0.00		0.00%	0.0%	
		0.00	0.00		0.00%	0.0%	
		0.00	0.00		0.00%	0.0%	
1		0.00	0.00			0.0%	
1			\$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) (o)
		Total Benefits			% for Cov. Svcs		State Medicaid	Act	
	Service Category	Reimb + Actual Cost Sh.	Plan Cost Sharing	Actual Cost Sharing	Plan Reimb	Allowed	Cost Sharing	Required Bene. cost sharing	sh. Me cov
	Innationt Facility	-	\$0.00	\$0.00					
a. b.	Inpatient Facility Skilled Nursing Facility	0.00		\$0.00					
c. d.	Home Health Ambulance	0.00	0.00						
e.	DME/Prosthetics/Diabetes	0.00	0.00						
f. g.	OP Facility - Emergency OP Facility - Surgery	0.00							
h.	OP Facility - Other	0.00							
ļi.	Professional Part B Rx	0.00							
J. k.	Other Medicare Part B	0.00							
i.	Transportation (Non-Covered)	0.00							
m. n.	Dental (Non-Covered) Vision (Non-Covered)	0.00							
0.	Hearing (Non-Covered)	0.00				0.000/			
p.	Suppl. Ben. Chpt 4 (Non-Covered)	0.00				0.00%			
q. r.	Other Non-Covered COB/Subrg. (outside claim system)	0.00				0.00%			
s.	Total Medical Expenses	0.00				0.00%			
		0.00				0.00%			
		0.00				0.00%			
		0.00				5.0070			+
		0.00	\$0.00		\$0.00			\$0.00	

C. All Beneficiaries
Cost and Required Revenue PMPM at Plan's Risk Factor:

0.0000

(g) (i) (h) (f) (j) (k) (c) (e) Total Benefits

I. General Information

5. Organization 6. Plan Name: 7. Plan Type: 8. MA-PD: Contract Number:
 Plan ID: 9. Enrollee Type: 10. MA Region: N/A Segment ID:
 Contract Year 11. Act. 2026

1. Contract Year:	8. MA-PD:		Act.
II. Development of Projected	Revenue Requirement	5.45.4 I	
Service Category		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	
. Professional		0.00	
. Part B Rx		0.00	
k. Other Medicare Part B		0.00	
. Transportation (Non-Covered)		0.00	
m. Dental (Non-Covered)		0.00	
n. Vision (Non-Covered)		0.00	
o. Hearing (Non-Covered)		0.00	
p. Suppl. Ben. Chpt 4 (Non-Covered)		0.00	
q. Other Non-Covered		0.00	
r. ESRD		0.00	
S.			
t. COB/Subrg. (outside claim system)		0.00	
u. Total Medical Expenses		\$0.00	
v. Non-Benefit Expense:	<u> </u>		
 Sales & Marketing 			
Direct Administration			
 Indirect Administration 			
 Net Cost of Private Reinsurance 			
	_		:

