

Plan Name: _____

Region: _____

Capitation Rate Calculation Sheet (CRCS)

Actuarial Assumptions - Rate Period

Schedule D1 - Voluntary

Note: Each line must be completed. Blank lines will be considered zero.

Premium Group: ADC/HR < 6 Mos. M & F

		(A)	(B)	(C)
	Category of Service	Utilization Rate Per Member Per Year	Cost Per Unit	Cost Per Member Per Month (A * B) / 12
1 .	Inpatient Hospital - Medical/Surgical *			
2 .	Inpatient Hospital - Inpatient Mental Health/Drug and Alcohol Treatment Only			
3 .	Primary Care Physician			
4 .	Physician Specialist			
5 .	Ambulatory Surgery			
6 .	Other Professional Services			
7 .	Emergency Room			
8 .	Mental Health - Outpatient			
9 .	Drug & Alcohol Treatment - Outpatient			
10 .	Home Health Care			
11 .	Diagnostic Test, Lab & X-Ray			
12 .	Vision Care Including Eyeglasses			
13 .	Durable Medical Equipment			
14 .	Other Medical			
	Capitation Rate - Core Medical Benefits			
15 .	(SUM OF LINES 1 -14)			
Optional Benefits:				
16 .	Dental			
17 .	Non-Emergent Transportation			
18 .	Emergent Transportation			
19 .	Family Planning			
20 .	Administration			
21 .	Profit/Reserves			

1. (*) - Please report the projected newborn hospital birth cost on Schedule D11.

Note: The rate(s) proposed on Schedule C must reflect the amounts shown on this schedule. The proposed rate for a given benefit package should equal the sum of the pmpm values for the core benefits, the optional benefits in the county(s), administration and profit/reserves.

Plan Name: _____

Region: _____

Capitation Rate Calculation Sheet (CRCS)

Actuarial Assumptions - Rate Period

Schedule D2 - Voluntary

Note: Each line must be completed. Blank lines will be considered zero.

Premium Group: ADC/HR 6 Mos. - 14 F

		(A)	(B)	(C)
	Category of Service	Utilization Rate Per Member Per Year	Cost Per Unit	Cost Per Member Per Month (A * B) / 12
1 .	Inpatient Hospital - Medical/Surgical			
2 .	Inpatient Hospital - Inpatient Mental Health/Drug and Alcohol Treatment Only			
3 .	Primary Care Physician			
4 .	Physician Specialist			
5 .	Ambulatory Surgery			
6 .	Other Professional Services			
7 .	Emergency Room			
8 .	Mental Health - Outpatient			
9 .	Drug & Alcohol Treatment - Outpatient			
10 .	Home Health Care			
11 .	Diagnostic Test, Lab & X-Ray			
12 .	Vision Care Including Eyeglasses			
13 .	Durable Medical Equipment			
14 .	Other Medical			
Capitation Rate - Core Medical Benefits				
15 .	(SUM OF LINES 1 -14)			
Optional Benefits:				
16 .	Dental			
17 .	Non-Emergent Transportation			
18 .	Emergent Transportation			
19 .	Family Planning			
Administration and Profit/Reserves				
20 .	Administration			
21 .	Profit/Reserves			

Note: The rate(s) proposed on Schedule C must reflect the amounts shown on this schedule. The proposed rate for a given benefit package should equal the sum of the pmpm values for the core benefits, the optional benefits in the county(s), administration and profit/reserves.

Plan Name: _____
 Region: _____

Capitation Rate Calculation Sheet (CRCS)

Actuarial Assumptions - Rate Period

Schedule D3 - Voluntary

Note: Each line must be completed. Blank lines will be considered zero.

