

I. General Information

1. Contract Number:		5. Organization Name:		9. Enrollee Type:	
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:	2026	8. MA-PD:		12. SNP:	

II. Base Period Background Information

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

1. Time Period Definition	Incu	01/01/2024	2 Member Months	Total	Non-DE#	DE#	6.1
	Incu	12/31/2024	3 Risk Score			0.0000	
	Paid through:		4 Completion Factor				
			5. Level of significance				

III. Base Period Data (at Plan's Risk Factor) for 1/1/2024-12/31/2024

(b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l)

IV. Projection Assum

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Service Category	Net PMPM	Cost Sharing	Util Type	Total Benefits			Util. Adjustments to Contract Period		
				Annualized Utilization	Avg Cost per Unit	Allowed PMPM	Util/1000 Trend	Benefit Plan Change	Population Change
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/Subgr. (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	0.00							
	\$0.00	\$0.00				\$0.00			
t. Subtotal Medicare-covered service categories						\$0.00			

V. Base Period Summary for 1/1/2024-12/31/2024 (excludes Optional Supplemental)

ESRD	Hospice	All Other	Total				
1. CMS Revenue				\$0	Non-Benefit Expenses:		8. Gain/(Loss) Margin
2. Premium Revenue				\$0	7a. Sales & Marketing		
3. Total Revenue	\$0	\$0	\$0	\$0	7b. Direct Administration		Percentage of Revenue:
7c. Indirect Administration				0.0%	7d. Net Cost of Private Reinsurance		9b. Non-Benefit Expenses
4. Net Medical Expenses				\$0			
9c. Gain/(Loss) Margin	0.0%			0			
5. Member Months				0			
7e. Total Non-Benefit Expenses	\$0						10a. Medicaid F
PMPMs:							10b. Medicaid Cost
6a. Revenue PMPM	\$0.00	\$0.00	\$0.00	\$0.00			10b1. Benefit expenses
6b. Net Medical PMPM	\$0.00	\$0.00	\$0.00	\$0.00			10b2. Non-benefit exp
6c. Non-Benefit PMPM				\$0.00			
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 estimated average burden for this collection of information is 15 minutes 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 regarding this burden estimate or any aspect of this collection of information, including suggestions for reducing this burden, write to the Office of Management and Budget, Paperwork Reduction Project (1545-0047), Washington, DC 20503.

CMS - 10142

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

3. Segment ID:  
4. Contract Year: 2026

7. Plan Type:  
8. MA-PD:

11. Act. Swap/Equiv Apply:

II. Projected Allowed Costs

Note: DE# re

Contract Year Allowed Costs at Plan's Risk Factor:							
(c) Service Category	(e) Util Type	(g) Projected Experience Rate			(j) Manual Rate		(k) Allowed PMPM
		(f) Annual Util/1000	(g) Avg Cost per Unit	(h) Allowed PMPM	(i) Annual Util/1000	(j) Avg Cost per Unit	
a. Inpatient Facility		0		\$0.00		\$0.00	
b. Skilled Nursing Facility		0		0.00		0.00	
c. Home Health		0		0.00		0.00	
d. Ambulance		0		0.00		0.00	
e. DME/Prosthetics/Diabetes		0		0.00		0.00	
f. OP Facility - Emergency		0		0.00		0.00	
g. OP Facility - Surgery		0		0.00		0.00	
h. OP Facility - Other		0		0.00		0.00	
i. Professional		0		0.00		0.00	
j. Part B Rx		0		0.00		0.00	
k. Other Medicare Part B		0		0.00		0.00	
l. Transportation (Non-Covered)		0		0.00		0.00	
m. Dental (Non-Covered)		0		0.00		0.00	
n. Vision (Non-Covered)		0		0.00		0.00	
o. Hearing (Non-Covered)		0		0.00		0.00	
p. Suppl. Ben. Chpt 4 (Non-Covered)		0		0.00		0.00	
q. 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	
		0		0.00		0.00	
r. COB/Subrg. (outside claim system)				0.00			
s. Total Medical Expenses				\$0.00			
t. Subtotal Medicare-covered service categories				\$0.00			

1. Contract No: 5. Org Name: 9. Enrollee Type:  
2. Plan ID: 6. Plan Name: 10. MA Region: N/A  
3. Segment ID: 7. Plan Type: 11. Act. Swan/  
4. Contract Year: 2026 8. MA-PD:

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
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IV. Mapping of PBP service categories to BPT