							Pari
5. Total Non-Benefit Expense				\$0.00			
w. Gain/(Loss) Margin							
x. Total Revenue Requirement y1. Net Medical Expense % of Revenue y2.				\$0.00 0.0%			
Non-Benefit % of Revenue			-	0.0%			
y3. Gain/(Loss) Margin % of Revenue			<u> </u>	0.0%			
III. Development of Projected C	 Contract Year ESRD "Su	ıbsidy"					
CY member months entered by county		0					
CY ESRD member months CY Out-of-Area (OOA) member months		0					
Basic benefits (user entries must be reported as "per E					Supplemental Benef		
Revenue - CMS capitation					Non-ESRD CY cost : additional benefits	sharing reduct	tions Non-I
- Civi3 capitation					additional benefits		
CY Medical Expenses for Basic Services							
CY Non-Benefit Expenses for Basic Services					ESRD CY cost shari	ng reductions	
CY Margin Requirement for Basic Services	\$0.0				ESRD CY additional		
CY Gain/(Loss) Margin for Basic Services Cost for CY basic benefits allocated to plan members	\$0.0 \$0.0			Incremental CY cost of cost sh Total CY ESRD "subsidy" =	aring reductions Increr \$0.00	mental CY cos	st of addition
Cost for C+ basic benefits allocated to plan members	\$0.0	U		TOTAL CT ESRD SUBSIDY -	\$0.00		
Entries must be reported as "Per Member Per Month" ((PMPM).	7					
Medicaid Projected Revenue		_					
2. Medicaid Projected Cost (not in bid)	\$0.00	_					
2a. Benefit expenses 2b. Non-benefit expenses		_					
25. Non Bonone expenses							
Contract Number: 5. Organizatio	n Name:			9. Enrollee Type:		13. Region	n Name:
· ·				•			
2. Plan ID: 6. Plan Name	4			10. MA Region:	N/A		
3. Segment ID: 7. Plan Type: 4. Contract Year: 2026 8. MA-PD:				11. Act. Swap/Equiv		14. SNP T	Type:
				Apply: 12 SNP			
II. Benchmark and Bid Development	Total	Non-DE#	DE#	Note: DE	# refers to Dual Eligible	e Beneficiaries	without fu
Member Months (Section VI) Standardized A/B Benchmark (@ 1.000)	0 <mark></mark> \$0.00		٥				
Medicare Secondary Payer Adjustment	\$0.00						
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						
4 March and the second of the							
Member months entered by county (Sect. VI) ESRD member months	0						
3. Hospice member months							
Out-of-Area (OOA) member months	0						
5. Total member months	0						
	NATURAL DESIGNATION OF THE PROPERTY OF THE PRO						
	Weighting						
Statutory Component - Region N/A	47.5%						
2. Plan Bid Component (from CMS)*	52.5%	N/A					
3. Standardized A/B Benchmark	100.0%						
* See instructions - if Line 2 is not filled in, then Line 8 of Se	ction II will be used.						
III. Savings/Basic Member Premium Development							
V. Quality Rating							
	\$0.00						
1. Savings							
2. Rebate	\$0.00 \$0.00						
Rebate Basic Member Premium	\$0.00						
Rebate Basic Member Premium Quality Bonus Rating (per CMS)	\$0.00						
Rebate Basic Member Premium Quality Bonus Rating (per CMS) New org/low enrollment indicator (per CMS)	\$0.00 Not applicable						
2. Rebate 3. Basic Member Premium 1. Quality Bonus Rating (per CMS) 2. New org/low enrollment indicator (per CMS) 3. Rebate %	\$0.00 Not applicable 50.0%						
2. Rebate 3. Basic Member Premium 1. Quality Bonus Rating (per CMS) 2. New org/low enrollment indicator (per CMS) 3. Rebate % VI: County Level Detail and Service Area Summary	\$0.00 Not applicable 50.0%						
2. Rebate 3. Basic Member Premium 1. Quality Bonus Rating (per CMS) 2. New org/low enrollment indicator (per CMS) 3. Rebate % VI: County Level Detail and Service Area Summary 1. Use of plan-provided ISAR factors? (Regional Plans only	\$0.00 Not applicable 50.0% - enter Yes or No)	(f)	(a)	(h)	(1)	(i)	(k
2. Rebate 3. Basic Member Premium 1. Quality Bonus Rating (per CMS) 2. New org/low enrollment indicator (per CMS) 3. Rebate % VI: County Level Detail and Service Area Summary 1. Use of plan-provided ISAR factors? (Regional Plans only (b) (c) (d) State/County	\$0.00 Not applicable 50.0% - enter Yes or No) (e) Proj Member	(f) Proj Risk	(g) Plan Provided	(h) MA Risk Ratebook	(i) MA Risk Ratebook	(j) ISAR	ISAR-A
2. Rebate 3. Basic Member Premium 1. Quality Bonus Rating (per CMS) 2. New org/low enrollment indicator (per CMS) 3. Rebate % VI: County Level Detail and Service Area Summary 1. Use of plan-provided ISAR factors? (Regional Plans only (b) (c) (d)	\$0.00 Not applicable 50.0% r - enter Yes or No) (e)						ISAR-A
2. Rebate 3. Basic Member Premium 1. Quality Bonus Rating (per CMS) 2. New org/low enrollment indicator (per CMS) 3. Rebate % VI: County Level Detail and Service Area Summary 1. Use of plan-provided ISAR factors? (Regional Plans only (b) (c) (d) State/County Code State County Name	\$0.00 Not applicable 50.0% - enter Yes or No) (e) Proj Member	Proj Risk	Plan Provided	MA Risk Ratebook	MA Risk Ratebook	ISAR	ISAR-A
2. Rebate 3. Basic Member Premium 4. Quality Bonus Rating (per CMS) 2. New org/low enrollment indicator (per CMS) 3. Rebate % VI: County Level Detail and Service Area Summary 1. Use of plan-provided ISAR factors? (Regional Plans only (b) (c) (d) State/County Code State County Name 2. Total or Weighted Average for Service Area:	\$0.00 Not applicable 50.0% - enter Yes or No) (e) Proj Member	Proj Risk Factors	Plan Provided	MA Risk Ratebook	MA Risk Ratebook Risk-Adjusted	ISAR	ISAR-A
2. Rebate 3. Basic Member Premium 1. Quality Bonus Rating (per CMS) 2. New org/low enrollment indicator (per CMS) 3. Rebate % VI: County Level Detail and Service Area Summary 1. Use of plan-provided ISAR factors? (Regional Plans only (b) (c) (d) State/County Code State County Name 2. Total or Weighted Average for Service Area: 3. County Level Detail:	\$0.00 Not applicable 50.0% - enter Yes or No) (e) Proj Member Months	Proj Risk Factors	Plan Provided ISAR factors	MA Risk Ratebook Unadjusted	MA Risk Ratebook Risk-Adjusted	ISAR scale	ISAR-A
2. Rebate 3. Basic Member Premium 1. Quality Bonus Rating (per CMS) 2. New org/low enrollment indicator (per CMS) 3. Rebate % VI: County Level Detail and Service Area Summary 1. Use of plan-provided ISAR factors? (Regional Plans only (b) (c) (d) State/County	\$0.00 Not applicable 50.0% - enter Yes or No) (e) Proj Member Months	Proj Risk Factors	Plan Provided ISAR factors	MA Risk Ratebook Unadjusted	MA Risk Ratebook Risk-Adjusted	ISAR scale	(k ISAR-Ai Bi

