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

				Total	Non-DE#	DE#	
1. Time Period Definition			2 Member Months		0	0	6. I
Incu		01/01/2024	3 Risk Score			0.0000	
Incu		12/31/2024	4 Completion Factor				
Paid through:			5. Level of significance				

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

IV. Projection Assum

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

Service Category	Net PMPM	Cost Sharing	Util Type	Total Benefits: Annualized	Total Benefits: Avg Cost per Unit	Total Benefits: Allowed PMPM	Util. Adjustments to Contract Period: 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/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	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			9a. Net Medical Expenses		0.0%			
4. Net Medical Expenses					$0	7d. Net Cost of Private Reinsurance		9b. Non-Benefit Expenses
9c. Gain/(Loss) Margin	0.0%							
5. Member Months			0	0				
7e. Total Non-Benefit Expenses	$0							
PMPMs:								10a. Medicaid F
6a. Revenue PMPM	$0.00	$0.00	$0.00	$0.00				10b. Medicaid Cost
6b. Net Medical PMPM	$0.00	$0.00	$0.00	$0.00				10b1. Benefit expenses
6c. Non-Benefit PMPM				$0.00				10b2. Non-benefit exp
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 numb 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.*

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

3. Segment ID:		7. Plan Type:		11. Act. Swap/Equiv Apply:	1
4. Contract Year:	2026	8. MA-PD:			

II. Projected Allowed Costs **Note: DE# re**

Contract Year Allowed Costs at Plan's Risk Factor:

(c)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	
Service Category	**Util Type**	**Projected Experience Rate**			**Manual Rate**			C
		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		
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		
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. Swap/	
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

IV. Mapping of PBP service categories to BPT

PBP line	BPT category
1a 1b 2	a1
3	a2
4a 4b 4c 5	b
6	h5
7a 7b 7c 7d 7e 7f	f
7g 7h 7i 7j 7k 8a	f
8b 9a 9b 9c 9d 10a	f
10b 11a 11b 11c	h3, h5
12	c
13a	i1
13b 13c	i2, i6
13d, 13e, 13f	i4
13g, 13h	i2, i5, i6
14a 14b 14c 14d	i3
14e 15	i2, i6
16a	i2, i6
16b 16c 17a 17b	i3
18a 18b 18c V/T	i4
19a	i1
19b	i2
	h1
	h2
	h5, g
	g
	h5
	h5, k
	d
	l
	e1
	e2
	e2
	h4
	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)

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

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	**Effective Co After OO
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				

t. Actual combined plan deductible: *Actual in-

u. ** PMPM impact of in-network 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 in

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.	
4. Contract Year:	2026	8. MA-PD:		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: 0.0000

(c) (f) (h) (i) (j) (k)

Service Category	Total Benefits				% for Cov. Svcs		FFS Medicare Actl. 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%	

f.	OP Facility - Emergency	0.00	0.00				0.0%	
g.	OP Facility - Surgery	0.00	0.00				0.0%	
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%	
k.	Other Medicare Part B	0.00	0.00				0.0%	
l.	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%	
o.	Hearing (Non-Covered)	0.00	0.00			0.00%	0.0%	
p.	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%	
		0.00	0.00				0.0%	
		-	$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 Required Bene. cost sharing	Act sh. Me cov
Service Category	Reimb + Actual Cost Sh.	Plan Cost Sharing	Actual Cost Sharing	Plan Reimb	Allowed	Cost Sharing		
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			0.00%			
q. Other Non-Covered	0.00	0.00			0.00%			
r. COB/Subrg. (outside claim system)	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%			
	0.00	0.00						
	-	$0.00	$0.00	$0.00			$0.00	

C. All Beneficiaries

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

0.0000

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

I. General Information

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

II. Development of Projected Revenue Requirement

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
i. Professional	0.00
j. Part B Rx	0.00
k. Other Medicare Part B	0.00
l. 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:	
1. Sales & Marketing	
2. Direct Administration	
3. Indirect Administration	
4. Net Cost of Private Reinsurance	

z1. Re

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

III. Development of Projected Contract Year ESRD "Subsidy"

CY member months entered by county	0	
CY ESRD member months	0	
CY Out-of-Area (OOA) member months	0	
Basic benefits (user entries must be reported as "per ESRD member per month") CY Revenue		Supplemental Benefits Non-ESRD CY cost sharing reductions Non-ES additional benefits
- CMS capitation		
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 additiona
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/Equiv Apply:	
4. Contract Year: 2026 8. MA-PD:		12. SNP:	14. SNP Type:

II. Benchmark and Bid Development — **Note: DE# refers to Dual Eligible Beneficiaries without full M**

	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**		

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%	
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 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) State/County Code	(c) State	(d) County Name	(e) Proj Member Months	(f) Proj Risk Factors	(g) Plan Provided ISAR factors	(h) MA Risk Ratebook Unadjusted	(i) MA Risk Ratebook Risk-Adjusted	(j) ISAR scale	(k) 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. Ac
4. Contract Year: 2026	8. MA-PD:		

