April 14, 2003

Addendum No. 1

to

REQUEST FOR PROPOSALS ("RFP") FOR PRESCRIPTION DRUG PHARMACY NETWORK AND PRESCRIPTION DRUG MAIL ORDER PROGRAM SERVICES

For: City of Chicago, Board of Education of the City of Chicago, City Colleges of Chicago, Chicago Transit Authority, Chicago Housing Authority, Chicago Park District and County of Cook (collectively, "Agencies")

For which Proposals were scheduled to be received no later than 3:00 p.m., Chicago time, on Friday, April 4, 2003, by the City of Chicago Department of Procurement Services, Bid and Bond Room (Room 301 of City Hall.)

Respondent must acknowledge receipt of this Addendum No. 1 in its Proposal AND should complete and return the attached Acknowledgment by facsimile to 312-744-7679, Attn: Gail Borenstein. Respondents that do not acknowledge this Addendum No. 1 may be deemed non-responsive and eliminated from further consideration by the Agencies.

I. Notice of Postponement of Proposal Due Date

The Agencies have extended the deadline for submitting Proposals to **Thursday, May 15, 2003 at 3:00 p.m.** All other submission requirements, except as modified in this Addendum No. 1, shall remain the same.

II. Revisions to the RFP

The information contained in this Section II of this Addendum No. 1 is incorporated by reference into the original RFP issued on January 31, 2003. Respondents are advised that these Revisions may be referred to in the responses in Section IV (Questions and Responses).

1. Exhibit 11 (Plan Designs by Agency) of the RFP is deleted and replaced with the new Exhibit 11R (Plan Designs by Agency Revised 03/14/03), attached to this Addendum No. 1 as Attachment 1. All references in the RFP to Exhibit 11 are now deemed to apply to Exhibit 11R.

2. Exhibit 12 (Total Prescriptions by Agency) of the RFP is deleted and replaced with the new Exhibit 12R (Total Prescriptions by Agency Revised 03/14/03), attached to this Addendum No. 1 as Attachment 2. All references in the RFP to Exhibit 12 are now deemed to apply to Exhibit 12R.

3. Exhibit 1C (City of Chicago Special Conditions Regarding Minority and Women Business Enterprise (M/WBE) Commitment), Page 6 of 10, was inadvertently omitted from the RFP. The omitted page 6 is attached to this Addendum No. 1 as Attachment 3.

4. Interrogative O.11 of the RFP is deleted and replaced with the following:

> "Present a complete cost proposal that specifies the cost of each component of the prescription drug pharmacy network, each component of the prescription drug mail order program and each component of the Integrated Program. (See tables on pages 46, 47 and 48 as a guideline.) The tables are a guideline that set forth the minimum amount of information which should be provided as part of Respondent's preliminary cost proposal; however, Respondents are expected and encouraged to include and itemize all components of their proposed fees, whether or not those components are listed in the tables on pages 46, 47 and 48."

Respondent is responsible for incorporating the above replacement language for Interrogative O.11 into its Proposal.

5. A new item is added to the Statement of Services (on page 20 of the RFP):

> "52. To renegotiate in good faith with the Agencies if plan designs change during the life of the contracts."

Respondent is responsible for incorporating the above additional requirement under the Statement of Services to which the Respondent must agree in its Proposal.

6. Two forms included in Exhibit 4 (Chicago Transit Authority) were inadvertently not identified as specific exhibits. These documents were located at the back of Exhibit 4A, immediately in front of Exhibit 4B. These forms are identified as the Exhibits indicated below and are hereby incorporated into the RFP as said Exhibits:

Exhibit 4J	Non-Disclosure Statement – Prime Consultant
Exhibit 4K	Non-Disclosure Statement – Sub-Consultant

7. In addition to the requirements set forth in Section II.B (Required Contents of Proposals) of the RFP, and the documentation and forms required under each Agency's M/W/DBE exhibit and policies, Respondents must complete and submit with their Proposal the following forms and schedules in order to be considered responsive by the respective Agencies:

City of Chicago
- Exhibit 1B-Insurance Certificate of Coverage
- Exhibit ID-Economic Disclosure Statement and Affidavit