Contract Number:		 Organization Name: 	9. Enrollee Type:
2. Plan ID:		6. Plan Name:	10. MA Region:
Segment ID: Contract Year:	2026	7. Plan Type: 8. MA-PD:	11
			Ac

II. Other Information						
A. Part B Information 1. Maximum Pt B premium buydown amt.	, per CMS	\$174.70	Rebate Allocation for Part B PMPM Rebate Allocation for Part B Part B Rebate Allocation, round	Premium art B premium (maximum value=\$174 led to one decimal (see instructions)	.70)	\$
III. Dier AID Did Common						
III. Plan A/B Bid Summary A. Overview			3. MA Rebate Allocation			
		1	MA Rebate 2. Reduce A/B Cost Sharing 3. Other A/B Mand Suppl Benefits	Medical	Rebate PMPM Allocation Non-Benefit Gain/(Loss)	Margin
Net medical cost	Medica	re- A/B Mandatory 4	l. Pt B Premium Buydown	l n	/a n/a	n/a
Non-benefit expense Gain/(loss) margin	covered	d Supplemental	. Pt D Premium Buydown Basic . Pt D Premium Buydown Suppl	0	0.00 \$0.00 .00 0.00	\$0.00 0.00
Total revenue requirement				0	.00 n/a .00 n/a	n/a n/a
				0	.00 n/a	n/a
		\$0.00				
Standardized A/B Benchmark Plan A/B Benchmark	\$0.00 \$0.00 0.0000	7	' Total	10.00	"" Unalloc. reba	te \$0.00
Risk Factor Conversion Factor	0.0000					
IV. Contact Information MA Plan Bid Co	ontact:			V. Working Model Text	Вох	
Name, Position Phone Number Email Address				The contents are NOT upl	t the discretion of the Plan spons oaded in the bid submission, and	will
MA Certifying Actuary: Name, Credentia Address	ls Phone Number Er	nail		be deleted during finalizat	tion. See instructions for details.	
MA Additional BPT Actuarial Contact: Name, Position Phone Number Email Add	ress					
Date Prepared						
Contract Number:		5. Organization Name:		9. Enrollee Type:		13. Nan
2. Plan ID:		6. Plan Name:		10. MA Region:	N/A	ivali
Segment ID: Contract Year: 2026		7. Plan Type: 8. MA-PD:		11. Act. Swap/Equiv Apply:		14. Typ
I Shade roun				12 CND:		тур
II. Optional Supplemental Packages					4.5	em
(b) (c)	(d)	(e)	(f)	(g)	(h)	(i)
Package ID		Allowed Medical Expense PMPM	Enrollee	Net PMPM	Non-	G
	Description	РМРМ	Cost Sharing PMPM	value	Benefit Expense	(Loss

	Weighted Avg. Total	\$0.00	\$0.00	\$0.00	\$0.00	
5				\$0.00		
4				\$0.00		
3				\$0.00		
2				\$0.00		
1				\$0.00		

