ADDENDUM NO. 2

May 26, 2022

Title: Pharmacy Benefit Management Services

RFP # H22-0025

1. **General**
   This addendum revises RFP documents. This addendum is issued to respondents of record prior to execution of contract, and forms a part of contract documents and modifies previously issued documents. Insofar as previously issued contract documents are inconsistent with modifications indicated by this addendum, modifications indicated by this addendum shall govern. Where any part of the contract documents are modified by this addendum, all unaltered provisions shall remain in effect.

2. **Addendum Acknowledgement Form**
   Acknowledge receipt of this addendum in the space provided on the Addendum Acknowledgement Form. Proposers must include the signed form with their response. Failure to do so will subject Proposers to disqualification.

3. **Changes and Clarifications**
   A. Proposal Due Date Changed: From: 6/17/2022 by 2:00 p.m. Central Time
   To: **7/15/2022 by 2:00 p.m. Central Time**

   i. Following changes to the timeline

RFP Activity	Estimated Date
Proposal Due Date	**7/15/22**
Evaluation of RFP (Tentative)	7/18/22-8/5/22
System Demonstrations (Tentative)	8/8/22-8/10/22
System References (Tentative)	8/8/22-8/10/22
Notification of Decision (Tentative)	August/September 2022

   B. Update to Section 4.3.1 to the format below for vendor comments

	Functional Requirements	Will commit to meeting requirement (Y/N)	Response code (Y/D/M/T/N)
4.3.1.1	Provide a dedicated clinical pharmacist with at least 2 years' government program Pharmacy Benefit Management experience and expertise in the following: formulary management, formulary development and maintenance, clinical programming, benefit design, consultative clinical support.		
Comments:			
4.3.1.3	Proposer will lead at least four (4) onsite meetings (quarterly reviews) to review/discuss the utilization and performance of the CCH prescription drug program. These meetings will be at no additional cost to CCH; the Proposer shall be responsible for all costs (travel and otherwise) associated with attending the CCH quarterly review meetings.		
Comments:			

C. Responses to vendor questions

4. Attachments

A. CountyCare Membership_Last 12 months by LOB
B. PNDS
C. Member Census_May 2022

Responses to vendor questions

#	Section of the RFP	Question	CCH Response
1.	1.3.2 CareLink Uninsured	What Line of Business do these members fall under, and are these members rebate eligible?	This is a program for people who are uninsured, under 200% of the federal poverty level, and do not qualify for other insurance. It is a stand-alone product. This program is not eligible for the rebates.
2.	1.3.2 CareLink Uninsured	Attachment A – PBM_Financial-Workbook does not appear to have a pricing tab for this Line of Business. What is the expectation to illustrating pricing?	Please provide a summary of proposed pricing for this line of business. Bidders do not need to fill out a defined template for this pricing.
3.	1.3.3 Dual Eligible D-SNP product	Is there a membership projection for the Dual Eligible D-SNP product? When is the expected Go Live date? Please confirm the bidder is expected to provide a formulary for this product.	The expected go-live date for this line of business would be January 2024. We would expect PBM to provide formulary and support CMS submission.
4.	1.3.4 Marketplace Exchange product	Is there a membership projection for the Marketplace Exchange product? When is the expected Go Live date? Please confirm the bidder is expected to provide a formulary for this product.	The expected go-live date is January 2025. Bidder would be expected to support initial and annual formulary submission including category and class count.

#	Section of the RFP	Question	CCH Response
5.	4.3.1.7 If CCH, or its designee, elects to perform prior authorizations, Proposer will allow CCH to perform any or all prior authorizations internally and will reimburse CCH for resulting costs if Proposer performs any prior authorizations in error.	Please provide a description of the scope of delegation of the PA service including which lines of business CCH intends to manage? If CCH is performing their own PA what tool/system will be used? If using our PA tool how many users will be required from CCH? Also please clarify and define "performs any prior authorization in error".	The prior authorization process will be delegated in totality (initial review, peer to peer, appeals, state fair hearings). Performs a prior authorization in error – means you approved a request that should have been denied or you deny a request that should have been approved

#	Section of the RFP	Question	CCH Response
6.	4.3.1.11 Provide all information and data requested by CCH or its auditor necessary for completion of audits (including without limitation detailed claim files, eligibility files, plan design documents, rebate contract samples, retail network contract samples, and MAC lists) with all data elements representing values at the time of adjudication within the requested timeframe or an agreed upon date with CCH and at no additional cost to CCH. Proposer agrees the claim data files will identify any claims that are excluded from the discount guarantee calculations and the permitted contract basis for the exclusion, or Proposer will send an exclusion file including the specific NDCs or claim numbers to be excluded and the permitted contract basis for exclusion.	Concerning rebate contract review, will it be acceptable to allow for 10 contracts?	If a change to a requirement is requested, please note this in the RFP response and provide the rationale.

