

WORKSHEET 1 - MA BASE PERIOD EXPERIENCE AND PROJECTION ASSUMPTIONS

Note: See bid instructions for ESRD and hospice exclusions.

MA-2026.1

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

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

II. Base Period Background Information

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

1. Time Period Definition		Total		Non-DE#		DE#		6. Bids In Base			
Incurred from:		01/01/2024		0		0		Contr-Plan-Seg ID		Member Months	
Incurred to:		12/31/2024				0.0000					
Paid through:											
3. Risk Score											
4. Completion Factor											
5. Level of significance											

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

IV. Projection Assumptions

VI. Base Period Risk-Sharing Payment Adjustments

(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(l)	(m)	(n)	(o)	(p)	(q)
Service Category	Net PMPM	Cost Sharing	Util Type	Total Benefits			Util. Adjustments to Contract Period				Unit Cost Adjustment		Additive Adjustments		
				Annualized Util/1000	Avg Cost per Unit	Allowed PMPM	Util/1000 Trend	Benefit Plan Change	Population Change	Other Factor	Provider Payment Change	Other Factor	Util/1000	PMPM	
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									
t. Subtotal Medicare-covered service categories						\$0.00									

(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

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

1. CMS Revenue		ESRD	Hospice	All Other	Total	\$0	Non-Benefit Expenses:	8. Gain/(Loss) Margin	\$0
2. Premium Revenue					\$0		7a. Sales & Marketing		
3. Total Revenue		\$0	\$0	\$0	\$0		7b. Direct Administration		
4. Net Medical Expenses					\$0		7c. Indirect Administration		
5. Member Months				0	0		7d. Net Cost of Private Reinsurance		
6a. Revenue PMPM		\$0.00	\$0.00	\$0.00	\$0.00		7e. Total Non-Benefit Expenses	\$0	
6b. Net Medical PMPM		\$0.00	\$0.00	\$0.00	\$0.00				
6c. Non-Benefit PMPM					\$0.00				
6d. Gain/(Loss) Margin PMPM					\$0.00				
Percentage of Revenue:							9a. Net Medical Expenses	0.0%	
							9b. Non-Benefit Expenses	0.0%	
							9c. Gain/(Loss) Margin	0.0%	
10a. Medicaid Revenue									
10b. Medicaid Cost					\$0				
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 OMB control number for this information collection is 0938-0944. The time required to complete this information collection is estimated to average 30 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

I. General Information

1. Contract Number:	5. Organization Name:	9. Enrollee Type:	13. Region Name:	N/A
2. Plan ID:	6. Plan Name:	10. MA Region:	N/A	
3. Segment ID:	7. Plan Type:	11. Act. Swap/Equiv Apply:	15. VBID-C:	N
4. Contract Year: 2026	8. MA-PD:	12. SNP:	14. SNP Type:	N/A