			Net Medical	Non-Ben Expense	
1. Total \$: for all OSB packa			Evnence		
2. PMPM (based on OSB n	nembership)		\$0.00		\$0.00
I. General Informat	ion				
	anization Name: n Name:			9. Er	rollee Type:
	n Type:				
Contract Year: 2026 8. Deductik		MSA			
II. Base Period Background Information	ne Amount.				
			-		
Time Period Definition		2. Member Mon	ths		
	1/01/2024	3. Risk Score	actor		
Paid through:	2/31/2024	4. Completion Fa	actor		
i dia tinoagii.					
III. Base Period Data (at Plan's Risk Facto		(g)		((i)	IV. Projec
	(f)		otal Benefits	((i)	IV. Projec
	(f)		otal Benefits Avg Cost per Unit	((i) Allowed	
Service Category	(f)	T Annualized	Avg Cost per Unit	Allowed	Util. Adjus
Service Category Inpatient Facility	(f)	T Annualized	Avg Cost per Unit	Allowed	Util. Adjus
Service Category Inpatient Facility Skilled Nursing Facility Home Health	(f)	T Annualized	Avg Cost per Unit \$0.00	Allowed	Util. Adjus
Service Category Inpatient Facility Skilled Nursing Facility Home Health Ambulance DME/Prosthetics/Diabetes	(f)	T Annualized	\$0.00 \$0.00 0.00	Allowed	Util. Adjus
Inpatient Facility Skilled Nursing Facility Home Health Ambulance DME/Prosthetics/Diabetes OP Facility - Emergency	(f)	T Annualized	Avg Cost per Unit \$0.00	Allowed	Util. Adjus
Service Category Inpatient Facility Skilled Nursing Facility Home Health Ambulance DME/Prosthetics/Diabetes OP Facility - Emergency OP Facility - Surgery OP Facility - Other	(f)	T Annualized	\$0.00 0.00 0.00 0.00	Allowed	Util. Adjus
Inpatient Facility Skilled Nursing Facility Home Health Ambulance DME/Prosthetics/Diabetes OP Facility - Emergency OP Facility - Surgery OP Facility - Other Professional Part B Rx	(f)	T Annualized	\$0.00 0.00 0.00 0.00 0.00	Allowed	Util. Adjus
Inpatient Facility Skilled Nursing Facility Home Health Ambulance DME/Prosthetics/Diabetes OP Facility - Emergency OP Facility - Surgery OP Facility - Other Professional	(f)	T Annualized	\$0.00 0.00 0.00 0.00 0.00 0.00	Allowed	Util. Adjus
Inpatient Facility Skilled Nursing Facility Home Health Ambulance DME/Prosthetics/Diabetes OP Facility - Emergency OP Facility - Surgery OP Facility - Other Professional Part B Rx	(f)	T Annualized	\$0.00 0.00 0.00 0.00 0.00 0.00 0.00	Allowed	Util. Adjus
Inpatient Facility Skilled Nursing Facility Home Health Ambulance DME/Prosthetics/Diabetes OP Facility - Emergency OP Facility - Other Professional Part B Rx	(f)	T Annualized	\$0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	Allowed	Util. Adjus
Inpatient Facility Skilled Nursing Facility Home Health Ambulance DME/Prosthetics/Diabetes OP Facility - Emergency OP Facility - Other Professional Part B Rx	(f)	T Annualized	\$0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	Allowed	Util. Adjus
Inpatient Facility Skilled Nursing Facility Home Health Ambulance DME/Prosthetics/Diabetes OP Facility - Emergency OP Facility - Other Professional Part B Rx	(f) Util Type	T Annualized	\$0.00 \$0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00	Allowed	Util. Adjus

PRA Disclosure Statement According to the Paperwork Reduction Act of 1995, no persons are required to respond to a c this information collection is 0938-0944. The time required to complete this information collection is estimated to average 3C data needed, and complete and review the information collection. If you have comments concerning the accuracy of the tim PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

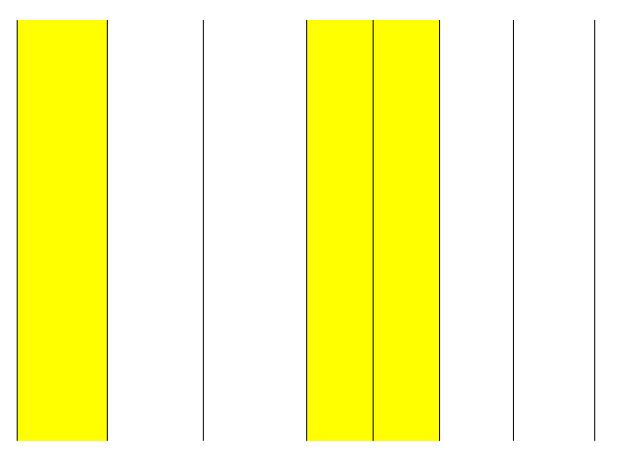
CMS - 10142

I. General Information

_				
1.	. Contract Number:	Organization	Enrollee Type:	A/B
2.	. Plan ID:	Name:	MSA	
3.	. Segment ID:	6. Plan Name:		
4.	. Contract Year:	7. Plan Type:		
		8. Deductible		
	2026	Amount:		