II. Other Information

A. Part B Information

1. Maximum Pt B premium buydown amt., per CMS $174.70

B. Rebate Allocation for Part B Premium

1. PMPM Rebate Allocation for Part B premium (maximum value=$174.70)
2. Part B Rebate Allocation, rounded to one decimal (see instructions) $

III. Plan A/B Bid Summary

A. Overview

	Medicare-covered	A/B Mandatory Supplemental
1. Net medical cost		
2. Non-benefit expense		
3. Gain/(loss) margin		
4. Total revenue requirement	$0.00	
5. Standardized A/B Benchmark	$0.00	
6. Plan A/B Benchmark	$0.00 0.0000	
7. Risk Factor	0.0000	
8. Conversion Factor		

B. MA Rebate Allocation

	Rebate PMPM Allocation		
	Medical	Non-Benefit	Gain/(Loss) Margin
1. MA Rebate	n/a	n/a	n/a
2. Reduce A/B Cost Sharing	$0.00	$0.00	$0.00
3. Other A/B Mand Suppl Benefits	0.00	0.00	0.00
4. Pt B Premium Buydown	0.00	n/a	n/a
5. Pt D Premium Buydown Basic	0.00	n/a	n/a
6. Pt D Premium Buydown Suppl	0.00	n/a	n/a
7 Total	--	-- Unalloc. rebate	$0.00

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

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.

Date Prepared

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

II. Optional Supplemental Packages

(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)
Package ID	Description	Allowed Medical Expense PMPM	Enrollee Cost Sharing PMPM	Net PMPM value	Non-Benefit Expense		G (Loss)

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 the contract level.)

	Net Medical Expenses	Non-Benefit Expenses	Gain/(Lo Margi
1. Total $: for all OSB packages combined			
2. PMPM (based on OSB membership)	$0.00	$0.00	

I. General Information

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

II. Base Period Background Information

1. Time Period Definition		2. Member Months	
Incurred from:	01/01/2024	3. Risk Score	
Incurred to:	12/31/2024	4. Completion Factor	
Paid through:			

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

IV. Projecti

	(c)	(f)	(g)		(i)	
Service Category	Util Type	Total Benefits			Util. Adjustı	
		Annualized Util/1000	Avg Cost per Unit	Allowed PMPM	Util/1000 Trend	
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 c this information collection is 0938-0944. The time required to complete this information collection is estimated to average 30 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:		5. Organization Name:	9. Enrollee Type: A/B
2. Plan ID:		6. Plan Name:	MSA
3. Segment ID:		7. Plan Type:	
4. Contract Year:		8. Deductible Amount:	
	2026		

II. Projected Allowed Costs

Contract Year Allowed Costs at Plan's Risk Factor:
(c) (e)

Service Category	Util Type	(f) Projected Experience Rate: Annual Util/1000	(g) Projected Experience Rate: Avg Cost per Unit	(h) Projected Experience Rate: Allowed PMPM	(i) Annual Util/1000
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. COB/Subrg. (outside claim system)				0.00	
m. Total Medicare Covered Medical Expenses				**$0.00**	

WORKSHEET 3 - MSA BENCHMARK PMPM

Note: See bid instructions for ESRD and hospice exclusi

I. General Information

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

II. Contact Information

MSA Plan Contact Person:

Name, Position
Phone Number Email Address

MSA Certifying Actuary:

Name, Credentials Phone Number Email Address

MSA Additional BPT Actuarial Contact:

Name, Position
Phone Number Email Address

Date Prepared (MM/DD/YYYY)

IV. Quality Bonus Rating

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

III: County Level Detail and Service Area Summary

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

WORKSHEET 4 - MSA ENROLLEE DEPOSIT AND PLAN PAYMENT PMPM

Note: See bid instructions for ESRD and hospice exclusions.

I. General Information

1. Contract Number:		5. Organization Name:	
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	
		Total	**0.00%**	**$0.00**	**$0.00**

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

a. Plan Medical Expenses

b. Non-Benefit Expense:

b. Non-Benefit Expense:	
1. Sales & Marketing	**$0.00**
2. Direct Administration	
3. Indirect Administration	
4. Net cost of private reinsurance	
5. Total Non-Benefit Expense	**$0.00**
c. Gain/(Loss) Margin	**$0.00**
d. Total Plan Revenue Requirement	**$0.00**
e. Projected Plan Benchmark	**0.0%**
f. Projected	**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: 2026	8. Deductible Amount:	

II. Optional Supplemental Packages

	(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

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

13. Region Name: N/A

15. VBID-C: N

14. SNP Type: N/A

Bids In Base	Contr-Plan-Seg ID	Member Months	Contr-Plan-Seg ID	Member Months

ıptions

(m) (n) (o) (p) (q)