Premium Group: ADC/HR 15 - 20 F

		(A) Utilization Rate Per Member Per Year	(B) Cost Per Unit	(C) Cost Per Member Per Month (A * B) / 12
1 .	Inpatient Hospital - Medical/Surgical			
2 .	Inpatient Hospital - Inpatient Mental Health/Drug and Alcohol Treatment Only			
3 .	Primary Care Physician			
4 .	Physician Specialist			
5 .	Ambulatory Surgery			
6 .	Other Professional Services			
7 .	Emergency Room			
8 .	Mental Health - Outpatient			
9 .	Drug & Alcohol Treatment - Outpatient			
10 .	Home Health Care			
11 .	Diagnostic Test, Lab & X-Ray			
12 .	Vision Care Including Eyeglasses			
13 .	Durable Medical Equipment			
14 .	Other Medical			
Capitation Rate - Core Medical Benefits				
15 .	(SUM OF LINES 1 -14)			
Optional Benefits:				
16 .	Dental			
17 .	Non-Emergent Transportation			
18 .	Emergent Transportation			
19 .	Family Planning			
Administration and Profit/Reserves				
20 .	Administration			
21 .	Profit/Reserves			

Note: The rate(s) proposed on Schedule C must reflect the amounts shown on this schedule. The proposed rate for a given benefit package should equal the sum of the pmpm values for the core benefits, the optional benefits in the county(s), administration and profit/reserves.

Plan Name: _____

Region: _____

Capitation Rate Calculation Sheet (CRCS)

Actuarial Assumptions - Rate Period

Schedule D4 - Voluntary

Note: Each line must be completed. Blank lines will be considered zero.

Premium Group: ADC/HR 6 Mos. - 20 M

		(A) Utilization Rate Per Member Per Year	(B) Cost Per Unit	(C) Cost Per Member Per Month (A * B) / 12
1 .	Inpatient Hospital - Medical/Surgical			
2 .	Inpatient Hospital - Inpatient Mental Health/Drug and Alcohol Treatment Only			
3 .	Primary Care Physician			
4 .	Physician Specialist			
5 .	Ambulatory Surgery			
6 .	Other Professional Services			
7 .	Emergency Room			
8 .	Mental Health - Outpatient			
9 .	Drug & Alcohol Treatment - Outpatient			
10 .	Home Health Care			
11 .	Diagnostic Test, Lab & X-Ray			
12 .	Vision Care Including Eyeglasses			
13 .	Durable Medical Equipment			
14 .	Other Medical			
Capitation Rate - Core Medical Benefits				
15 .	(SUM OF LINES 1 -14)			
Optional Benefits:				
16 .	Dental			
17 .	Non-Emergent Transportation			
18 .	Emergent Transportation			
19 .	Family Planning			
20 .	Administration			
21 .	Profit/Reserves			

Note: The rate(s) proposed on Schedule C must reflect the amounts shown on this schedule. The proposed rate for a given benefit package should equal the sum of the pmpm values for the core benefits, the optional benefits in the county(s), administration and profit/reserves.

Plan Name: _____
 Region: _____

Capitation Rate Calculation Sheet (CRCS)

Actuarial Assumptions - Rate Period

Schedule D5 - Voluntary

Note: Each line must be completed. Blank lines will be considered zero.

Premium Group: ADC 21 - 64 M & F

		(A) Utilization Rate Per Member Per Year	(B) Cost Per Unit	(C) Cost Per Member Per Month (A * B) / 12
1 .	Inpatient Hospital - Medical/Surgical			
2 .	Inpatient Hospital - Inpatient Mental Health/Drug and Alcohol Treatment Only			
3 .	Primary Care Physician			
4 .	Physician Specialist			
5 .	Ambulatory Surgery			
6 .	Other Professional Services			
7 .	Emergency Room			
8 .	Mental Health - Outpatient			
9 .	Drug & Alcohol Treatment - Outpatient			
10 .	Home Health Care			
11 .	Diagnostic Test, Lab & X-Ray			
12 .	Vision Care Including Eyeglasses			
13 .	Durable Medical Equipment			
14 .	Other Medical			
Capitation Rate - Core Medical Benefits				
15 .	(SUM OF LINES 1 -14)			
Optional Benefits:				
16 .	Dental			
17 .	Non-Emergent Transportation			
18 .	Emergent Transportation			
19 .	Family Planning			
20 .	Administration			
21 .	Profit/Reserves			

Note: The rate(s) proposed on Schedule C must reflect the amounts shown on this schedule. The proposed rate for a given benefit package should equal the sum of the pmpm values for the core benefits, the optional benefits in the county(s), administration and profit/reserves.