Board of Education of the City of Chicago
- Exhibit 2D-Contractor's Disclosure Form

Chicago Housing Authority
- Exhibit 3D-Subcontractor Information Submittal (as applicable)
- Exhibit 3E-Conractor's Affidavit
- Exhibit 3F-Equal Employment Opportunity Compliance Certificate
- Exhibit 3I-Statement of Bidder's Qualifications
- Exhibit 3J-General Contract Conditions: Non-Construction (HUD-5370-C)
- Exhibit 3L-Representations, Certifications and Other Statements of Bidders: Public and Indian Housing Programs (HUD-5369-A)
- Exhibit 3M-Instructions to Offerors: Non-Construction (HUD-5369-B)

Exhibit 3N-Certifications and Representations of Offerors:
Non-Construction Contract (HUD-5369-C)
Exhibit 3O-Instructions to Bidders for Contracts:
Public and Indian Housing Programs (HUD-5369)

Chicago Transit Authority
Exhibit 4D-Certification of Primary Participant Regarding Debarment, Suspension and Other Responsibility Matters
Exhibit 4E-Certification of Lower Tier Participant Regarding Debarment, Suspension and Other Responsibility Matters
Exhibit 4F-Certification Regarding a Drug Free Workplace
Exhibit 4G-Lobbying Certification
Exhibit 4H-Brief History of Your Company
Exhibit 4I-Disclosure of Ownership
Exhibit 4J-Non-Disclosure Statement – Prime Consultant
Exhibit 4K-Non-Disclosure Statement – Sub-Consultant

City Colleges of Chicago
Exhibit 5A-Conditions of Purchase

Chicago Park District
Exhibit 6B-Insurance Requirements
Exhibit 6I-Proposor's Affidavit
Exhibit 6J-Non-Collusion Affidavit
Exhibit 6L-Vendor Information Form

County of Cook
Exhibit 7D-Contractor Certifications
Exhibit 7E-Execution by a Sole Proprietor (as applicable)
Exhibit 7F-Execution by a Partnership (and/or a Joint Venture) (as applicable)
Exhibit 7G-Execution by a Corporation (as applicable)

8. Exhibit 2A (Board of Education of the City of Chicago, General Terms and Conditions) is hereby modified by adding the "Exhibit 2A Rider" attached to this Addendum No. 1 as Attachment 4.

III. Clarifications

Respondents are advised that these Clarifications may be referred to in the responses in Section IV (Questions and Responses).

1. M/W/DBE Commitment

The Agencies strongly encourage Respondents to develop and propose aggressive and meaningful levels of M/W/DBE participation, through both direct and indirect participation in accordance with each Agency's policies. Some suggested areas to consider for direct and indirect M/W/DBE participation include, but are not limited to, the following: pharmaceuticals, drugs, insurance, marketing, advertising, printing, auditing, accounting, temporary employment agencies, messenger services, computer services and supplies, shipping services and supplies and janitorial services and supplies. Respondents that are submitting Proposals to provide both prescription drug pharmacy network services and prescription drug mail order services should

submit a different M/W/DBE compliance plan for each, as the operational differences between the two may allow for a higher level of participation under each scope of service.

It is the policy of each Agency that the M/W/DBE participation percentage applies against all dollars expended to the Contractor under their respective Agency contracts. In the event that Respondent is unable to fully comply with the policy, Respondent may apply for a reduction to or waiver of the M/W/DBE goals in accordance with each Agency's requirements regarding reductions and waivers as set forth in each Agency's exhibit. Such requirements generally include that Respondent must provide a written request for the reduction or waiver, a demonstration of good faith efforts to achieve full compliance with the M/W/DBE goals, an explanation for why the goals may be difficult to achieve and all supporting documentation as appropriate. Respondents are reminded that a request for a reduction or waiver is not a guarantee that it will be granted by any Agency.

Respondents are responsible for familiarizing themselves with the specific instructions and requirements of each Agency's M/W/DBE policies. Some of the areas in which the Agencies vary in their requirements include, but are not limited to, participation percentages, acceptable certifying agencies, acceptability of current or pending certifications, reporting requirements, direct and indirect participation and waiver requests.