#	Section of the RFP	Question	CCH Response
7.	4.3.1.13 Proposer agrees to manage multiple products with multiple lines of business, multiple networks, different preferred drug lists, and different prior authorization requirements. At the outset, able to manage at least two pharmacy networks, one for external non-CCH pharmacies, and one for CCH pharmacies, each with different preferred drug lists, different prior authorization requirements, different point-of-sale edits.	How many distinct lines of business need to be supported? Can you please describe the number of combinations of different products defined by products, formularies, networks?	It is anticipated that over time formularies would need to be supported for Medicare, Medicaid, D-SNP, Exchange and Uninsured/Carelink. Medicaid will require two distinct formularies, one for CCH internal pharmacies and one for the external network.
8.	4.3.1.21 Proposer agrees to provide monthly CCH-specific call center reporting broken out by line of business inclusive of, but not limited to, monthly reports detailing the number and types of calls received according to date and time, as well as response call dates and times, and calls abandoned.	How many lines of business are needed for reporting?	Reporting of the call center metric is expected to be by product broken down for member and provider calls, instead of book of business reports. Up to five. Initially Medicaid. Future state based on the product go live Medicare, D-SNP, Carelink, Exchanges.

#	Section of the RFP	Question	CCH Response
9.	At a minimum all reports will include metrics and reporting elements required by NCQA, CMS and DHFS. Any missed SLAs will be identified by the PBM with a description of the root cause and plan for corrective action upon delivery of the reports to the client.		Blank question
10.	4.3.1.24 Proposers agrees to provide, in addition to the monthly standard package of reports, the following (at no additional cost): At least quarterly reports on pharmacy network compliance with contract requirements, applicable laws, and regulations.	Please provide additional detail on what CCH defines as the pharmacy network compliance report.	Network adequacy report showing total number of pharmacy outlets within specific time and distance standards as outlined in our master agreement with HFS. Total number of pharmacies applying to become in network. Any applicable report requested by HFS identifying pharmacy spend for covered individuals.
11.	4.3.1.33 Proposer confirms it will be responsible for payment of any monetary fines levied against CCH by CMS, DHFS or any other government authority as a result of an action by the Proposer that incurred the citation.	Are you willing to accept limitations on the fine amounts?	No

#	Section of the RFP	Question	CCH Response
12.	4.3.1.35 Proposer agrees to operate and maintain a call center appropriately staffed to provide member, provider and pharmacy assistance related to agreed upon services inclusive of, but not limited to: member calls, triage of clinical authorizations, COB requests, claims-on-line, formulary inquiries, overrides (shortages, emergencies, operational), claim back orders and refill-to-soon requests.	Can “claim back orders” be defined?	Back orders are defined as a pharmacy supplier issue. Shortages would relate to a manufacturer issue that is reported to the FDA.
13.	4.3.1.40 Proposer shall use the same AWP pricing methodology and AWP pricing source (e.g., Medi-Span) for billing CCH as used for paying pharmacies. Please identify the pricing source.	Are you open to other pricing methodologies such as NADAC?	Yes, however, please also complete the included pricing templates in the format provided.

#	Section of the RFP	Question	CCH Response
14.	4.3.1.46 Proposer's financial offering (discounts, dispensing fees, administrative fees, rebates, and definitions) will not change under any of the following conditions. If Proposer retains the right to make changes to the financial offering, the contract must include the thresholds that apply to making a change to the financial offering. -Change in total members -Gender/Age distribution -Drug mix change -Change in plan design	Based on item 4.3.1.108 CCH may make up to 50 drug changes to the formulary. This may have an impact on rebate guarantees. Is CCH willing to accept financial offering changes under this scenario?	Yes
15.	4.3.1.56 Proposer agrees to establish an electronic interface with CCH's vendors (e.g., Proposer, TPA, vision, dental, claims, and other vendors as determined by CCH) for the purposes of exchanging membership files and benefit administration.	How many vendors are being asked to connect with during terms of contract?	You may be asked to connect with up to 5 vendors at the start of the contract and then additional depending on the vendors selected for the implementation of new products