Plan Name: _____

Region: _____

Capitation Rate Calculation Sheet (CRCS)

Actuarial Assumptions - Rate Period

Schedule D6 - Voluntary

Note: Each line must be completed. Blank lines will be considered zero.

Premium Group: HR 21 - 29 M & F

		(A)	(B)	(C)
	Category of Service	Utilization Rate Per Member Per Year	Cost Per Unit	Cost Per Member Per Month (A * B) / 12
1 .	Inpatient Hospital - Medical/Surgical			
2 .	Inpatient Hospital - Inpatient Mental Health/Drug and Alcohol Treatment Only			
3 .	Primary Care Physician			
4 .	Physician Specialist			
5 .	Ambulatory Surgery			
6 .	Other Professional Services			
7 .	Emergency Room			
8 .	Mental Health - Outpatient			
9 .	Drug & Alcohol Treatment - Outpatient			
10 .	Home Health Care			
11 .	Diagnostic Test, Lab & X-Ray			
12 .	Vision Care Including Eyeglasses			
13 .	Durable Medical Equipment			
14 .	Other Medical			
Capitation Rate - Core Medical Benefits				
15 .	(SUM OF LINES 1 -14)			
Optional Benefits:				
16 .	Dental			
17 .	Non-Emergent Transportation			
18 .	Emergent Transportation			
19 .	Family Planning			
Administration and Profit/Reserves				
20 .	Administration			
21 .	Profit/Reserves			

Note: The rate(s) proposed on Schedule C must reflect the amounts shown on this schedule. The proposed rate for a given benefit package should equal the sum of the pmpm values for the core benefits, the optional benefits in the county(s), administration and profit/reserves.

Plan Name: _____

Region: _____

Capitation Rate Calculation Sheet (CRCS)

Actuarial Assumptions - Rate Period

Schedule D7 - Voluntary

Note: Each line must be completed. Blank lines will be considered zero.

Premium Group: HR 30 - 64 M & F

		(A) Utilization Rate Per Member Per Year	(B) Cost Per Unit	(C) Cost Per Member Per Month (A * B) / 12
1 .	Inpatient Hospital - Medical/Surgical			
2 .	Inpatient Hospital - Inpatient Mental Health/Drug and Alcohol Treatment Only			
3 .	Primary Care Physician			
4 .	Physician Specialist			
5 .	Ambulatory Surgery			
6 .	Other Professional Services			
7 .	Emergency Room			
8 .	Mental Health - Outpatient			
9 .	Drug & Alcohol Treatment - Outpatient			
10 .	Home Health Care			
11 .	Diagnostic Test, Lab & X-Ray			
12 .	Vision Care Including Eyeglasses			
13 .	Durable Medical Equipment			
14 .	Other Medical			
Capitation Rate - Core Medical Benefits				
15 .	(SUM OF LINES 1 -14)			
Optional Benefits:				
16 .	Dental			
17 .	Non-Emergent Transportation			
18 .	Emergent Transportation			
19 .	Family Planning			
Administration and Profit/Reserves				
20 .	Administration			
21 .	Profit/Reserves			

Note: The rate(s) proposed on Schedule C must reflect the amounts shown on this schedule. The proposed rate for a given benefit package should equal the sum of the pmpm values for the core benefits, the optional benefits in the county(s), administration and profit/reserves.

Plan Name: _____
 Region: _____

Capitation Rate Calculation Sheet (CRCS)

Actuarial Assumptions - Rate Period

Schedule D8 - Voluntary

Note: Each line must be completed. Blank lines will be considered zero.