II. Projected Allowed Costs

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

Contract Year Allowed Costs at Plan's Risk Factor:									Total			Non-DE#		DE#	
									0			0		0	
									0.0000			0.0000		0.0000	
(c)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(l)	(m)	(n)	(o)	(p)	(q)	(r)	
Service Category	Util Type	Projected Experience Rate			Manual Rate			Credibility	Blended Rate					% of svcs provided OON	
		Annual Util/1000	Avg Cost per Unit	Allowed PMPM	Annual Util/1000	Avg Cost per Unit	Allowed PMPM		Annual Util/1000	Avg Cost per Unit	Total Allowed PMPM	Non-DE# Allowed PMPM	DE# Allowed PMPM		
a. Inpatient Facility		0	\$0.00	\$0.00		\$0.00			0	\$0.00	\$0.00				
b. Skilled Nursing Facility		0	0.00	0.00		0.00			0	0.00	0.00				
c. Home Health		0	0.00	0.00		0.00			0	0.00	0.00				
d. Ambulance		0	0.00	0.00		0.00			0	0.00	0.00				
e. DME/Prosthetics/Diabetes		0	0.00	0.00		0.00			0	0.00	0.00				
f. OP Facility - Emergency		0	0.00	0.00		0.00			0	0.00	0.00				
g. OP Facility - Surgery		0	0.00	0.00		0.00			0	0.00	0.00				
h. OP Facility - Other		0	0.00	0.00		0.00			0	0.00	0.00				
i. Professional		0	0.00	0.00		0.00			0	0.00	0.00				
j. Part B Rx		0	0.00	0.00		0.00			0	0.00	0.00				
k. Other Medicare Part B		0	0.00	0.00		0.00			0	0.00	0.00				
l. Transportation (Non-Covered)		0	0.00	0.00		0.00			0	0.00	0.00				
m. Dental (Non-Covered)		0	0.00	0.00		0.00			0	0.00	0.00				
n. Vision (Non-Covered)		0	0.00	0.00		0.00			0	0.00	0.00				
o. Hearing (Non-Covered)		0	0.00	0.00		0.00			0	0.00	0.00				
p. Suppl. Ben. Chpt 4 (Non-Covered)		0	0.00	0.00		0.00			0	0.00	0.00				
q. Other Non-Covered		0	0.00	0.00		0.00			0	0.00	0.00				
r. COB/Subrg. (outside claim system)				0.00							0.00				
s. Total Medical Expenses				\$0.00			\$0.00	0%				\$0.00	\$0.00	\$0.00	
								0%	CMS Guideline Credibility						
t. Subtotal Medicare-covered service categories				\$0.00			\$0.00	0%				\$0.00	\$0.00	\$0.00	

Note: See bid instructions for ESRD and hospice exclusions.

1. Contract No:	5. Org Name:	9. Enrollee Type:	13. Region Name:	N/A
2. Plan ID:	6. Plan Name:	10. MA Region:	N/A	
3. Segment ID:	7. Plan Type:	11. Act. Swap/Equiv Apply:		15. VBID-C: N
4. Contract Year: 2026	8. MA-PD:	12. SNP:	14. SNP Type:	N/A

Is there a plan-level OOP maximum? (Yes/No, then enter amount)	1. In Network	NO		2. Out of Network	NO		3. Combined	NO		
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(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(l)	(m)	(n)	(o)	
Service Category	Description	Measure- ment Unit Code	In-Network Effective Deductible PMPM*	In-Network Cost Sharing After Deductible					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)	
				In-Network Util/1000 or PMPM	Description of Cost Sharing / Add'l Days / Benefit Limits****	Effective Copay / Coin Before OOP Max	**Effective Copay / Coin After OOP Max	In-Network PMPM					
a.1.	Inpatient Facility	Acute Mental Health						\$0.00	\$0.00			\$0.00	
a.2.	Inpatient Facility								0.00	0.00			0.00
b.	Skilled Nursing Facility								0.00	0.00			0.00
c.	Home Health								0.00	0.00			0.00
d.	Ambulance								0.00	0.00			0.00
e.1.	DME/Prosthetics/Diabetes	DME						0.00	0.00			0.00	
e.2.	DME/Prosthetics/Diabetes	Prosthetics/Diabetes						0.00	0.00			0.00	
f.	OP Facility - Emergency	Lab Radiology Mental Health Renal Dialysis Other						0.00	0.00			0.00	
g.	OP Facility - Surgery								0.00	0.00			0.00
h.1.	OP Facility - Other								0.00	0.00			0.00
h.2.	OP Facility - Other								0.00	0.00			0.00
h.3.	OP Facility - Other								0.00	0.00			0.00
h.4.	OP Facility - Other								0.00	0.00			0.00
h.5.	OP Facility - Other								0.00	0.00			0.00
i.1.	Professional		PCP						0.00	0.00			0.00
i.2.	Professional		Specialist excl. MH						0.00	0.00			0.00
i.3.	Professional	Mental Health (MH)						0.00	0.00			0.00	
i.4.	Professional	Therapy (PT/OT/ST)						0.00	0.00			0.00	
i.5.	Professional	Radiology						0.00	0.00			0.00	
i.6.	Professional	Other						0.00	0.00			0.00	
j.	Part B Rx							0.00	0.00			0.00	
k.	Other Medicare Part B							0.00	0.00			0.00	
l.	Transportation (Non-Covered)							0.00	0.00			0.00	
m.	Dental (Non-Covered)							0.00	0.00			0.00	
n.1.	Vision (Non-Covered)	Professional						0.00	0.00			0.00	
n.2.	Vision (Non-Covered)	Hardware						0.00	0.00			0.00	
o.1.	Hearing (Non-Covered)	Professional						0.00	0.00			0.00	
o.2.	Hearing (Non-Covered)	Hardware						0.00	0.00			0.00	
p.	Suppl. Ben. Chpt 4 (Non-Covered)							0.00	0.00			0.00	
q.	Other Non-Covered							0.00	0.00			0.00	
								0.00	0.00			0.00	
								0.00	0.00			0.00	
								0.00	0.00			0.00	
								0.00	0.00			0.00	
								0.00	0.00			0.00	
								0.00	0.00			0.00	
								0.00	0.00			0.00	
								0.00	0.00			0.00	
s.	Total		\$0.00					\$0.00	\$0.00		\$0.00	\$0.00	