#	Section of the RFP	Question	CCH Response
16.	4.3.1.57 Proposer agrees to accept updates and apply revised information to the provider network database within one business day of receipt.	Please expand on the nature of the updates and revised information.	Proposer agrees to comply with section 5.10.6 Provider Directory language utilized in master agreement: **5.10.6 Provider directory**. Contractor shall meet all Provider directory requirements under 305 ILCS 5/5-30.3 and 42 CFR §438.10, including: 5.10.6.1 Ensure its Provider directory is available to Enrollees and Providers via Contractor's web portal and in paper form upon request. 5.10.6.2 Request, at least annually, Provider office hours for each Provider type and publish such hours in the Provider directory. 5.10.6.3 Confirm with Providers who have not submitted claims within the six (6) months prior to the start of this Contract that the Provider intends to remain in the network and correct any incorrect Provider directory information. 5.10.6.4 Conspicuously display an e-mail address and a toll-free number to which any individual may report an inaccuracy in the Provider directory. 5.10.6.5 Provider directory information in paper form must be updated at least monthly and electronic Provider directories must be updated no later than thirty (30) days after Contractor receives updated Provider information. 5.10.6.6 Investigate and correct any inaccurate information communicated from any person or from Department within thirty (30) days after receiving the report
17.	4.3.1.85 Proposer shall conduct both pre-payment and retrospective, post-payment audits/investigations.	What is the expectation with Pre-payment audit/investigation?	Pre-payment audits include validating coding updates will process correctly before they are deployed to production.

#	Section of the RFP	Question	CCH Response
18.	4.3.2.7 Proposer agrees to offer a contracted network of qualified pharmacies conveniently located throughout Cook County which must be contractually willing and able to provide pharmacy services to CCH members seven (7) days/week, including delivery services to home or network provider at no additional cost to member or CCH.	Do all network pharmacies in Cook County must be able to provide service 7 days a week and also deliver to member and provider offices at no charge? Or, is this a sub-network?	Sub-network
19.	4.3.2.14 Proposer agrees to meet Medicaid network adequacy with its currently contracted network in Cook County.	Can you please provide a Zip Code based census of members by LOB as well as the network adequacy requirements?	**5.8.1.1.7** Pharmacy access. Contractor shall ensure an Enrollee has access to at least one (1) pharmacy within a fifteen (15)–mile radius of or fifteen (15)–minute drive from the Enrollee's residence. If an Enrollee lives in a Rural Area, the Enrollee shall have access to at least one (1) pharmacy within a sixty (60)–mile radius of or sixty (60)–minute drive from the Enrollee's residence Please see attachment Member Census_May 2022
20.	4.3.2.20 Proposer agrees to accept payment up to sixty (60) days post adjudication if there is a delay in the State of Illinois paying capitation to CCH.	Is there an expectation that the proposer fund the claims in good faith while awaiting payment from the plan? Or, do the network pharmacies not get paid for claims while the proposer waits for CCH funding of claims?	Proposers are not required to pre-fund claims to pharmacies. However, if proposers are willing to pre-fund claims for a defined period of time (i.e. – 15 days) please note that in the response.
21.	4.3.3.33 Proposer agrees to provide and maintain a member and provider portal.	Please provide more detail on the functionality of a provider portal. Also does "provider" mean Pharmacy or Prescriber?	The provider portal is for the pharmacy and allows them to review any required regulatory or network requirements.

