WORKSHEET 1 - MA BASE PERIOD EXPERIENCE AND PROJECTION ASSUMPTI

I. General Information

1. Contract Number:		5. Organization Name		9. Enrollee Type:		1
2. Plan ID:		6. Plan Name:		10. MA Region:		
3. Segment ID:		7. Plan Type:		11. Act. Swap/Equiv Apply:	N/A	
				12. SNP:		
4. Contract Year:	2027	8. MA-PD:				1

II. Base Period Background Information

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

					To	Non-DE#	DE#
1. Time Period Definition			2	Member Months	0		0
Incurred from:		01/01/2025	3	Risk Score			0.0000
Incurred to:	12/31/2025		4	Completion Factor			
Paid through:							
			5. Level of significance				

6. Bids In Base

III. Base Period Data (at Plan's Risk Factor) for 1/1/2025-12/31/2025

IV. Projection Assumptions

Service Category	Net PMPM (b)	Cost Sharing (c)	Util Type (d)	Total Benefits: Annualized Util/1000 (e)	Total Benefits: Avg Cost per Unit (f)	Total Benefits: Allowed PMPM (g)	Util. Adjustments to Contract Period: Util/1000 Trend (h)	Util. Adjustments to Contract Period: Benefit Plan Change (i)	Util. Adjustments to Contract Period: Population Change (j)	Util. Adjustments to Contract Period: Other Factor (k)
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			0.00					
	0.00	0.00								
	$0.00	**$0.00**				**$0.00**				
t. Subtotal Medicare-covered service categories						$0.00				

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

V. Base Period Summary for 1/1/2025-12/31/2025 (excludes Optional Supplemental)

	ESRD	Hospice	All Other	Total
1. CMS Revenue				$0
2. Premium Revenue				$0
3. Total Revenue		$0	$0	$0
7c. Indirect Administration			9a. Net Medical Expenses	0.0%
4. Net Medical Expenses				$0
9c. Gain/(Loss) Margin		0.0%		
5. Member Months			0	0
7e. Total Non-Benefit Expenses		$0		
PMPMs:				
6a. Revenue PMPM		$0.00	$0.00	$0.00
6b. Net Medical PMPM		$0.00	$0.00	$0.00
6c. Non-Benefit PMPM				$0.00
6d. Gain/(Loss) Margin PMPM				$0.00

Non-Benefit Expenses:
7a. Sales & Marketing
7b. Direct Administration
7d. Net Cost of Private Reinsurance

8. Gain/(Loss) Margin
Percentage of Revenue:
9b. Non-Benefit Expenses
10a. Medicaid Revenue
10b. Medicaid Cost
10b1. Benefit expenses
10b2. Non-benefit expenses

PRA Disclosure Statement *According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OM 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 tin Maryland 21244-1850.*

CMS - 10142

1. Contract Number:		5. Organization Name:	9. Enro
2. Plan ID:		6. Plan Name:	10. N/A
3. Segment ID:		7. Plan Type:	11.
4. Contract Year:	2027	8. MA-PD:	Act. Swa

II. Projected Allowed Costs

Note: DE# refe

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**			Cred
		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		
b. Skilled Nursing Facility		0	0.00	0.00		0.00		
c. Home Health		0	0.00	0.00		0.00		
d. Ambulance		0	0.00	0.00		0.00		
e. DME/Prosthetics/Diabetes		0	0.00	0.00		0.00		
f. OP Facility - Emergency		0	0.00	0.00		0.00		
g. OP Facility - Surgery		0	0.00	0.00		0.00		
h. OP Facility - Other		0	0.00	0.00		0.00		
i. Professional		0	0.00	0.00		0.00		
j. Part B Rx		0	0.00	0.00		0.00		
k. Other Medicare Part B		0	0.00	0.00		0.00		
l. Transportation (Non-Covered)		0	0.00	0.00		0.00		
m. Dental (Non-Covered)		0	0.00	0.00		0.00		
n. Vision (Non-Covered)		0	0.00	0.00		0.00		
o. Hearing (Non-Covered)		0	0.00	0.00		0.00		
p. Suppl. Ben. Chpt 4 (Non-Covered)		0	0.00	0.00		0.00		
q. Other Non-Covered		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		
r. COB/Subrg. (outside claim system)				0.00				
s. Total Medical Expenses				**$0.00**			**$0.00**	
t. Subtotal Medicare-covered service categories				$0.00			$0.00	

1. Contract No:
2. Plan ID:
3. Segment ID:
4. Contract Year:
5. Org Name:
6. Plan Name:
7. Plan Type:
8. MA-PD:

N/A

II. Maximum Cost Sharing Per Member Per Year

Is there a plan-level OOP maximum? (Yes/No, then enter amount)	1. In Network	NO		2. Out of Network	NO