2. Legal Actions

Respondents are advised that the Agencies are aware of recent lawsuits, pending litigation and current investigations regarding the business practices of prescription benefits managers ("PBMs"), alleging such practices as unfair competition, violation of anti-kickback laws, drug manufacturer favoritism and undisclosed rebates. Respondents are advised that the Agencies consider such actions material to this RFP process, and pursuant to Section II.B.7 (Required Content of Proposals – Legal Actions), expect full disclosure from Respondents with regard to their involvement with and their position on any and every such action, settlement and investigation including the results of such actions, settlements or investigations. Respondents that are short-listed as a result of the evaluation process are advised that this is an ongoing requirement, and are expected to provide to the Agencies updated and current information on these matters as it becomes available. Respondents are further advised that the ongoing status of any such action or investigation, as well as any findings, determinations, resolutions and/or any other resulting information, may be considered by the Agencies at any stage of the evaluation process and/or contract period, if any contract is awarded.

3. Exhibits and Forms

Respondents are advised that in the event that any Agency updates, changes or modifies any of the forms or schedules as published in the RFP, or develops any new forms or schedules, Respondents will be required to complete the revised and/or new forms and schedules in order to remain in contention for, and as a condition precedent to, award of any contract.

IV. Questions and Responses

The following questions and requests for clarification were submitted in accordance with the instructions provided in Section A.1. (Communications Between the Agencies and Respondents) of the RFP, and received in writing at the Pre-Proposal Conference held on February 24, 2003. The Agencies' response (in italics) follows each question or request.

1. Exhibit 8, "Demographics: Current Employee Counts by Zip Code" Can the Agencies provide their respective Employee Counts By Zip Code in an electronic format? (Microsoft Excel would be the most preferred method)

   Employee Counts by Zip Codes will not be provided in electronic format.

2. Regarding Exhibit 9, "Top 25-50 Drugs (By Agency)": Can the Agencies provide their respective Top 25-50 Drugs in an electronic format? Can they provide more specific information about each drug such as: NDC and Strength? If this information is unavailable, please let us know how the Agencies would like us to determine which NDC to use in completing Exhibit 9? (While the Claims Information included on the CD does contain the data fields we would need to complete Exhibit 9, it appears to not break-out drugs by Agency so it cannot be applied to Exhibit 9).

   The Agencies will not provide any additional information, electronically or otherwise. More specific information about each drug cannot be provided. Claims information in Exhibit 13 may be used as a representative sample for all Agencies. Respondents should use the information provided and their own business knowledge to make recommendations and develop pricing proposals. Respondents should make appropriate assumptions and determinations as to NDC, strength, etc. and clearly document those assumptions and determinations for review by the Agencies.

3. Regarding the Implementation and Effective Date(s): (a) Please confirm expectations regarding the date provided in the RFP, June 2003. Is this when the initial implementation process will begin? (b)What are the targeted effective date(s) for each Agency?

   At this time, it is anticipated that implementation and effective dates will be in the 4th Quarter of 2003 and the 1st Quarter of 2004. The dates will vary by Agency depending on contract negotiations between the selected Respondent(s) and each Agency.

4. 47. The question reads: "To provide a specific aggregate "Stop Loss" contract for the Agency (non self-insured) whose level of participation is limited by its size, so as not to allow them to be self-insured." Please elaborate on what is being required, and for which Agency(ies) it would apply.

   Stop Loss Insurance pertains to the smallest Agency. It does not apply to any of the other Agencies. This Agency has approximately 550 participants, excluding dependents, and has a past claims experience of approximately $363,000, which included PPO and HMO. It is possible that this Agency will not require a Stop Loss Insurance Policy; however, if the management of this Agency determines that exposure beyond a certain dollar limit is not in the best interest of the Agency, Stop Loss Insurance will be required for the amount above that dollar limit.

5. M14. Please explain what is meant by "passive formularies." From the Agency(ies) perspective, what is the difference between a "passive formulary" and an "open formulary?"

   A passive formulary list is a formulary that has not been distributed to Subscribers.