#	Section of the RFP	Question	CCH Response
22.	4.3.3.35 Proposer will support an annual LIS grace period if requested by CCH.	Please provide more information and background CCH annual LIS grace period.	If Cook County Health elects to offer a grace period, they will need the following support from the Proposer: 1. The PBM must operationally allow for LIS status to be overridden for the duration of the grace period 2. The overrides must have a feature to be termed once the grace period ends or the LIS status is updated 3. Provide a special true-up report for LIS grace period members who have not had a change in LIS status once the grace period ends or have their status updated by CMS
23.	4.4.5.1 New proposers: Identify the CCH currently contracted pharmacies not in Proposer's current Illinois network	Please identify current CCH contracted pharmacies	Please see attached PNDS spreadsheet
24.	4.4.5.7 Please provide a GEO access analysis to determine member impact on pharmacy network disruption for both standard and narrow pharmacy networks by pharmacy network.	Please provide member census by Zip code and include the access standards.	**5.8.1.1.7** Pharmacy access. Contractor shall ensure an Enrollee has access to at least one (1) pharmacy within a fifteen (15)–mile radius of or fifteen (15)–minute drive from the Enrollee's residence. If an Enrollee lives in a Rural Area, the Enrollee shall have access to at least one (1) pharmacy within a sixty (60)–mile radius of or sixty (60)–minute drive from the Enrollee's residence Please see attachment Member Census_May 2022
25.	4.4.8.1 Describe Proposer's 340B solution and how it will support CCH's 340B strategy with CCH pharmacies. Outline any fees associated with these services	Please explain the current roles and responsibilities for CCH and the PBM for the current 340B program.	The pharmacies eligible to dispense under 340B are identified by the PBM via HRSA (www.hrsa.gov). The PBM contracts with most of those pharmacies under standard retail contracts, so they are not noted differently. When submitting claims, pharmacies use an indicator (SCC=20) to reflect that they filled the prescription through their 340B inventory. The PBM can report on that indicator.

#	Section of the RFP	Question	CCH Response
26.	4.4.9.6 Describe Proposer's Medicaid Support Act Program Description.	This Act seems applicable to an eligibility administrator. Is CCH expecting PBM to additionally be delegated that role that would traditionally be performed by and eligibility administrator?	The SUPPORT Act is federally mandated and seeks to better treat and align health care delivery around substance use disorder and opioid recovery. Section 1004 of the SUPPORT Act requires that health plans have certain clinical edits and oversight processes in place to be compliant. How does the Proposer help plans meet the necessary requirements? What standard clinical edits and reporting packages does the Proposer offer?
27.	4.4.9.14 Proposer must be willing and able to satisfy all pharmacy benefit management related requirements in DHFS-MCO model Medicaid managed care contract as amended and available here: https://www2.illinois.gov/hfs/MedicalProviders/cc/Pages/ManagedCareContracts.aspx. Proposer shall respond to each requirement in the Model Contract, including without limitation § 5.3, and state for each requirement how Proposer intends to comply with each applicable provision of the contract. This applies during both implementation and maintenance of business.	Please clarify the expectation of the bidder's response given the complexity and length of the PBM related requirements in DHFS-MCO model Medicaid managed care contract due to the page limitation requirement of the bidder's response. Is a blanket confirmation for all requirements acceptable? Are bidders expected to list and include all such requirements and their confirmation to each with the page limitation of this RFP? When the State modifies the contract between the State and the Plan what will be the process of notifying the PBM of these changes?	All key requirements from the contract that are critical to the PBM are listed in the functional requirements of the RFP. Answers should be included in the table provided by confirming the ability to meet the requirements internally or with the delegate. Additional details of those specific functions should be in the RFP. Statement with the confirmation to comply with all state requirements not listed in the RFP would be sufficient with the review during the implementation and pre-delegation prior to contract go live. Future state modification or contract amendment will be communicated from the plan to the PBM.

#	Section of the RFP	Question	CCH Response
28.	4.4.10.1.3 Describe how Proposer identifies, reconciles, and corrects a member's status relating to Low Income Subsidy (LISs) and Medicaid-eligibility.	This seems applicable to an eligibility administrator. Is CCH expecting PBM to additionally be delegated that role that would traditionally be performed by and eligibility administrator?	What support, if any, do you offer plans to reconcile PDEs related to LIS/eligibility? Do you partner with the eligibility vendor to correct errors and resolve rejected PDEs?
29.	4.4.10.1.18 Describe Proposer organization's process to manage LTC, Hospice and Transplant files through eligibility updates that support Part B vs. D payment requirements. Also describe Proposer's process to support an adequate pharmacy network for members in LTC facilities.	Please clarify the expectations including roles, responsibilities and source data, regarding this member eligibility service.	Current hospice process: PBM provides a monthly retrospective report, the plan reviews the report and directs the PBM as to how to manage the PDEs and refund the member, if needed. Current transplant/LTC process: Review is done by the plan and then they direct the PBM as to how to manage the PDEs and refund the member, if needed. Does the proposer have any similar models in place today to support their existing plans?
30.	4.4.10.3.2 Describe whether the Proposer is willing to guarantee Star Ratings for Medicare Part D and provide the number of 4, 4.5, and 5 Star Part D clients Proposer manages today.	Can you Provide Current Rating and current denominators for Part D measures?	This will be for a new Medicare product –DSNP, the current rating is N/A.
31.	4.4.10.4.8 How will Proposer work to integrate pharmacy prior authorization requests into a broader prior authorization process maintained by CCH for medical service from a user-interface perspective?	Please provide a summary of the medical PA process as well as the system you use.	The current PA process occurs with the PBM PA system. A non-clinician does the initial review. If approvable, it is approved. If not, the case goes for a clinical review.