IV. Mapping of PBP service categories to BPT

PBP line	BPT category
1a 1b 2	a1
3	a2
4a 4b 4c	b
5a, 5b	h5
6	f
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 C After O(**	
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							
e.1.	DME/Prosthetics/Diabetes	Health Renal Dialysis							
e.2.	DME/Prosthetics/Diabetes	Other							
f.	OP Facility - Emergency	PCP							
g.	OP Facility - Surgery	Specialist excl. MH Mental							
h.1.	OP Facility - Other	Health (MH) Therapy							
h.2.	OP Facility - Other	(PT/OT/ST) 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-ne

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 instr

I. General Information

1. Contract Number:		5. Organization Name:	9. Enrollee Type:		13. Region
2. Plan ID:		6. Plan Name:	10. MA Region:	N/A	
3. Segment ID:		7. Plan Type:	11. Act. Swap/Equiv Apply:		14. SNP Type:
4. Contract Year:	2027	8. MA-PD:	12. SNP		

II. Development of Projected Revenue Requirement

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

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

(c)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(l)	(m)	(n)	(o)
	Total Benefits				**% for Cov. Svcs**					**Medicare Covered (w/A**	
Service Category	Allowed PMPM	Plan Cost Sharing		Net PMPM	Allowed	Cost Sharing	FFS Medicare Actl. Equiv. cost sharing	Plan cost sh. for Medicare-covered svcs.		Allowed PMPM	FFS AE Cost Sharing
a. Inpatient Facility	$0.00	$0.00		$0.00			0.0%			$0.00	
b. Skilled Nursing Facility	0.00	0.00		0.00			0.0%	0.00		0.00	
c. Home Health	0.00	0.00		0.00			0.0%	0.00		0.00	
d. Ambulance	0.00	0.00		0.00			0.0%	0.00		0.00	
e. DME/Prosthetics/Diabetes	0.00	0.00		0.00			0.0%	0.00		0.00	
f. OP Facility - Emergency	0.00	0.00		0.00			0.0%	0.00		0.00	
g. OP Facility - Surgery	0.00	0.00		0.00			0.0%	0.00		0.00	
h. OP Facility - Other	0.00	0.00		0.00			0.0%	0.00		0.00	
i. Professional	0.00	0.00		0.00			0.0%	0.00		0.00	
j. Part B Rx	0.00	0.00		0.00			0.0%	0.00		0.00	
k. Other Medicare Part B	0.00	0.00		0.00			0.0%	0.00		0.00	
l. Transportation (Non-Covered)	0.00	0.00		0.00			0.0%	0.00		0.00	
m. Dental (Non-Covered)	0.00	0.00		0.00			0.0%	0.00		0.00	
n. Vision (Non-Covered)	0.00	0.00		0.00			0.0%	0.00		0.00	
o. Hearing (Non-Covered)	0.00	0.00		0.00			0.0%	0.00		0.00	
p. Suppl. Ben. Chpt 4 (Non-Covered)	0.00	0.00		0.00			0.0%	0.00		0.00	
q. Other Non-Covered											
r. COB/Subrg. (outside claim system)	0.00	0.00		0.00	0.00%	0.00%	0.0%	0.00		0.00	
s. Total Medical Expenses	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%	0.0%	0.00		0.00	

	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(l)	(m)	(o)
	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%	0.0%	0.00	0.00	
	0.00	0.00		0.00	0.00%	0.00%	0.0%	0.00	0.00	
	0.00	0.00		0.00		0.00%	0.0%	0.00	0.00	
	$0.00	$0.00		$0.00			$0.00		$0.00	

B. DE# (Dual Eligible Beneficiaries without full Medicare cost sharing liability)
Cost and Required Revenue PMPM at Plan's Risk Factor: 0.0000

