

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. VBID-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#	
Incurred from:	01/01/2024	2. Member Months	0			3. Risk Score	0.0000
Incurred to:	12/31/2024	4. Completion Factor					
Paid through:		5. Level of significance					
6. Bids In Base		Contr-Plan-Seg ID	Member Months	Contr-Plan-Seg ID	Member Months		

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)	(u)	(v)
Service Category	Net PMPM	Cost Sharing	Util Type	Total Benefits			Util. Adjustments to Contract Period				Unit Cost Adjustment		Additive Adjustments			Service Category	Net PMPM
				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											\$0.00
t. Subtotal Medicare-covered service categories						\$0.00											\$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	\$0	7a. Sales & Marketing		Percentage of Revenue:	
3. Total Revenue		\$0	\$0	\$0	\$0	\$0	7b. Direct Administration		9a. Net Medical Expenses	0.0%
4. Net Medical Expenses					\$0	\$0	7c. Indirect Administration		9b. Non-Benefit Expenses	0.0%
5. Member Months				0	0	0	7d. Net Cost of Private Reinsurance		9c. Gain/(Loss) Margin	0.0%
PMPMs:						\$0	7e. Total Non-Benefit Expenses	\$0	10a. Medicaid Revenue	
6a. Revenue PMPM	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00			10b. Medicaid Cost	\$0
6b. Net Medical PMPM	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00			10b1. Benefit expenses	
6c. Non-Benefit PMPM					\$0.00	\$0.00			10b2. Non-benefit expenses	
6d. Gain/(Loss) Margin PMPM					\$0.00	\$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 - MA 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:	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#	
										1. Projected member months	0	0	0	0	0	
										2. Projected risk factor	0.0000	0.0000	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			Non-DE# Allowed PMPM	DE# Allowed PMPM	% 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					
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			
t. Subtotal Medicare-covered service categories				\$0.00				\$0.00	0%	CMS Guideline Credibility	\$0.00	\$0.00	\$0.00			

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. VBID-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			(h) Net PMPM		(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		
	(e) Allowed PMPM	(f) Plan Cost Sharing	(g) Net PMPM	(h) Allowed	(i) Cost Sharing	(m) Allowed PMPM	(n) FFS AE Cost Sharing			(o) Net PMPM	(p) Net PMPM for Add'l Svcs.	(q) Reduction of A/B Cost Sh.	(r) 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	\$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	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	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	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	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	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	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	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	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	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	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	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	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	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	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	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	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	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

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			(h) Plan Reimb		(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		
	(e) Reimb + Actual Cost Sh.	(f) Plan Cost Sharing	(g) Actual Cost Sharing	(h) Plan Reimb	(i) Allowed	(j) Cost Sharing	(m) Allowed PMPM			(n) Medicaid Cost Sharing	(o) Net PMPM	(p) Net PMPM for Add'l Svcs.	(q) Reduction of A/B Cost Sh.	(r) 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	\$0.00

C. All Beneficiaries

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

(c) Service Category	(e) Total Benefits			(h) Net	(i) Allowed	(j) Cost Sharing	(k) FFS Medicare Actl. Equiv. cost sharing	(l) Plan cost sh. for Medicare-covered svcs.	(m) Medicare Covered	(o) Net	(p) Net PMPM for	(q) Reduction of	(r) Benefits
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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

VI: County Level Detail and Service Area Summary										VII: Other Medicare Information									
1. Use of plan-provided ISAR factors? (Regional Plans only - enter Yes or No)																			
(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(l)	(m)	(n)	(o)	(p)	(q)	(r)	(s)	(t)	(u)
State/County Code	State	County Name	Proj Member Months	Proj Risk Factors	Plan Provided ISAR factors	MA Risk Ratebook Unadjusted	MA Risk Ratebook Risk-Adjusted	ISAR scale	ISAR-Adjusted Bid	Risk Payment Rate		Original Medicare cost sharing (c.s.)			FFS costs to 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
2. Total or Weighted Average for Service Area:			0	0	0.00	\$0.00	\$0.00	0	\$0.00	39.440%	60.560%	0.0%	0.0%	0.0%	n/a	n/a	n/a	0	n/a
3. County Level Detail:																			
Out of Area																			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	8. MA-PD:	12. SNP:	14. SNP Type: N/A	