#	Section of the RFP	Question	CCH Response
32.	PGs Star Rating Performance - The PBM will pay a penalty for each at-risk measure that reports below 3.0 Stars as specified by the Penalty Allocation outlined below: Appeals Auto-Forward: $10,000, Weight 1.5 Medication Adherence for Diabetes Medications: $10,000, Weight 3 Medication Adherence for Hypertension (RAS antagonists): $10,000, Weight 3 Medication Adherence for Cholesterol (Statins): $10,000, Weight 3 MTM Program Completion Rate for CMR: $10,000, Weight 1 Total At-Risk Stars Weight 11.5 3.0 Weighted Average Target: 34.5 4.0 Weighted Average Target: 46 Penalties may be adjusted annually based on Stars measures and ratings.	Please explain the methodology That CCH uses for the weighted averages. 3.0 Weighted Average Target: 34.5 4.0 Weighted Average Target: 46 Can the plan provide current denominators for Part D measures?	The Contractor will use the final ratings sent by CMS so the same methodology as CMS will be utilized. This will be for the new Medicare product; the current rating and denominators are N/A.

#	Section of the RFP	Question	CCH Response
33.	4.4.10.1.18 Describe Proposer organization's process to manage LTC, Hospice and Transplant files through eligibility updates that support Part B vs. D payment requirements. Also describe Proposer's process to support an adequate pharmacy network for members in LTC facilities.	Please clarify the expectations including roles, responsibilities and source data, regarding this member eligibility service. Is this specifically for the first sentence and not the second?	Current hospice process: PBM provides a monthly retrospective report, the plan reviews the report and directs the PBM as to how to manage the PDEs and refund the member, if needed. Current transplant/LTC process: Review is done by the plan and then they direct the PBM as to how to manage the PDEs and refund the member, if needed. Does the proposer have any similar models in place today to support their existing plans?
34.	General RFP Question	Please advise when claims data will be made available to bidders that have submitted the ITB/NDA.	Claims Data have been made available to each Proposer that intend to bid and a
35.	General RFP Question	Given that the data release is being held up by Addendum #1 RFP-H22-0025 and the revised NDA form, will Cook County Health please extend the proposal due date by five (5) business days?	Yes. Revised RFP timeline: Proposal due date: 6/24/2022 Evaluation (tentative) 6/27-7/14 Demonstration (tentative) 7/18-7/19 Notification (tentative) August
36.	General RFP Question	Will the data release for RFP # H22 – 0025 be the same data release that was a part of RFP # H21 – 0039?	Yes
37.	4.4.5 Network for Medicaid and Medicare	Please provide census files for each of your member populations for GeoAccess reports and confirmation of Network performance guarantees.	Please see the attached spreadsheet, CountyCare Membership Last 12 months by LOB **5.8.1.1.7** Pharmacy access. Contractor shall ensure an Enrollee has access to at least one (1) pharmacy within a fifteen (15)–mile radius of or fifteen (15)–minute drive from the Enrollee's residence. If an Enrollee lives in a Rural Area, the Enrollee shall have access to at least one (1) pharmacy within a sixty (60)–mile radius of or sixty (60)–minute drive from the Enrollee's residence

#	Section of the RFP	Question	CCH Response
38.	N/A	A signed NDA has been completed, when can we expect to receive data?	See Question 34.
39.	N/A	Please provide all of the details in the data to complete the projections tabs in the financial workbook.	Claims data will include sufficient information to complete financial workbook
40.	N/A	Please confirm each line of businesses formularies.	Medicare uses a template formulary (e.g., PBM standard) Medicaid follows a state-led PDL
41.	N/A	If custom for Med D, we'll need their formulary in NDC format with tiering (preferred, non-preferred, excluded) and UM (PA, Steps, QLs, MNPAs, brand steps)	There is no custom formulary for Med D
42.	N/A	If bidding Med D, does the client have a strip strategy in place and if so, what is the strategy?	No
43.	Section 4.2	Vendor does not meet Minimum Qualifications 1 and 7. Please confirm Vendor will still be evaluated as part of the RFP process.	Not meeting minimum qualifications for question 1 will eliminate a bidder from the evaluation process. For question 7 – NCQA accreditation is required at the time of contracting. Bidder will be evaluated under the evidence that NCQA accreditation is in progress and scheduled before the end of 2022
44.	Section 4.3	"Applicants should include and explicitly address how proposer will meet or why proposer cannot meet each of the below requirements in their response to this RFP." Please advise where Vendor should input the above language in Section 4.3.1, given the section is presented in a table format.	Please see addendum change and clarification B with updated table to allow vendor input.