(c)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(l)	(m)	(o)
	Total Benefits				% for Cov. Svcs		State Medicaid Required Bene. cost sharing	Actual cost sh. for Medicare-covered svcs.	Medicare Covered (w/Medicai	
Service Category	Reimb + Actual Cost Sh.	Plan Cost Sharing	Actual Cost Sharing	Plan Reimb	Allowed	Cost Sharing			Allowed PMPM	Medicaid Cost Sharing
a. Inpatient Facility	$0.00	$0.00	$0.00						$0.00	
b. Skilled Nursing Facility	0.00	0.00	0.00					0.00	0.00	
c. Home Health	0.00	0.00	0.00					0.00	0.00	
d. Ambulance	0.00	0.00	0.00					0.00	0.00	
e. DME/Prosthetics/Diabetes	0.00	0.00	0.00					0.00	0.00	
f. OP Facility - Emergency	0.00	0.00	0.00					0.00	0.00	
g. OP Facility - Surgery	0.00	0.00	0.00					0.00	0.00	
h. OP Facility - Other	0.00	0.00	0.00					0.00	0.00	
i. Professional	0.00	0.00	0.00					0.00	0.00	
j. Part B Rx	0.00	0.00	0.00					0.00	0.00	
k. Other Medicare Part B	0.00	0.00	0.00					0.00	0.00	
l. Transportation (Non-Covered)	0.00	0.00	0.00		0.00%	0.00%		0.00	0.00	
m. Dental (Non-Covered)	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	
o. Hearing (Non-Covered)	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	
q. Other Non-Covered	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	
s. Total Medical Expenses	$0.00	$0.00	$0.00	$0.00			$0.00		$0.00	

C. All Beneficiaries
Cost and Required Revenue PMPM at Plan's Risk Factor: 0.0000

(c)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(l)	(m)	(n)	(o)
	Total Benefits										Medicare Covered
Service Category				Net 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							

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:	14. SNP Type:
4. Contract Year: 2027	8. MA-PD:	12. SNP:	

II. Development of Projected Revenue Requirement

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

z1. Related-Party Allowed Cost 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") CY Revenue - CMS capitation

Supplemental Benefits
Non-ESRD CY cost sharing reductions Non-ESRD CY additional benefits $0.00 $0.00

CY Medical Expenses for Basic Services
CY Non-Benefit Expenses for Basic Services
CY Margin Requirement for Basic Services $0.00
CY Gain/(Loss) Margin for Basic Services $0.00
Cost for CY basic benefits allocated to plan members $0.00

ESRD CY cost sharing reductions
ESRD CY additional benefits
Incremental CY cost of cost sharing reductions Incremental CY cost of additional benefits $0.00 $0.00
Total CY ESRD "subsidy" = $0.00

Include ESRD

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: 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: 2027	8. MA-PD:	12. SNP:	14. SNP Type: N/A

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	45.6%	
2. Plan Bid Component (from CMS)*	54.4%	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. Act. Swap/Equiv Apply:
4. Contract Year: 2027	8. MA-PD:		12. SNP:

II. Other Information

A. Part B Information

1. Maximum Pt B premium buydown amt., per CMS	$202.90

B. Rebate Allocation for Part B Premium

1. PMPM Rebate Allocation for Part B premium (maximum value=$202.90)	
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	0	
3. Gain/(loss) margin		
4. Total revenue requirement	0	
	0	
	$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) Margi**
1. MA Rebate	n/a	n/a	n/a
2. Reduce A/B Cost Sharing	$0.00	$0.00	$0.0
3. Other A/B Mand Suppl Benefits	0.00	0.00	0.00
4. Pt B Premium Buydown	0.00	n/a	n/a r
5. Pt D Premium Buydown Basic	0.00	n/a	n/a
6. Pt D Premium Buydown Suppl	0.00	n/a	
7 Total		$0.00 Unalloc. rebate	$0.0

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:

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.

Name, Position Phone Number Email Address

Date Prepared

1. Contract Number:		5. Organization Name:		9. Enrollee Type:	1 R
2. Plan ID:		6. Plan Name:		10. MA Region:	N/A
3. Segment ID:		7. Plan Type:		11. Act. Swap/Equiv Apply:	1 S T
4. Contract Year:	2027	8. MA-PD:			

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	Gai (Loss) M
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 1/1/2025-12/31/2025 (Note: This section must be reported at the contract level.)

	Net Medical Expense	Non-Benefit Expenses	Gain/(Loss Margin
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: 2027 8. Deductible Amount:

II. Base Period Background Information

1. Time Period Definition
Incurred from: 01/01/2025
Incurred to: 12/31/2025
Paid through:

2. Member Months
3. Risk Score
4. Completion Factor

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

Service Category	Util Type	(c)	(f) Total Benefits: Annualized Util/1000	(g) Total Benefits: Avg Cost per Unit	(h) Total Benefits: Allowed PMPM	(i) Util. Adjustr: Util/1000 Trend	(j)
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 col this information collection is 0938-0944. The time required to complete this information collection is estimated to average 30 I data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.*

CMS - 10142

I. General Information

1. Contract Number:
2. Plan ID:
3. Segment ID:
4. Contract Year: 2027
5. Organization
6. Plan Name:
7. Plan Type: MSA
8. Deductible Amount:

II. Projected Allowed Costs

Contract Year Allowed Costs at Plan's Risk Factor:

Service Category	Util Type	(c)	(e)	(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	I
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		

	0	0.00	0.00		
	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 e

I. General Information

1. Contract Number:
2. Plan ID:
3. Segment ID:
4. Contract Year: 2027
5. Organization Name:
6. Plan Name:
7. Plan Type: MSA
8. Deductible Amount:
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 applic

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: 2. County Level Detail:			0	0	$0.00	$0.00	Plan Benchma
Out of Area							

Note: See bid instructions for ESRD and hospice exclusions.