****NOTE: Cells H25:H64 and cells M25:M64 can be used at the discretion of the Plan sponsor. The contents are NOT uploaded in the bid submission, and will be deleted during finalization. See instructions for details.

PBP line	BPT category
1a	a1
1b	a2
2	b
3	h5
4a	f
4b	f
4c	f
5	h3, h5
6	c
7a	i1
7b	i2, i6
7c	i4
7d	i2, i5, i6
7e	i3
7f	i2, i6
7g	i2, i6
7h	i3
7i	i4
7j	i1
7k	i2
8a	h1
8b	h2
9a	h5, g
9b	g
9c	h5
9d	h5, k
10a	d
10b	i
11a	e1
11b	e2
11c	e2
12	h4
13a	q
13b	q
13c	q
13d, 13e, 13f	q
13g, 13h	q
14a	k, i1, i2, i6
14b	i1, i2, i6
14c	p
14d	i1, i2, i6
14e	i1, i2, i6
15	j
16a	i2, i6
16b	m
16c	m
17a	n1
17b	n2
18a	o1
18b	o2
18c	o2
V/T	
19a	
19b	

WORKSHEET 4 - MA PROJECTED REVENUE REQUIREMENT PMPM

Note: See bid instructions for ESRD and hospice exclusions.

I. General Information

1. Contract Number:	5. Organization Name:	9. Enrollee Type:	13. Region Name:	N/A
2. Plan ID:	6. Plan Name:	10. MA Region:		N/A
3. Segment ID:	7. Plan Type:	11. Act. Swap/Equiv Apply:		15. VBIID-C: N
4. Contract Year: 2026	8. MA-PD:	12. SNP:	14. SNP Type:	N/A