II. Projected Allowed Costs

				(f)	(g)	(h)	(i)
			Util Type	Projected Annual	Avg Cost		Annual
Service Cat	egory			Util/1000	per Unit	PMPM	Util/1000
. Inpatient Facil	itv			ol	\$0.00	\$0.00	
. Skilled Nursing	g Facility			0	0.00	0.00	
Home Health Ambulance				0	0.00	0.00	
DME/Prosthet OP Facility - Er				0	0.00	0.00	
OP Facility - Su	ırgery			0	0.00	0.00	
OP Facility - Of Professional	ther			0	0.00	0.00	
Part B Rx	D 4 D			0	0.00	0.00	
Other Medicar	re Part B			0	0.00	0.00	
				0	0.00	0.00	
				0	0.00	0.00	
				0	0.00		
	utside claim system) e Covered Medical I					0.00	1
General Information Contract Number: Plan ID:	6. P	Organization Name: lan Name:			Note: See bi	d instructions for ESRD a	and hospice ex
Contract Number: Plan ID: Segment ID:	5. C 6. P 7. P 8. D	Organization Name:	MSA				and hospice ex
Contract Number: Plan ID: Segment ID: Contract Year:	5. C 6. P 7. P 8. D	Organization Name: lan Name: lan Type:	MSA		9. Enrollee Tyl IV. Quality Bonus Rati	pe: A/B	and hospice ex
Contract Number: Plan ID: Segment ID: Contract Year: 20 Contact Information	5. C 6. P 7. P 8. D	Organization Name: lan Name: lan Type:	MSA		9. Enrollee Tyl	pe: A/B	und hospice ex
Contract Number: Plan ID: Segment ID: Contract Year: 20 Contact Information	5. C 6. P 7. P 8. D	Organization Name: lan Name: lan Type:	MSA		9. Enrollee Tyl IV. Quality Bonus Ratin 1. Quality Bonus Rating	pe: A/B	
Contract Number: Plan ID: Segment ID: Contract Year: 20 Contact Information SA Plan Contact Person: Name, Position Phone Number Email Act	5. C 6. P 7. P 8. D	Organization Name: lan Name: lan Type:	MSA		9. Enrollee Tyl IV. Quality Bonus Ratin 1. Quality Bonus Rating	pe: A/B	
Contract Number: Plan ID: Segment ID: Contract Year: 20 Contact Information SA Plan Contact Person: Name, Position Phone Number Email Act SA Certifying Actuary:	5. C 6. P 7. P 8. D	Organization Name: lan Name: lan Type:	MSA		9. Enrollee Tyl IV. Quality Bonus Ratin 1. Quality Bonus Rating	pe: A/B	
Contract Number: Plan ID: Segment ID: Contract Year: 20 Contact Information SA Plan Contact Person: Name, Position Phone Number Email Act SA Certifying Actuary: Name, Credentials Phone	5. C 6. P 7. P 8. D 26	Organization Name: lan Name: lan Type:	MSA		9. Enrollee Tyl IV. Quality Bonus Ratin 1. Quality Bonus Rating	pe: A/B	
Contract Number: Plan ID: Segment ID: Contract Year: 20 Contact Information SA Plan Contact Person: Name, Position Phone Number Email Act SA Certifying Actuary: Name, Credentials Phone	5. C 6. P 7. P 8. D 26	Organization Name: lan Name: lan Type:	MSA		9. Enrollee Tyl IV. Quality Bonus Ratin 1. Quality Bonus Rating	pe: A/B	
Contract Number: Plan ID: Segment ID: Contract Year: 20 Contact Information A Plan Contact Person: Name, Position Phone Number Email Act A Certifying Actuary: Name, Credentials Phone A Additional BPT Actuari Name, Position	5. C 6. P 7. P 8. D 26	Organization Name: lan Name: lan Type:	MSA		9. Enrollee Tyl IV. Quality Bonus Ratin 1. Quality Bonus Rating	pe: A/B	
Contract Number: Plan ID: Segment ID: Contract Year: 20 Contact Information SA Plan Contact Person: Name, Position Phone Number Email Act Additional BPT Actuari Name, Position Phone Number Email Actuari Name, Position Phone Number Email Actuari Date Prepared (MM/DD/	5. C 6. P 7. P 8. D 26 ddress he Number Email Address lal Contact: ddress	Organization Name: lan Name: lan Type:	MSA		9. Enrollee Tyl IV. Quality Bonus Ratin 1. Quality Bonus Rating	pe: A/B	
Contract Number: Plan ID: Segment ID: Contract Pear: 20 Contact Information A Plan Contact Person: Name, Position Phone Number Email Act A Certifying Actuary: Name, Credentials Phone Name, Position Phone Number Email Actuari Name, Position Phone Number Email Actuari Name, Position Phone Number Email Actuari County Level Detail and St	5. C 6. P 7. P 8. D 26 ddress he Number Email Address lal Contact: ddress	Organization Name: lan Name: lan Type:	(e)		9. Enrollee Tyl IV. Quality Bonus Ratin 1. Quality Bonus Rating 2. New/low indicator (p	ng er CMS)	
General Information Contract Number: Plan ID: Segment ID: Contract Year: 20 Contact Information SA Plan Contact Person: Name, Position Phone Number Email Act SA Certifying Actuary: Name, Credentials Phone Name, Position Phone Number Email Actuari County Level Detail and S (b) State/County	5. C 6. P 7. P 8. D 26 26 ddress The Number Email Address al Contact: ddress TYYYY) Service Area Summary	organization Name: lan Name: lan Type: neductible Amount:		mber Projected Risk	9. Enrollee Tyl IV. Quality Bonus Rating 1. Quality Bonus Rating 2. New/low indicator (p	pe: A/B	
General Information Contract Number: Plan ID: Segment ID: Contract Year: 20 Contact Information SA Plan Contact Person: Name, Position Phone Number Email Act SA Certifying Actuary: Name, Credentials Phone SA Additional BPT Actuari Name, Position Phone Number Email Act Date Prepared (MM/DD/ County Level Detail and S (b) State/County	5. C 6. P 7. P 8. D 26 ddress ddress de Number Email Address ial Contact: ddress ryyyy) Service Area Summary (c)	organization Name: Ian Name: Ian Type: Deductible Amount:	(e)	mber Projected Risk	9. Enrollee Tyl IV. Quality Bonus Ratin 1. Quality Bonus Rating 2. New/low indicator (p	ng er CMS) MA Risk Ratebook	Not applicable