6. H2. The question reads: "Each Agency will routinely provide the enrollment information via electronic transmission. Enrollment and termination information for PHSA participants is provided on paper. A full, positive census of PHSA enrollment and termination data is provided

on a weekly basis. Describe how you would update eligibility for PHSA participants." Please explain what PHSA refers to. Please provide more information relative to the scope of the requirement, specifically; average weekly enrollment within the PHSA population and average additions and deletions on a weekly basis.

PHSA refers to the Public Health Service Act - more commonly referred to as COBRA (Consolidated Omnibus Budget Reconciliation Act) - is the continuation of coverage for terminated employees and their dependents who become ineligible to continue their coverage under a group health plan. Enrollment varies by Agency. PHSA enrollment and termination date will be provided periodically, either electronically or on paper, depending on the Agency.

7. O12-B. The question reads: "Provide a summary report by plan of benefit which lists costs associated with: generic drugs, brand drugs on formulary, non-formulary drugs." Please elaborate. What is meant by "plan of benefit?"

Plan of benefit refers to the different schedules of co-payment for each Agency. For example, one Agency may offer three different plans to their employees, such a POS, PPO and HMO. Each such plan may have a different co-payment structure and variations in plan design. Respondents are also directed to refer ***to Revision No. 4****, by which Interrogative O.11 is replaced.*

8. O12-C. The question reads: "Provide for each entity a report by therapeutic class; that displays formulary dispensing within class. For each therapeutic class, what percentage of drugs dispensed (include dollars and volume) were in the formulary? For any class with less than 70% formulary dispensing, please analyze (prescription drug pharmacy network and prescription drug mail order program Services) the results and advise us as to how you would increase formulary dispensing."
The instructions to this question imply that we should use Exhibit 13 (the CD) to reply. The question asks for a report for each entity (Agency). Since the CD only includes data for one entity (Agency), the report we provide to each entity (Agency) will be the same, and will not be entity specific. Please confirm that we should only use the data included on the CD to respond to this question.

The data on the CD-ROM is specific to one Agency; it is a representative sample of the population and can be applied to all Agencies. Respondents are also directed to refer to ***Revision No. 4****, by which Interrogative O.11 is replaced.*

9. Clarification on multiple billing requests:

Question 24 asks: "To provide each Agency with periodic billing, no less frequently than monthly, for the medication furnished during the billing period.

Question H-5 reads: "The agencies expect to be billed no more frequently than monthly."

Based on these statements: It is our interpretation that we would bill the Agencies weekly for prescription medication claims (so pharmacies that dispensed the medication can be reimbursed), and we would bill the Agencies monthly for applicable administrative fees. Please confirm.

The Agencies expect to be billed on a monthly basis, but will also consider billing on a more frequent basis if financial incentives are proposed and negotiated with each Agency.

10. Exhibit 11: Please confirm how many members are enrolled in each Plan within each Agency. Will all of the members within each population be required to enroll in the prescription benefit plan?

Enrollment by specific plan will be a function of annual selection by members within each Agency.

11. Exhibit 13 (CD): Does the claims data included in Exhibit 13 (CD) represent all Plans listed in Exhibit 11 under the City of Chicago (PPO, POS, HMO, HMO)?

The claims data in Exhibit 13 does not represent the enrollment in the insured plans. Respondents are directed to refer to ***Revision No. 1****, by which Exhibit 11 is replaced with Exhibit 11R.*

12. Request clarification regarding M14, please define "passive formularies".

Refer to Response No. 5.

13. Regarding the Pricing Tables, is a PBM offering an Integrated Product required to provide pricing tables for "Drug Pharmacy Network" and "Drug Mail Order Program"?

Respondents must clearly indicate if they are submitting Proposals to provide prescription drug pharmacy network Services, the prescription drug mail order program Services or both categories (the "Integrated Program"). Each Agency reserves the right to negotiate based on what is in the best interest of the respective Agency.

14. Request clarification regarding P1-1, Network Size. Please define where the "fees associated with this activity" are identified.

The "fees associated with this activity" include the vendor's fee revenue, which may include but is not limited to rebate sharing, manufacturer sharing, administrative fees and any other ancillary fees.