II. Development of Projected Revenue Requirement

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

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

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

B. DE# (Dual Eligible Beneficiaries without full Medicare cost sharing liability)

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

(c) Service Category	(e) Total Benefits				(i) % for Cov. Svcs		(k) State Medicaid Required Bene. cost sharing	(l) Actual cost sh. for Medicare- covered svcs.	(m) Medicare Covered (w/Medicaid cost sh.)			(p) A/B Mand Suppl (MS) Benefits		
	Reimb + Actual Cost Sh.	Plan Cost Sharing	Actual Cost Sharing	Plan Reimb	Allowed	Cost Sharing			Allowed PMPM	Medicaid Cost Sharing	Net PMPM	Net PMPM for Add'l Svcs.	Reduction of A/B Cost Sh.	Total
a. Inpatient Facility	\$0.00	\$0.00	\$0.00					\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
b. Skilled Nursing Facility	0.00	0.00	0.00					0.00	0.00	0.00	0.00	0.00	0.00	0.00
c. Home Health	0.00	0.00	0.00					0.00	0.00	0.00	0.00	0.00	0.00	0.00
d. Ambulance	0.00	0.00	0.00					0.00	0.00	0.00	0.00	0.00	0.00	0.00
e. DME/Prosthetics/Diabetes	0.00	0.00	0.00					0.00	0.00	0.00	0.00	0.00	0.00	0.00
f. OP Facility - Emergency	0.00	0.00	0.00					0.00	0.00	0.00	0.00	0.00	0.00	0.00
g. OP Facility - Surgery	0.00	0.00	0.00					0.00	0.00	0.00	0.00	0.00	0.00	0.00
h. OP Facility - Other	0.00	0.00	0.00					0.00	0.00	0.00	0.00	0.00	0.00	0.00
i. Professional	0.00	0.00	0.00					0.00	0.00	0.00	0.00	0.00	0.00	0.00
j. Part B Rx	0.00	0.00	0.00					0.00	0.00	0.00	0.00	0.00	0.00	0.00
k. Other Medicare Part B	0.00	0.00	0.00					0.00	0.00	0.00	0.00	0.00	0.00	0.00
l. Transportation (Non-Covered)	0.00	0.00	0.00		0.00%	0.00%		0.00	0.00	0.00	0.00	0.00	0.00	0.00
m. Dental (Non-Covered)	0.00	0.00	0.00		0.00%	0.00%		0.00	0.00	0.00	0.00	0.00	0.00	0.00
n. Vision (Non-Covered)	0.00	0.00	0.00		0.00%	0.00%		0.00	0.00	0.00	0.00	0.00	0.00	0.00
o. Hearing (Non-Covered)	0.00	0.00	0.00		0.00%	0.00%		0.00	0.00	0.00	0.00	0.00	0.00	0.00
p. Suppl. Ben. Chpt 4 (Non-Covered)	0.00	0.00	0.00		0.00%	0.00%		0.00	0.00	0.00	0.00	0.00	0.00	0.00
q. Other Non-Covered	0.00	0.00	0.00		0.00%	0.00%		0.00	0.00	0.00	0.00	0.00	0.00	0.00
r. COB/Subrg. (outside claim system)	0.00	0.00	0.00			0.00%		0.00	0.00	0.00	0.00	0.00	0.00	0.00
s. Total Medical Expenses	\$0.00	\$0.00	\$0.00	\$0.00			\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00

C. All Beneficiaries

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

(c)	(e) Total Benefits				(i)	(j)	(k)	(l)	(m)	(n) Medicare Covered	(o) Net	(p) A/B Mand Suppl (MS) Benefits		
				Net								Net PMPM for	Reduction of	

WORKSHEET 4 - MA PROJECTED REVENUE REQUIREMENT PMPM

Note: See bid instructions for ESRD and hospice exclusions.

I. General Information

1. Contract Number:	5. Organization Name:	9. Enrollee Type:	13. Region Name:	N/A
2. Plan ID:	6. Plan Name:	10. MA Region:		N/A
3. Segment ID:	7. Plan Type:	11. Act. Swap/Equiv Apply:	15. VBIID-C:	N
4. Contract Year: 2026	8. MA-PD:	12. SNP:	14. SNP Type:	N/A