II. Other Information		
A. Part B Information	B. Rebate Allocation for Part B Premium	C. Rebate Allocations
1. Maximum Pt B premium buydown amt., per CMS \$174.70	1. PMPM Rebate Allocation for Part B premium (maximum value=\$174.70) [Redacted]	1. Reduce A/B Cost Sharing (max. value=\$0.00) [Redacted]
	2. Part B Rebate Allocation, rounded to one decimal (see instructions) \$0.00	2. Other A/B Mand Suppl Benefits (max. value=\$0.00) [Redacted]

III. Plan A/B Bid Summary																																																																																																																															
A. Overview	B. MA Rebate Allocation	C. Development of Estimated Plan Premium																																																																																																																													
<table border="1"> <thead> <tr> <th></th> <th>Medicare-covered</th> <th>A/B Mandatory Supplemental</th> </tr> </thead> <tbody> <tr> <td>1. Net medical cost</td> <td>\$0.00</td> <td>\$0.00</td> </tr> <tr> <td>2. Non-benefit expense</td> <td>\$0.00</td> <td>\$0.00</td> </tr> <tr> <td>3. Gain/(loss) margin</td> <td>0.00</td> <td>0.00</td> </tr> <tr> <td>4. Total revenue requirement</td> <td>\$0.00</td> <td>\$0.00</td> </tr> <tr> <td>5. Standardized A/B Benchmark</td> <td>\$0.00</td> <td></td> </tr> <tr> <td>6. Plan A/B Benchmark</td> <td>\$0.00</td> <td></td> </tr> <tr> <td>7. Risk Factor</td> <td>0.0000</td> <td></td> </tr> <tr> <td>8. Conversion Factor</td> <td>0.0000</td> <td></td> </tr> </tbody> </table>		Medicare-covered	A/B Mandatory Supplemental	1. Net medical cost	\$0.00	\$0.00	2. Non-benefit expense	\$0.00	\$0.00	3. Gain/(loss) margin	0.00	0.00	4. Total revenue requirement	\$0.00	\$0.00	5. Standardized A/B Benchmark	\$0.00		6. Plan A/B Benchmark	\$0.00		7. Risk Factor	0.0000		8. 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IV. Contact Information	
MA Plan Bid Contact:	
Name, Position	[Redacted]
Phone Number	[Redacted]
Email Address	[Redacted]
MA Certifying Actuary:	
Name, Credentials	[Redacted]
Phone Number	[Redacted]
Email Address	[Redacted]
MA Additional BPT Actuarial Contact:	
Name, Position	[Redacted]
Phone Number	[Redacted]
Email Address	[Redacted]
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.
[Redacted]

* 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.

WORKSHEET 7 - OPTIONAL SUPPLEMENTAL BENEFITS

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. VBID-C:	N
4. Contract Year: 2026	8. MA-PD:	12. SNP:	14. SNP Type:	N/A

II. Optional Supplemental Packages

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

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	
		(c)	(f)	(g)	(h)	(i)	(j)	(k)		(l)	(m)	(n)
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			

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. 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)	(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	Plan Benchmark
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	\$0.00	Part A	Part B
b. 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		
c. Gain/(Loss) Margin			
d. Total Plan Revenue Requirement	\$0.00		
e. Projected Plan Benchmark	\$0.00		
f. Projected Monthly Enrollee Deposit	\$0.00	\$0.00	\$0.00
g. Percent of Plan Revenue			
1. Medical Expenses	0.0%		
2. Non-Benefit Expense	0.0%		
3. Gain/(Loss) Margin	0.0%		
h. Standardized Plan Benchmark	\$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	