Premium Group: SSI 6 Mos. - 20 M & F

		(A)	(B)	(C)
	Category of Service	Utilization Rate Per Member Per Year	Cost Per Unit	Cost Per Member Per Month (A * B) / 12
1 .	Inpatient Hospital - Medical/Surgical			
2 .	Primary Care Physician			
3 .	Physician Specialist			
4 .	Ambulatory Surgery			
5 .	Other Professional Services			
6 .	Emergency Room			
7 .	Home Health Care			
8 .	Diagnostic Test, Lab & X-Ray			
9 .	Vision Care Including Eyeglasses			
10 .	Durable Medical Equipment			
11 .	Other Medical			
Capitation Rate - Core Medical Benefits				
12 .	(SUM OF LINES 1 -11)			
Optional Benefits:				
13 .	Dental			
14 .	Non-Emergent Transportation			
15 .	Emergent Transportation			
16 .	Family Planning			
17 .	Administration			
18 .	Profit/Reserves			

Note: The rate(s) proposed on Schedule C must reflect the amounts shown on this schedule. The proposed rate for a given benefit package should equal the sum of the pmpm values for the core benefits, the optional benefits in the county(s), administration and profit/reserves.

Plan Name: _____
 Region: _____

Capitation Rate Calculation Sheet (CRCS)

Actuarial Assumptions - Rate Period

Schedule D9 - Voluntary

Note: Each line must be completed. Blank lines will be considered zero.

Premium Group: SSI 21 - 64 M & F

		(A)	(B)	(C)
	Category of Service	Utilization Rate Per Member Per Year	Cost Per Unit	Cost Per Member Per Month (A * B) / 12
1 .	Inpatient Hospital - Medical/Surgical			
2 .	Primary Care Physician			
3 .	Physician Specialist			
4 .	Ambulatory Surgery			
5 .	Other Professional Services			
6 .	Emergency Room			
7 .	Home Health Care			
8 .	Diagnostic Test, Lab & X-Ray			
9 .	Vision Care Including Eyeglasses			
10 .	Durable Medical Equipment			
11 .	Other Medical			
Capitation Rate - Core Medical Benefits				
12 .	(SUM OF LINES 1 -11)			
Optional Benefits:				
13 .	Dental			
14 .	Non-Emergent Transportation			
15 .	Emergent Transportation			
16 .	Family Planning			
17 .	Administration			
18 .	Profit/Reserves			

Note: The rate(s) proposed on Schedule C must reflect the amounts shown on this schedule. The proposed rate for a given benefit package should equal the sum of the pmpm values for the core benefits, the optional benefits in the county(s), administration and profit/reserves.

Plan Name: _____
 Region: _____

Capitation Rate Calculation Sheet (CRCS)

Actuarial Assumptions - Rate Period

Schedule D10 - Voluntary

Note: Each line must be completed. Blank lines will be considered zero.

Premium Group: SSI 65+ M & F

		(A)	(B)	(C)
	Category of Service	Utilization Rate Per Member Per Year	Cost Per Unit	Cost Per Member Per Month (A * B) / 12
1 .	Inpatient Hospital - Medical/Surgical			
2 .	Primary Care Physician			
3 .	Physician Specialist			
4 .	Ambulatory Surgery			
5 .	Other Professional Services			
6 .	Emergency Room			
7 .	Home Health Care			
8 .	Diagnostic Test, Lab & X-Ray			
9 .	Vision Care Including Eyeglasses			
10 .	Durable Medical Equipment			
11 .	Other Medical			
Capitation Rate - Core Medical Benefits				
12 .	(SUM OF LINES 1 -11)			
Optional Benefits:				
13 .	Dental			
14 .	Non-Emergent Transportation			
15 .	Emergent Transportation			
16 .	Family Planning			
17 .	Administration			
18 .	Profit/Reserves			

Note: The rate(s) proposed on Schedule C must reflect the amounts shown on this schedule. The proposed rate for a given benefit package should equal the sum of the pmpm values for the core benefits, the optional benefits in the county(s), administration and profit/reserves.