II. Development of Projected Revenue Requirement

Service Category				PMPM							PMPM	Add'l Svcs.	A/B Cost Sh.	Total
a.	Inpatient Facility			\$0.00							\$0.00	\$0.00	\$0.00	\$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
m.	Dental (Non-Covered)			0.00							0.00	0.00	0.00	0.00
n.	Vision (Non-Covered)			0.00							0.00	0.00	0.00	0.00
o.	Hearing (Non-Covered)			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
q.	Other Non-Covered			0.00							0.00	0.00	0.00	0.00
r.	ESRD			0.00							0.00	0.00	0.00	0.00
s.														
t.	COB/Subrg. (outside claim system)			0.00							0.00	0.00	0.00	0.00
u.	Total Medical Expenses			\$0.00							\$0.00	\$0.00	\$0.00	\$0.00
v.	Non-Benefit Expense:													
1.	Sales & Marketing										\$0.00			\$0.00
2.	Direct Administration										0.00			0.00
3.	Indirect Administration										0.00			0.00
4.	Net Cost of Private Reinsurance										0.00			0.00
5.	Total Non-Benefit Expense			\$0.00							\$0.00	0.00	0.00	\$0.00
w.	Gain/(Loss) Margin										\$0.00	0.00	0.00	\$0.00
x.	Total Revenue Requirement			\$0.00							\$0.00	0.00	0.00	\$0.00
y1.	Net Medical Expense % of Revenue			0.0%							0.0%			0.0%
y2.	Non-Benefit % of Revenue			0.0%							0.0%			0.0%
y3.	Gain/(Loss) Margin % of Revenue			0.0%							0.0%			0.0%

III. Development of Projected Contract Year ESRD "Subsidy"

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

IV. Projected Medicaid Data

Entries must be reported as "Per Member Per Month" (PMPM).	
1. Medicaid Projected Revenue	
2. Medicaid Projected Cost (not in bid)	\$0.00
2a. Benefit expenses	
2b. Non-benefit expenses	

I. General Information

1. Contract Number:	5. Organization Name:	9. Enrollee Type:	13. Region Name:	N/A
2. Plan ID:	6. Plan Name:	10. MA Region:	N/A	
3. Segment ID:	7. Plan Type:	11. Act. Swap/Equiv Apply:		15. VBID-C: N
4. Contract Year: 2026	8. MA-PD:	12. SNP:	14. SNP Type:	N/A

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

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

IV. Standardized A/B Benchmark - Regional Plans Only

	Weighting	
1. Statutory Component - Region N/A	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.		

VIII. Projected CY Member Months

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

III. Savings/Basic Member Premium Development

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

V. Quality Rating

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

VI: County Level Detail and Service Area Summary

1. Use of plan-provided ISAR factors? (Regional Plans only - enter Yes or No)					
(b)	(c)	(d)	(e)	(f)	(g)
State/County Code	State	County Name	Proj Member Months	Proj Risk Factors	Plan Provided ISAR factors
2. Total or Weighted Average for Service Area:			0	0	0.00
3. County Level Detail:					
Out of Area					

VII: Other Medicare Information

(n)			(o)			(p)			(q)			(r)			(s)			(t)			(u)		
Original Medicare cost sharing (c.s.)						FFS costs to weight Medicare c.s.						Metropolitan Statistical Area											
Inpatient		SNF		Pt B (excl HH)		Inpatient		SNF		Pt B (excl HH)		MM		MSA name									
0.0%		0.0%		0.0%		n/a		n/a		n/a		0 n/a											
												0% predominant MSA											

I. General Information				
1. Contract Number:	5. Organization Name:	9. Enrollee Type:	13. Region Name:	N/A
2. Plan ID:	6. Plan Name:	10. MA Region:	N/A	
3. Segment ID:	7. Plan Type:	11. Act. Swap/Equiv Apply:	15. VBID-C:	N
4. Contract Year:	2026	12. SNP:	14. SNP Type:	N/A

II. Other Information		
A. Part B Information		C. Rebate Allocations
1. Maximum Pt B premium buydown amt., per CMS		1. Reduce A/B Cost Sharing (max. value=\$0.00)
\$174.70		2. Other A/B Mand Suppl Benefits (max. value=\$0.00)

Plan A/B Bid Summary						
A. Overview		B. MA Rebate Allocation		C. Development of Estimated Plan Premium		
1. Net medical cost 2. Non-benefit expense 3. Gain/(loss) margin 4. Total revenue requirement 5. Standardized A/B Benchmark 6. Plan A/B Benchmark 7. Risk Factor 8. Conversion Factor						

IV. Contact Information

MA Plan Bid Contact:

Name, Position

Phone Number

Email Address

MA Certifying Actuary:

Name, Credentials

Phone Number

Email Address

MA Additional BPT Actuarial Contact:

Name, Position

Phone Number

Email Address

Date Prepared

V. Working Model Text Box

This section can be used at the discretion of the Plan sponsor. The contents are NOT uploaded in the bid submission, and will be deleted during finalization. See instructions for details.