WORKSHEET 4 - MSA ENROLLEE DEPOSIT AND PLAN PAYMENT PMPM

Note: See bid instructions for ESRD and hospice exclusions.

5. Organization 1. Contract Number: 6. Plan Name: 2. Plan ID:

3. Segment ID: 4. Contract Year: MSA

7. Plan Type: 8. Deductible Amount: 2026

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 Claim Deductible (I
1	40.4250			¢0.00	
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
 h. Non-Benefit Expense

1. Sales & Mar 2. Direct Admi 3. Indirect Adn 4. Net cost of p	keting nistration				\$0.00
			E Tot	al Non	\$0.00
			Benet		
			Expei c.	ıse	\$0.00
			Gain/	(Loss)	\$0.00
				al Plan	\$0.00
			Revei Requi	nue irement	0.0%
			e. Pro	jected	0.0%
				hmark	0.0%
			f. Pro	jected	\$0.00
	V	WORKSHEET 5 - M	SA OPTIONAL SI	JPPLEMENTAL E	BENEFITS
2. Plan ID: 3. Segment ID: 4. Contract Ye	ar:	2026 I. Optional Supplementa	6. Plan Nam 7. Plan Type 8. Deductib	e:	MSA
		b) (c)	(d)	(e)	(f)
Package ID	Description	Allowed Medical Expense PMPM	Enrollee Cost Sharing PMPM	Net PMPM value	Non- Benefit Expense
1				\$0.00	
2				\$0.00	
3				\$0.00	
4				\$0.00	
5				\$0.00	
	Weighted Avg. Total	\$0.00	\$0.00	\$0.00	\$0.00
	II	II. Base Period Summary	for 1/1/2024-12/31/202	4 (Note: This section r	Non-Benefit
	1 Total \$: for all OS	SB packages combined			Expenses
	2 PMPM (based or	· -		\$0.00	\$0.00