15. Please explain further what is the Agency requesting in the section, "The Respondent(s) Must Agree" Number 47, "To provide a specific aggregate "Stop Loss" contract for the Agency whose level of participation is limited by its size, so as not to allow them to be self-insured."

Refer to Response No. 4.

16. Is there an "Intent to Bid" Form that needs to be completed?

No.

17. Our firm is not a drug-only provider. Given the fact that we currently have no business placed with some of the Agencies, we can provide a quote for some of the Agencies (vs. all of the Agencies?)

Proposals must include all participating Agencies.

18. Reference page 4, "Format of Proposals", is it a requirement that the Proposal be responded to on "double-sided, recycled, recyclable and chlorine-free paper"?

The Agencies encourage that the Proposals meet these conditions, but it is not a strict requirement. Please refer to Section II.A (Format of Proposals) of the RFP.

19. If a prospective proposer is not the entity actually providing the services, and therefore not in possession of certain information, would that disqualify our proposal?

Respondents should obtain and provide whatever information they feel is sufficient to document their qualifications to provide the services and to be responsive to the RFP. If any subcontractor provides a substantial portion of the services for the Respondent, or affects the Respondent's ability to provide the services, the Respondent should consider documenting the subcontractor's qualifications as well.

20. Would enrollment-banded pricing be acceptable?

Respondent should submit responsive cost proposals, clearly documenting all assumptions.

21. Can we presume that drugs are to be carved out on all products/all vendors?

No, but the Agencies reserve the right to carve out drug requirements from their insured plans.

22. Is it the intent of all Agencies to terminate any current Prescription Drug contract even while it is still in force?

Refer to Response No. 3.

23. Are the Agencies stipulating that they will only negotiate during the next three years with those vendors who respond to this RFP?

No.

24. Reference page 15, number 19: "To provide insurance covering all operations of the prescription drug pharmacy network or prescription drug mail order program Services and/or its subcontractors at no cost to the Agencies as set forth in each Agency exhibit." Please provide clarification of this request.

Refer to the insurance requirements of each Agency in their respective Exhibits.

25. To accurately estimate rebates to recommend disease management programs and to predict savings (as requested in question K5 and K6), we will need historical claims data from all participants in the Coalition. Can we get at least six months worth of detailed claims data electronically for this analysis to supplement the data we received from the City of Chicago?

Refer to Response No. 2.

26. In question H2 you say that "Enrollment and termination information for PHSA participants is provided on paper". Please define PHSA.

Refer to Response No. 6.

27. In question I10 you ask, "I10. How are pharmacy DAWS (dispensed as written) charged to the account?" Please define "Pharmacy DAWs".

A pharmacy DAW is where the pharmacy substitutes one drug for another, typically for such reasons as out of stock conditions or individual/chain pharmacy purchasing economies.

28. Question K1 says, How do you typically work with case management and/or utilization review vendors in medical plans? What information do you typically exchange?" With which case management and/or utilization review vendor do coalition members contract? How many vendors would the PBM be expected to provide data to?

Respondent must express a willingness and ability to work with utilization and case management vendors. The selected Respondent(s) are expected to develop programs that could be implemented with utilization and case management vendors for each Agency. The name of any incumbent utilization or case management vendor is not relevant to the process.

29. Question M2 asks for the "AWP 100" price. Please define this term.

Average Wholesale Price 100 – in a quantity of 100 units of the drug.

30. Section A of Question Q12 asks for detailed information by NDC number. Does the Coalition expect this data for each NDC on the market or for those NDC numbers included on the CD-Rom?

Please refer to Response No. 2.

31. Sections B and C of Question O12 asks for reports. Should we use the data on the CD-Rom for this analysis?

Yes.

32. Exhibit 11 expresses the City of Chicago copays for Generic and Non-formulary as identical amounts. Can you confirm that these identical figures are accurate:

*Respondents are directed to refer to **Revision No. 1**, by which Exhibit 11 is replaced by Exhibit 11R.*

33. Will any of the exhibits be made available in electronic format?

No.

34. Is the data supplied from each participant's current ASO pharmacy plan or a combination of their insured and ASO pharmacy coverage?