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

I. General Information

1. Contract Number:	5. Organization Name:	9. Enrollee Type:	13. Region Name:	N/A
2. Plan ID:	6. Plan Name:	10. MA Region:	N/A	
3. Segment ID:	7. Plan Type:	11. Act. Swap/Equiv Apply:	15. VBIID-C:	N
4. Contract Year: 2026	8. MA-PD:	12. SNP:	14. SNP Type:	N/A

II. Optional Supplemental Packages

(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)
Package ID	Description	Allowed Medical Expense PMPM	Enrollee Cost Sharing PMPM	Net PMPM value	Non-Benefit Expense	Gain/(Loss) Margin	Premium	Projected Member Months
1				\$0.00			\$0.00	
2				\$0.00			\$0.00	
3				\$0.00			\$0.00	
4				\$0.00			\$0.00	
5				\$0.00			\$0.00	
	Weighted Avg. Total	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	0

III. Base Period Summary for 1/1/2024-12/31/2024 (Note: This section must be reported at the contract level.)

	Net Medical Expenses	Non-Benefit Expenses	Gain/(Loss) Margin	Premium	Member Months
1. Total \$: for all OSB packages combined			\$0		
2. PMPM (based on OSB membership)	\$0.00	\$0.00	\$0.00	\$0.00	

WORKSHEET 1 - MSA BASE PERIOD EXPERIENCE AND PROJECTION ASSUMPTIONS

Note: See bid instructions for ESRD and hospice exclusions.

MSA-2026.1

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

I. General Information

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

II. Base Period Background Information

1. Time Period Definition	2. Member Months	5. Bids In Base	Contr-Plan-Seg ID	% of MMs
Incurred from: 01/01/2024			a.	
Incurred to: 12/31/2024	3. Risk Score		b.	
Paid through:	4. Completion Factor		c.	
			d.	

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

IV. Projection Assumptions

(c)		(f)	(g)	(h)	(i)	(j)	(k)	(l)	(m)	(n)	(o)	(p)
Service Category		Util Type	Total Benefits		Util. Adjustments to Contract Period				Unit Cost/ Intensity Trend	Additive Adjustments		
			Annualized Util/1000	Avg Cost per Unit	Allowed PMPM	Util/1000 Trend	Benefit Plan Change	Population Change		Other Factor	Util/1000	PMPM
a.	Inpatient Facility			\$0.00								
b.	Skilled Nursing Facility			0.00								
c.	Home Health			0.00								
d.	Ambulance			0.00								
e.	DME/Prosthetics/Diabetes			0.00								
f.	OP Facility - Emergency			0.00								
g.	OP Facility - Surgery			0.00								
h.	OP Facility - Other			0.00								
i.	Professional			0.00								
j.	Part B Rx			0.00								
k.	Other Medicare Part B			0.00								
l.	COB/Subrg. (outside claim system)											
m.	Total Medicare Covered Medical Expenses				\$0.00							

PRA Disclosure Statement According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0944. The time required to complete this information collection is estimated to average 30 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

WORKSHEET 2 - MSA TOTAL PROJECTED ALLOWED COSTS PMPM

Note: See bid instructions for ESRD and hospice exclusions.