VI. Base Period

(u) (v)

	Service Category	Net PMPM
a.		
b.		
c.		
d.		
e.		
f.		
g.		
h.		
i.		
j.		
k.		
l.		
m.		
n.		
o.		
p.		
q.		
r.		0.00
s.		**$0.00**

	Unit Cost Adjustment		Additive Adjustments	
Other Factor	Provider Payment Change	Other Factor	Util/1000	PMPM

$0

0.0%

Revenue

$0

ɔenses

ɔer. 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 ıts 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

.4. SNP Type:

15. VBID-C: N
N/A

fers to Dual Eligible Beneficiaries without full Medicare cost sharing liability

	1. Projected member months		Total 0	Non-DE# 0	DE# 0	
	2. Projected risk factor		0.0000	0.0000	0.0000	
(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	
	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%			**$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		

(l)	(m)	(n)	(o)		
›pay / Coin ›P Max	In-Network PMPM	Total In-Network Cost Share PMPM	Out-of-Network Description of Cost Sharing / . . . Benefit Limits****	Out-of-Network Cost Sharing PMPM***	Grand Total Cost Share PMPM (INN+OON)
	$0.00	$0.00			$0.00
	0.00	0.00			0.00
	0.00	0.00			0.00
	0.00	0.00			0.00
	0.00	0.00			0.00
	0.00	0.00			0.00
	0.00	0.00			0.00
	0.00	0.00			0.00
	0.00	0.00			0.00
	0.00	0.00			0.00
	0.00	0.00			0.00
	0.00	0.00			0.00
	0.00	0.00			0.00
	0.00	0.00			0.00
	0.00	0.00			0.00
	0.00	0.00			0.00
	0.00	0.00			0.00
	0.00	0.00			0.00
	0.00	0.00			0.00
	0.00	0.00			0.00
	0.00	0.00			0.00
	0.00	0.00			0.00
	0.00	0.00			0.00
	0.00	0.00			0.00
	0.00	0.00			0.00
	0.00	0.00			0.00
	0.00	0.00			0.00
	0.00	0.00			0.00
	0.00	0.00			0.00
	0.00	0.00			0.00
	0.00	0.00			0.00
	0.00	0.00			0.00
	0.00	0.00			0.00
	0.00	0.00			0.00
	0.00	0.00			0.00
	0.00	0.00			0.00
	0.00	0.00			0.00
	0.00	0.00			0.00
	0.00	0.00			0.00
	0.00	0.00			0.00
	0.00	0.00			0.00
	0.00	0.00			0.00
	0.00	0.00			0.00
	0.00	0.00			0.00
	$0.00	**$0.00**		**$0.00**	**$0.00**
network			***Actual OON plan deductible:		

***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)	(o)	(p)	(q)	(r)
n cost sh. Medicare-ered svcs.	Medicare Covered (w/AE cost sh.)			A/B Mand Suppl (MS) Benefits		
	Allowed PMPM	FFS AE 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**	**$0.00**

(l)	(m)	(n)		(p)	(q)	(r)
ual cost for dicare- ered svcs.	Medicare Covered (w/Medicaid cost sh.)			A/B Mand Suppl (MS) Benefits		
	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**	**$0.00**

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

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

$0.00	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

l 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

	(l)	(m)	(n)	(o)	(p)	(q)	(r)	(s)	(t)	(u)
ɜted	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

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

Total	Maximum Value	
$ 0 . 0 0	$0.00 0.00 174.70 0.00 0.00	**C. Development of Estimated Plan Premium** $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 3. A/B Mandatory Supplemental premium **$0.00** 4. Basic MA premium 5. Total MA Enrollee Premium (excl. Opt. Suppl.) **6. Rounded MA Premium (excl. Opt. Suppl.)** 7. Part D Basic Premium
$ 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 **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) **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 ıe:	N/A		
SNP e:	15. VBID-C: N/A	N	

(j)

ain/) Margin	Premium	Projected Member Months

	$0.00	
	$0.00	
	$0.00	
	$0.00	
	$0.00	
$0.00	$0.00	0

›ss) n	Pre miu m	Member Months
$0		
$0.00	$0.00	

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

/B

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

on Assumptions

(j)	(k)	(l)	(	(n)	(	(

ments to Contract Period			Unit Cost/ Intensity Trend	Additive Adjustments	
Benefit Plan Change	Population Change	Other Factor		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)	(l)	(m)	(n)	(o)	(p)
Manual Rate		**Exper. Cred. %**	**Contract Year Rate**			% of svcs provided OON
Avg Cost per Unit	Allowed PMPM		Annual Util/1000	Avg Cost per Unit	Allowed PMPM	
$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	
	$0.00	**0%**			**$0.00**	
		0%	CMS Guideline Credibility			

ons.

9.

s Over PMPM)

	Part A	Part B

	$0.00	$0.00

	$0.00	$0.00

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	