PBP line	BPT category
1a 1b 2	a1
3	a2
4a 4b 4c 5	b
6	b
7a 7b 7c 7d 7e 7f	h5
7g 7h 7i 7j 7k 8a	f
8b 9a 9b 9c 9d 10a	f
10b 11a 11b 11c	f
12	f
13a	f
13b 13c	h3, h5
13d, 13e, 13f	c
13g, 13h	c
14a 14b 14c 14d	i1
14e 15	i2, i6
16a	i4
16b 16c 17a 17b	i4
18a 18b 18c V/T	i2, i5, i6
19a	i3
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
	q
	k, i1, i2, i6
	i1, i2, i6
	p
	i1, i2, i6
	i1, i2, i6
	j

i2, i6
m
m
n1
n2
o1
o2
o2

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

Service Category	Description	Measure- ment Unit Code	In-Network Effective Deductible PMPM*	In-Network Cost Sharing After Deductible		
				In-Network Util/1000 or PMPM	Description of Cost Sharing / Add'l Days / Benefit Limits****	Effective Copay / Coin Before OOP Max
a.1. Inpatient Facility	Acute					
a.2. Inpatient Facility	Mental Health					
b. Skilled Nursing Facility	DME					
c. Home Health	Prosthetics/Diabetes					
d. Ambulance	Lab Radiology Mental Health Renal Dialysis					
e.1. DME/Prosthetics/Diabetes	Other					
e.2. DME/Prosthetics/Diabetes	PCP					
f. OP Facility - Emergency	Specialist excl. MH					
g. OP Facility - Surgery	Mental Health (MH)					
h.1. OP Facility - Other	Therapy (PT/OT/ST)					
h.2. OP Facility - Other	Radiology					
h.3. OP Facility - Other	Other					
h.4. OP Facility - Other						
h.5. OP Facility - Other						
i.1. Professional						
i.2. Professional						
i.3. Professional						
i.4. Professional						
i.5. Professional						
i.6. Professional						
j. Part B Rx						
k. Other Medicare Part B						
l. Transportation (Non-Covered)						
m. Dental (Non-Covered)						
n.1. Vision (Non-Covered)	Professional					
n.2. Vision (Non-Covered)	Hardware					
o.1. Hearing (Non-Covered)	Professional					
o.2. Hearing (Non-Covered)	Hardware					
p. Suppl. Ben. Chpt 4 (Non-Covered)						
q. Other Non-Covered						
s. Total			\$0.00			

Actual combined plan deductible:

\*Actual in-

u. \*\*\*\*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

\*\* PMPM impact of in-network OOP max:

I. General Information

1. Contract Number:	5. Organization	9.
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:	

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

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



5. Total Non-Benefit Expense		\$0.00
w. Gain/(Loss) Margin		
x. Total Revenue Requirement		\$0.00
y1. Net Medical Expense % of Revenue y2.		0.0%
Non-Benefit % of Revenue		0.0%
y3. Gain/(Loss) Margin % of Revenue		0.0%

**III. Development of Projected Contract Year ESRD "Subsidy"**

CY member months entered by county	0		
CY ESRD member months	0		
CY Out-of-Area (OOA) member months	0		
Basic benefits (user entries must be reported as "per ESRD member per month") CY Revenue			Supplemental Benefits
- CMS capitation			Non-ESRD CY cost sharing reductions Non-ES additional benefits
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 Incremental CY cost of additional
Cost for CY basic benefits allocated to plan members	\$0.00		Total CY ESRD "subsidy" = \$0.00

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	

1. Contract Number:	5. Organization Name:	9. Enrollee Type:	13. Region Name:
2. Plan ID:	6. Plan Name:	10. MA Region: N/A	
3. Segment ID:	7. Plan Type:	11. Act. Swap/Equival Apply:	14. SNP Type:
4. Contract Year: 2026	8. MA-PD:	12. SNP:	

**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 M

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

**Weighting**

1. Statutory Component - Region N/A	47.5%	N/A
2. Plan Bid Component (from CMS)*	52.5%	
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.

**III. Savings/Basic Member Premium Development**

**V. Quality Rating**

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

1. Use of plan-provided ISAR factors? (Regional Plans only - enter Yes or No)									
(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(k)
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-Adjus Bid
2. Total or Weighted Average for Service Area:			0	0	0.00	\$0.00	\$0.00	0	
3. County Level Detail:									
Out of Area									

1. Contract Number:	5. Organization Name:	9. Enrollee Type:
2. Plan ID:	6. Plan Name:	10. MA Region:
3. Segment ID:	7. Plan Type:	11.
4. Contract Year: 2026	8. MA-PD:	Ac