The data is supplied from the ASO plan only.

35. Will all participants be able to submit eligibility electronically? How often will eligibility be sent?

This varies by Agency.

36. Please confirm that this will be an ASO venture only with no insured pharmacy business.

Refer to Response No. 34.

37. Will the participant's be carving out their current insured pharmacy business?

Refer to Response No. 21.

38. We have many questions about the current benefit designs for each agency and the number of lives covered under each benefit. To assist you in organizing the information, we have compiled a table, which is attached. Please provide the information discussed in the first column of the table for each plan, either in the table format or another format that is convenient for you.

Respondents should submit their Proposal based on the information provided.

39. Is the calculation of the MBE/WBE/DBE requirements based on the administrative fees charged to the Agencies? If not, what is the basis for calculating the percentage?

*Respondents are directed to refer to **Clarification No. 1** regarding M/W/DBE Commitment.*

40. What is the weight assigned to each of the evaluation criteria outlined in Section III Evaluating Proposals (pp. 7-9)?

This varies by Agency.

41. Can the Agencies provide electronic census data for each of the agencies?

Refer to Response No. 33.

42. What is the definition of transaction? Is it paid claims, paid plus denied claims, or another definition?

Respondents should document what comprises a "transaction" as it applies to their cost proposal.

43. When do the union contracts for each Agency expire? Will the Agencies consider making changes to plan design before contract expiration?

*Respondents are directed to refer to **Revision No. 5**, regarding changes to plan design.*

44. Please describe how each agency deals with loratidine/Claritin and other Non-Sedating Antihistamines? Does each agency cover the prescription drugs and/or the OTC in this class?

Non-sedating antihistamines are treated as any other prescription drug. Over-the-counter (OTC) medications are not covered in any of the Agencies' plans.

45. P. 15, Question 9: Please specify what types and amounts of insurance the vendor is required to provide.

Refer to Response No. 24.

46. PP. 15-16, Question 10: Please identify any information not covered under HIPAA that the agencies deem confidential. Please provide copies of all agency guidelines that the vendor will be required to follow. We assume that the vendor will be allowed to retain copies of all working records during and after the term the contract to allow for audits by the agencies and audits by manufacturers for rebate contracts. Please confirm this.

It is anticipated that all Agencies will be in full compliance with HIPAA by the federal deadlines. Record retention will be in accordance with HIPAA regulations.

47. P. 17, Question 20 and 21*:* Can the Agencies provide schedules for the on-site training sessions and open enrollment meetings? Will the Agencies provide last year's schedules for each of the Agencies? (We have included this as an item in the table mentioned in question 38.)

This information will be available at the time of contract negotiations.

48. P. 17, Question 2: What notifications are the selected vendor required to provide to Subscribers?

Notifications to be provided may include, but are not limited to, identification cards, legal requirements, error notifications, drug changes, formulary changes and marketing information.

49. P. 17, Questions 24*:* Please clarify what is required with regard to invoices. In particular, is the information outlined in this question required to be included on a paper invoice? Would the Agencies find it acceptable to receive paper invoices summarizing the charges and separate claims detail tapes that provide the required detailed information?

Yes.

50. P. 19, Question 39: Can the Agencies provide a list of the expected meetings with company representatives for each Agency? If available, please provide a list of such meetings for the most recent open enrollment season for each agency. Are any significant changes to the schedules expected?

Refer to Response No. 47.

51. P. 19, Question 47: Please explain the requirement for an aggregate Stop Loss contract for each agency. Does the PBM need to purchase insurance for each agency or simply report when claims have reached a specified level? What is the aggregate level for each agency?

Refer to Response No. 4.

52. P. 21, Question A 13: What is meant by "your entities"?

Respondents are directed to review the third paragraph of Section I (General Invitation) of the RFP for a discussion of "entity."

53. P. 24, Question C9: The implementation date noted in the RFP is June 1, 2003. However, the timetable outlined on page 3 of the RFP indicated the evaluation committee is expected to select the vendor on May 23, 2003. Please clarify the timeline for the selection of the vendors and the implementation date for each agency.