I. General Information

1. Contract Number:		5. Organization Name:		9. Er
2. Plan ID:		6. Plan Name:		
3. Segment ID:		7. Plan Type:	MSA	
4. Contract Year:	2027	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 (**
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	**$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

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:	2027	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 1/1/2025-12/31/2025 (Note: This section must be reported at the

1	Total $: for all OSB packages combined		
2	PMPM (based on OSB membership)	$0.00	$0.00

ONS

Note: See bid instructions for ESRD and hospice exclusions.
MA-2027.1
OMB Approved # 0938-0944 (Expires: 3/31/2027)

.3. Region Name:	N/A
.4. SNP Type:	N/A

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

VI. Base Period Risk-Sharing Payments

(o)	(p)	(q)		(u)	(v)
Unit Cost Adjustment		**Additive Adjustments**			
Provider Payment Change	**Other Factor**	**Util/1000**	**PMPM**		

	$0
	0.0%
	$0

MB 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,
ne 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,

13. Region Name:	N/A
14. SNP Type:	N/A

rs to Dual Eligible Beneficiaries without full Medicare cost sharing liability

	1. Projected member months risk		Total 0	Non-DE# 0	DE# 0	
	2. Projected factor		0.0000	0.0000	0.0000	
(l)	(	(n)	(o)	(p)	(q)	(r)
dibility	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:	N/A	

		3. Combined	NO		

(l)	(m)	(n)	(o)		
:opay / Coin OP 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**
twork plan			***Actual OON plan deductible:		

***PMPM impact of OON OOP max:

uctions for details.

N/A

N/A

	(p)	(q)	(r)	
\E cost sh.)		A/B Mand Suppl (MS) Benefits		
	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**

	(p)	(q)	(r)	
d cost sh.)		**A/B Mand Suppl (MS) Benefits**		
	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**

	(p)	(q)	(r)	(t)
		A/B Mand Suppl (MS) Benefits		
	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
	N/A			
	N/A			

(u)	
Projected Risk-Sharing Payments	
Service Category	**Net PMPM**
a.	
b.	
c.	
d.	
e.	
f.	
g.	
h.	
i.	
j.	
k.	
l.	
m.	
n.	
o.	
p.	
q.	
r.	
s.	
t.	
	0.00
	0.00

	$0.00	**$0.00**	**$0.00**	**$0.00**
	$0.00			$0.00
	0.00			0.00
	0.00			0.00
	0.00			0.00
	$0.00	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%**

edicare 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)
sted	Risk Payment	Rate	Original Medicare cost sharing (c.s.)			FFS costs t	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
$0.00	38.670%	61.330%	0.0%	0.0%	0.0%	n/a	n/a	n/a	0	n/a 0% predominant MSA

13. Region Name: N/A

N

14. SNP Type: 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)

in	Total	Maximum Value
	$0.00	$0.00 0.00
0	$0.00 0.00	202.90
	0.00	0.00
v/a	0.00	0.00
	0.00	

C. Development of Estimated Plan Premium

1. A/B Mandatory Supplemental revenue requirements	$0.00 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	**$0.00**
5. Total MA Enrollee Premium (excl. Opt. Suppl.)	
6. Rounded MA Premium (excl. Opt. Suppl.)	
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
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.

3. Region	N/A
4. PNP Type:	N/A

(j)

n/ Margin	Premium	Projected Member Months
	$0.00	
	$0.00	
	$0.00	
	$0.00	
	$0.00	
$0.00	$0.00	0

s)	Premium	Member Months
$0		
$0.00	$0.00	

/B

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

ction Assumptions

(k)	(l)	(m)	(n)	(	(p)
ments to Contract Period			**Unit Cost/ Intensity Trend**	**Additive Adjustments**	
Benefit Plan Change	**Population Change**	**Other Factor**		**Util/1000**	**PMPM**

llection 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 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			

exclusions.

cable

rk

rollee Type:	A/B

ns Over (PMPM)
)

)	Part A	Part B

)		
)		
)		
)	$0.00	$0.00

)	$0.00	$0.00

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

contract level.)

Net Medical Expenses	Non-Benefit Member Expenses	Gain/(Loss) Margin
$0		
$0.00	$0.00	