\$0.00

	ОМВ Арр	roved # 0938-0944 (E	MA-2026.1 Expires: 3/31/2027)			
13.	Region Name:	N/A	15. VBID-C:	N		
14.	SNP Type:	N/A				
Bids In Base	Contr-Plan-Seg ID	Member Months	Contr-Pla	n-Seg ID Member Months		
iptions (m)	(n)	(0)	(p)	(q)	(u)	(v)
					Service Category	Net PMF
					a. b.	
					c. d. e.	
					f. g. h.	
					i. j. k.	
					l. m. n.	
					o. p. q.	
					r. s.	
	Unit Cost Ac		Addi Adjustr	tive		
Other Factor	Provider Payment Change	Other Factor	Util/1000	РМРМ		

VI. Base Period

per. 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 sts concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports

_		
.3.	Region Name:	N/A

\$0

\$0

0.0%

.4. SNP Type:

15. VBID-C: N N/A

fers to Dual Eligible Beneficiaries without full Medicare cost sharing liability

		ember months sk factor	<u>Total</u> 0 0.0000	Non-DE# 0 0.0000	<u>DE#</u> 0 0.0000	
(I)	(m)	(n)	(0)	(p)	(q)	(r)
dibility			Blended Rate			% of svcs
	Annual Util/1000	Avg Cost per Unit	Total Allowed PMPM	Non-DE# Allowed PMPM	DE# Allowed PMPM	provided OON
	0	\$0.00	\$0.00			
	0	0.00	0.00			
	0	0.00	0.00			
	0	0.00	0.00			
	0	0.00	0.00			
	0	0.00	0.00			
	0	0.00	0.00			
	0	0.00	0.00			
	0	0.00	0.00			
	0	0.00	0.00			
	0	0.00	0.00			
	0	0.00	0.00			
	0	0.00	0.00			
	0	0.00	0.00			
	0	0.00	0.00			
	0	0.00	0.00			
	0	0.00	0.00			
			0.00			
0%	1		\$0.00	\$0.00	\$0.00	
	CMS Guideline C	redibility				
0%			\$0.00	\$0.00	\$0.00	
	13. Reg	gion .	N/A			
	14. SNF Typ		15. VBID-C: N N/A			
	1	3. Combined	NO			
		o. Combined	110			

		Total	Out-of-Network	Out-of-Network Cost	Grand Total
ppay / Coin P Max	In-Network PMPM	In-Network Cost Share PMPM	Description of Cost Sharing / Benefit Limits****	Sharing PMPM***	Cost Share PMPM (INN+OON)
	\$0.00	\$0.00			\$0.0
	0.00	0.00			0.
	0.00	0.00			0.
	0.00	0.00			0.
	0.00	0.00			0.
	0.00	0.00			0.
	0.00	0.00			0.
	0.00	0.00			0.
	0.00	0.00			0.
	0.00	0.00			0
	0.00	0.00			0
	0.00	0.00			0
	0.00	0.00			0
	0.00	0.00			0
	0.00	0.00			0
	0.00	0.00			0
	0.00	0.00			0
	0.00	0.00			0
	0.00	0.00			0
	0.00	0.00			0
	0.00	0.00			0
	0.00	0.00			0
	0.00	0.00			0
	0.00	0.00			0
	0.00	0.00			0
	0.00	0.00			0
	0.00	0.00			0
	0.00	0.00			0
	0.00	0.00			0
	0.00	0.00			0
	0.00	0.00			0
	0.00	0.00			0
	0.00	0.00			0
	0.00	0.00			0
	0.00	0.00			0
	0.00	0.00			0.
	0.00	0.00			0
	0.00	0.00			0
	0.00	0.00			0
	0.00	0.00			0
	\$0.00	\$0.00		\$0.00	\$0.

***PMPM impact of OON OOP max:

structions for details.

13. Region	N/A
14. SNP Type:	15. VBID-C: N N/A

(l)	(m)	(n)	(0)	(p) () (r)
n cost sh.	Me	dicare Covered (w/Al	E cost sh.)		A/B Mand Suppl (MS) Benefits
Medicare- rered svcs.	Allowed PMPM	FFS AE Cost Sharing	Net PMPM		Reduction of A/B Cost Sh.	Total
	\$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	\$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	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
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	0.00	0.00	0.00	0.00	0.00

(l) (m) (n) (p) (q) (r)

ual cost Medicare Covered (w/Medicaid cost sh.)					A/B Mand Suppl (MS) Benefits			
for dicare- rered svcs.	Allowed PMPM	Medicaid Cost Sharing	Net PMPM	Net PMPM for Add'l Svcs.	Reduction of A/B Cost Sh.	Total		
	#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	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		
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	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	0.00	0.00	0.00		
	\$0.00	\$0.00		\$0.00	\$0.00	\$0.00		

(l) (m) (n) (o) (p) (q) (r)