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**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:	
2. Plan ID:		6. Plan Name:	
3. Segment ID:		7. Plan Type:	MSA
4. Contract Year:	2026	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 Claim Deductible (I)
1	\$0-\$250			\$0.00	
2	\$251-\$2,000			0.00	
3	\$2001-\$4,000			0.00	
4	\$4001-\$6,000			0.00	
5	\$6001-\$8,000			0.00	
6	\$8001-\$10,000			0.00	
7	\$10,001-\$12,000			0.00	
8	\$12,001-\$15,000			0.00	
9	\$15,001-\$20,000			0.00	
10	\$20,001-\$30,000			0.00	
11	\$30,001-\$50,000			0.00	
12	\$50,001-\$70,000			0.00	
13	over \$70,000			0.00	
	<b>Total</b>		<b>0.00%</b>	<b>\$0.00</b>	<b>\$0.00</b>

**III. Development of Summary Information (Plan's Risk Factor)**

- a. Plan Medical Expenses
- b. Non-Benefit Expense:

- 1. Sales & Marketing
- 2. Direct Administration
- 3. Indirect Administration
- 4. Net cost of private reinsurance

\$0.00

- 5. Total Non-Benefit Expense
- c. Gain/(Loss) Margin
- d. Total Plan Revenue Requirement
- e. Projected Plan Benchmark
- f. Projected

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

**WORKSHEET 5 - MSA OPTIONAL SUPPLEMENTAL BENEFITS**

**I. General Information**

1. Contract Number:	5. Organization Name:	9. Enrollee Type:
2. Plan ID:	6. Plan Name:	MSA
3. Segment ID:	7. Plan Type:	
4. Contract Year:	8. Deductible Amount:	
2026		

**II. Optional Supplemental Packages**

Package ID	Description	(b) Allowed Medical Expense PMPM	(c) Enrollee Cost Sharing PMPM	(d) Net PMPM value	(e) 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

**III. Base Period Summary for 1/1/2024-12/31/2024 (Note: This section must be reported at th**

		Non-Benefit Expenses
1	Total \$: for all OSB packages combined	
2	PMPM (based on OSB membership)	\$0.00
		\$0.00



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

fers to Dual Eligible Beneficiaries without full Medicare cost sharing liability

(l)	(m)	(n)	(o)	(p)	(q)	(r)
redibility	Blended Rate					% of svcs provided OON
	Annual Util/1000	Avg Cost per Unit	Total Allowed PMPM	Non-DE# Allowed PMPM	DE# Allowed PMPM	
1. Projected member months			Total	Non-DE#	DE#	
2. Projected risk factor			0.0000	0	0.0000	
				0.0000		
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%	CMS Guideline Credibility					
0%			\$0.00	\$0.00	\$0.00	

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

	3. Combined	NO		
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	\$0.00	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%

RD CY

\$0.00  
\$0.00

I benefits

\$0.00  
\$0.00



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

State	(l) (m)		(n) (o) (p)			(q) (r) (s)			(t) (u)	
	Risk Payment	Rate	Original Medicare cost sharing (c.s.)			FFS costs t weight Medicare c.s.			Metropolitan 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

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

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

Total	Maximum Value		
		<b>C. Development of Estimated Plan Premium</b>	\$0.00 0.00
		1. A/B Mandatory Supplemental revenue requirements	0.00
		2. Less rebate allocations:	0.00
		2a. Reduce A/B Cost Sharing	0.00
		2b. Other A/B Mand Supplemental Benefits	0.00
\$	\$0.00	3. A/B Mandatory Supplemental premium	\$0.00
0	0.00	4. Basic MA premium	
.	174.70	5. Total MA Enrollee Premium (excl. Opt. Suppl.)	
0	0.00	<b>6. Rounded MA Premium (excl. Opt. Suppl.)</b>	<b>\$0.00</b>
0	0.00	7. Part D Basic Premium	
\$			
0			
.			
0			
\$			
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)	\$0.00
		<b>7d. Part D Basic Premium*</b>	<b>\$0.00</b>
		8. Part D Supplemental Premium	
		8a. Prior to rebates (rounded value from Rx BPT)	
		8b. A/B rebates allocated to Part D Suppl Premium	
		8c. A/B rebates for Part D Suppl Premium (rounded)	
		<b>8d. Part D Supplemental Premium</b>	
		<b>9. Total estimated plan premium*</b>	
		<b>10. Plan Intention for target PD basic premium</b>	
		* 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	N/A	
SNP	15. VBID-C:	N
SNP	N/A	

(j)

Plan/ ) Margin	Premium	Projected Member Months
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	Part A	Part B

	\$0.00	\$0.00

	\$0.00	\$0.00

Note: See bid instructions for ESRD and hospice exclusions.

A/B
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(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	