#	Section of the RFP	Question	CCH Response
45.	Section 4.3.1.34	Can CCH provide a breakout of the total number of prior authorizations performed by the current vendor by month over the last calendar year?	JAN 2021- 2,176 FEB 2021- 2,235 MAR 2021- 2,768 APR 2021- 2,539 MAY 2021- 2,234 JUN 2021- 2,365 JUL 2021- 2,100 AUG 2021- 2,667 SEP 2021- 2,583 OCT 2021- 3,165 NOV 2021- 2,707 DEC 2021- 2,390
46.	Section 4.3.2.21	Does CCH utilize its own P&T Committee for formulary management for any of its current lines of business?	For Medicaid, the state has a single PDL which we follow. The other portion on formulary management is done with Cook County Health in conjunction with the PBM and the P&T Committee.
47.	Section 5.5	Please confirm failure to meet the following requirement will not result in disqualification: "Consistent with Cook County, Illinois Code of Ordinances (Article IV, Division 8, and Section 34-267), and CCH has established a goal that MBE/WBE firms retained as subcontractors receive a minimum 35% MBE/WBE of this procurement. The Office of Contract Compliance has determined that the participation for this specific contract is 35% MBE/WBE participation."	CCH will evaluate bidders' response and good faith efforts to meet these requirements. If bidders are unable to meet this requirement, they should complete the required waiver request and demonstrate their good faith efforts to meet this requirement.

#	Section of the RFP	Question	CCH Response
48.	Section 5.6	"Failure to complete each tab and each requested item may result in disqualification." Many aspects of Attachment A are not applicable to Vendor's proposed model, which is NADAC-based, rather than AWP-based. Please confirm that a statement of "not applicable" will not result in disqualification.	Bidders are required to complete the included template. If bidder wishes to propose an alternative methodology, please additionally provide that pricing proposal.
49.	Section 5.7	"Provide the audited summary financial statements for the last two fiscal years." Vendor is a privately-held company and audited financial statements are not available for inclusion in our proposal. Please confirm failure to provide this deliverable will not result in disqualification.	Bidders must provide financial statements.
50.	General	Can CCH please provide historical claims data?	See Question 34.
51.	General	Can CCH provide a breakout of current membership by month and by line of business (Cook Medical Group, CareLink, Dual Eligible Special Needs Plans, Exchange, MoreCare, CountyCare) over the last calendar year?	CountyCare – Please see CountyCare Membership_Last 12 months by LOB Carelink – 28,874 as of 5/2022 DSNP – NA new product Exchanges – NA new product MoreCare – NA CountyCare is ending contract with MoreCare on 12/31/2022

#	Section of the RFP	Question	CCH Response
52.	General	Can CCH provide a breakout of total claims processed in the last calendar year by month and by line of business (Cook Medical Group, CareLink, Dual Eligible Special Needs Plans, Exchange, MoreCare, CountyCare)?	CountyCare **Year Month** / **Total Claims** 2021-01 242,795 2021-02 230,311 2021-03 272,201 2021-04 265,316 2021-05 261,706 2021-06 274,662 2021-07 267,341 2021-08 276,879 2021-09 276,053 2021-10 273,662 2021-11 272,265 2021-12 278,198 **Totals** **3,191,389**

ADDENDUM ACKNOWLEDGEMENT FORM

As required by the RFP, Proposers must submit this acknowledgement form with their response. One acknowledgement form per response, listing all addenda, is appropriate.

Addendum No.: _____

Addendum No.: _____

Addendum No.: _____

Addendum No.: _____

Addendum No.: _____

Addendum No.: _____

Company Name: _____

Representative's Name: _____

Signature: _____

Date: _____

END OF ADDENDUM