Medicare Covered A/B Mand Suppl (MS) Repetits

ļ!	Medicare Covered		A/B Mand Suppl (MS) Benefits			
		Net	Net PMPM for	Reduction of		

13. Region N/A

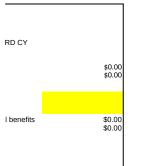
14. SNP Type: 15. VBID-C: N
N/A

PMP	Add'l Svcs.	A/B Cost Sh.	Total
\$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	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
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

elated-

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



IV. Projected Medicaid Data

N/A 15. VBID-C: N N/A

Medicare cost sharing liability

IV. Standardized A/B Benchmark - Regional Plans Only

VII: Other Medicare Information

	VII.	Other Medical	e illiorillation							
	(1)	(m)	(n)	(0)	(p)	(q)	(r)	(s)	(t)	(u)
ted	Risk Payment	Rate	Original Medicar	e cost sha	ring (c.s.)	FFS costs	t weight	Medicare c.s.	Metropolita	n Statistical Area
	A only	B only	Inpatient	SN	Pt B (excl HH)	Inpatient	SN	Pt B (excl HH)	MM	MSA name
\$0.00	39.440%	60.560%	0.0%	0.0%	0.0%	n/a		n/a n/a		0 n/a 0% predominant MSA
	13.	Region Name:	N/A	\						
N/A		SNP Type:	15. N/A	VBID-C:	N					

	C. Rebate Allocations	
0.00	 Reduce A/B Cost Sharing (max. value=\$0.00) Other A/B Mand Suppl Benefits (max. value=\$0.00) 	
	2. Other A/B Mand Suppl Benefits (max. value=\$0.00)	

Total Value \$ \$0.00 0 0.00 174.70 0 0.00 \$	C. Development of Estimated Plan Premium
0 0 \$ 0	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) 7d. Part D Basic Premium* 8. Part D Supplemental Premium
	8a. Prior to rebates (rounded value from Rx BPT) 8b. A/B rebates allocated to Part D Suppl Premium 8c. A/B rebates for Part D Suppl Premium (rounded) 8d. Part D Supplemental Premium 9. Total estimated plan premium*
	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.

Region ne:	N/A			
SNP e:	15. VBID-C: N/A	N		

(j)

	\$0.00	
	\$0.00	
	\$0.00	
	\$0.00	
	\$0.00	
\$0.00	\$0.00	0

n	Pre miu m	Member Months
\$0		
\$0.00	\$0.00	

MSA-2026.1 OMB Approved # 0938-0944 (Expires: 3/31/2027)

/B		

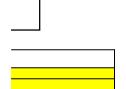
5. p:	Contr-Plan-Seg ID	% of MMs
a.		
b.		
c.		
d.		

j) (k) (l) ments to Contract Period			Unit Cost/	Addi	itive
Benefit Plan Population Other		Intensity	Adjustments		
Change	Change	Factor	Trend	Util/1000	PMPM

ollection of information unless it displays a valid OMB control number. The valid OMB control number for hours per response, including the time to review instructions, search existing data resources, gather the e estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn:

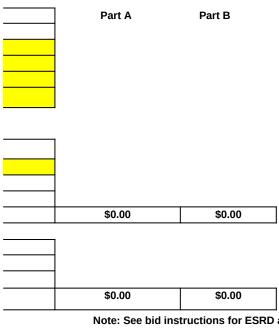
(j)	(k)	(1)	(m)	(n)	(o)	(p)
Manual Rate		Exper.		Contract Year		% of svcs
Avg Cost per Unit	Allowed PMPM	Cred. %	Annual Util/1000	Avg Cost per Unit	Allowed PMPM	provided OON
\$0.00			0	\$0.00	\$0.00	
0.00			0	0.00	0.00	
0.00			0	0.00	0.00	
0.00			0	0.00	0.00	
0.00			0	0.00	0.00	
0.00			0	0.00	0.00	
0.00			0	0.00	0.00	
0.00			0	0.00	0.00	
0.00			0	0.00	0.00	
0.00			0	0.00	0.00	
0.00			0	0.00	0.00	
					0.00	
İ	\$0.00	0%			\$0.00	
		0%	CMS Guideline	Credibility		

ons.



9.





Note: See bid instructions for ESRD and hospice exclusions.

A/B		

(g)	(h)	(i) (j)
Gain/ (Loss) Margin	Premium	Projected Member Months
	\$0.00	
	\$0.00	
	\$0.00	
	\$0.00	
	\$0.00	
\$0.00	\$0.00	0

e contract level.)				
Gain/(Loss) Margin	Premium			Member Months
\$0				
\$0.00	·	\$0.	00	·