I. General Information

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

II. Projected Allowed Costs

Contract Year Allowed Costs at Plan's Risk Factor:												
(c)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(l)	(m)	(n)	(o)	(p)
Service Category	Util Type	Projected Experience Rate			Manual Rate			Exper. Cred. %	Contract Year Rate			% of svcs provided OON
		Annual Util/1000	Avg Cost per Unit	Allowed PMPM	Annual Util/1000	Avg Cost per Unit	Allowed PMPM		Annual Util/1000	Avg Cost per Unit	Allowed PMPM	
a. Inpatient Facility		0	\$0.00	\$0.00		\$0.00			0	\$0.00	\$0.00	
b. Skilled Nursing Facility		0	0.00	0.00		0.00			0	0.00	0.00	
c. Home Health		0	0.00	0.00		0.00			0	0.00	0.00	
d. Ambulance		0	0.00	0.00		0.00			0	0.00	0.00	
e. DME/Prosthetics/Diabetes		0	0.00	0.00		0.00			0	0.00	0.00	
f. OP Facility - Emergency		0	0.00	0.00		0.00			0	0.00	0.00	
g. OP Facility - Surgery		0	0.00	0.00		0.00			0	0.00	0.00	
h. OP Facility - Other		0	0.00	0.00		0.00			0	0.00	0.00	
i. Professional		0	0.00	0.00		0.00			0	0.00	0.00	
j. Part B Rx		0	0.00	0.00		0.00			0	0.00	0.00	
k. Other Medicare Part B		0	0.00	0.00		0.00			0	0.00	0.00	
l. COB/Subrg. (outside claim system)				0.00							0.00	
m. Total Medicare Covered Medical Expenses				\$0.00			\$0.00	0%			\$0.00	
								0%	CMS Guideline Credibility			

Note: See bid instructions for ESRD and hospice exclusions.

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

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)	

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

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

WORKSHEET 4 - MSA ENROLLEE DEPOSIT AND PLAN PAYMENT PMPM

Note: See bid instructions for ESRD and hospice exclusions.

I. General Information

1. Contract Number:	5. Organization Name:	9. Enrollee Type:	A/B
2. Plan ID:	6. Plan Name:		
3. Segment ID:	7. Plan Type:	MSA	
4. Contract Year:	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 Claims Over Deductible (PMPM)
1.	\$0-\$250			\$0.00	
2.	\$251-\$2,000			0.00	
3.	\$2001-\$4,000			0.00	
4.	\$4001-\$6,000			0.00	
5.	\$6001-\$8,000			0.00	
6.	\$8001-\$10,000			0.00	
7.	\$10,001-\$12,000			0.00	
8.	\$12,001-\$15,000			0.00	
9.	\$15,001-\$20,000			0.00	
10.	\$20,001-\$30,000			0.00	
11.	\$30,001-\$50,000			0.00	
12.	\$50,001-\$70,000			0.00	
13.	over \$70,000			0.00	
Total			0.00%	\$0.00	\$0.00

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

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

\$0.00

Part A

Part B

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

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

\$0.00

\$0.00

\$0.00

\$0.00

WORKSHEET 5 - MSA OPTIONAL SUPPLEMENTAL BENEFITS

Note: See bid instructions for ESRD and hospice exclusions.

I. General Information

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

II. Optional Supplemental Packages

(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)
Package ID	Description	Allowed Medical Expense PMPM	Enrollee Cost Sharing PMPM	Net PMPM value	Non-Benefit Expense	Gain/(Loss) Margin	Premium	Projected Member Months
1				\$0.00			\$0.00	
2				\$0.00			\$0.00	
3				\$0.00			\$0.00	
4				\$0.00			\$0.00	
5				\$0.00			\$0.00	
	Weighted Avg. Total	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	0

III. Base Period Summary for 1/1/2024-12/31/2024 (Note: This section must be reported at the contract level.)

	Net Medical Expenses	Non-Benefit Expenses	Gain/(Loss) Margin	Premium	Member Months
1 Total \$: for all OSB packages combined			\$0		
2 PMPM (based on OSB membership)	\$0.00	\$0.00	\$0.00	\$0.00	