Refer to Response No. 3.

54. P. 28, Question E8: Are the Agencies willing to sign a confidentially agreement to protect our MAC price list?

Respondents are directed to review Section V (Confidentia lity) of the RFP. Each Agency will handle FOIA requests in accordance with its own policy.

55. Page 33, Question H5: This question specifies the agencies expect to be billed no more frequently than monthly. Item 24 on page 16 of the RFP specifies billing no less frequently than monthly. Our usual billing period is weekly. Please advise if weekly billing is agreeable to the agencies.

Refer to Response No. 9.

56. P. 43, Question O6: Please provide Exhibit 9 electronically, if available.

Refer to Respo nse No. 33.

57. Please indicate which agencies currently have total "carve out" plans and indicate the incumbent PBMs (by agency).

Refer to Response No. 21. The name of any incumbent contractor or provider is not relevant to this process.

58. For all plans, please provide the names of the medical providers (by agency).

The name of any incumbent contractor or provider is not relevant to this process.

59. Page 1 – Based on the cost exhibit, can we assume that the minimum number of prescriptions will be 1.1 million retail prescriptions and 350,000 mail prescriptions as of the effective date of the initial contract?

Volumes will be dependent on the effective dates of the contracts with each Agency. Refer to Response No. 3. Respondents are responsible f or any assumptions.

60. Page 3, Section D. Proposal Timeline – The timeline indicates that vendor award will occur on or about May 23. Question C9 on page 24 indicates that the start date to use for implementation is June 1. Please clarify the June 1 "implementation date". Is this the date that the selected respondent will begin working with the agencies to install the new pharmacy program, or is this the date they anticipate the first claim to be processed?

Refer to Response No. 3.

61. When is the earliest that a plan could begin using the new pharmacy program (effective date)?

Refer to Response No. 3.

62. What are the current expiration dates for the drug benefit for each agency?

Expiration dates vary among the Agencies.

63. Page 6 – MBE/WBE/DBE Commitment – Is the percentage of participation to be based on the claims processing transaction fee only or on some other basis? Please clarify the requirement.

*Respondents are directed to refer to **Clarification No. 1** regarding M/W/DBE Commitment.*

64. Page 7 – Professional and Technical Competence – Please clarify to what extent information needs to be provided for subcontractors, especially MBE/WBE/DBE subcontractors. For MBE/WBE/DBE subcontractors, is completing each Agency's exhibit sufficient? Do references need to be supplied for all subcontractors including MBE/WBE/DBE subcontractors?

Refer to Response No. 19.

65. Page 9, IV – Please clarify the statement, "Selected Respondent(s) must apply the same pricing for all the Agencies based on overall enrollment even though all Agencies are contracting separately". The pricing grid is based on number of prescriptions and not the number of enrollees. Is this reference to overall enrollment of the agencies versus overall enrollment of the membership? Our interpretation is that is Agency "A" has an annual volume of 1.4 million prescriptions and Agency "B" has a volume of 200,000 prescriptions, both agencies would get the price of their cumulative total.

Refer to Response No. 20.

66. Page 15, Item 6 – The Agency states that the Selected Respondent must reimburse the Agency if service is provided to an ineligible individual or a prescription filled for an ineligible drug or supply. Are we to assume that there will be no retroactive terminations from any of the Agencies? What happens if we are notified of a member's termination after the claim has been filled? Is the Selected Respondent then held responsible for the claim?

If there are retroactive terminations by an Agency, the Agency will not ask the Contractor to reimburse the Agency for drugs dispensed during the time between notification of the termination and the actual termination date. Errors related to dispensing ineligible drugs or supplies will always be the responsibility of the Contractor.

67. Page 17, Item 20 – In order for Respondents to determine proper staffing, can the Agencies identify how many training sessions will be required and their frequency? For example, will these trainings be held for each agency's benefit staff in one location or multiple locations?

Refer to Response No. 47.

68. Page 17, Item 21/Page 19, Item 39 - In order for Respondent to determine proper staffing, can the Agencies identify the number of on-site meetings, the locations and the frequency? For example are the open enrollment meetings typically held at one location or multiple locations?

Refer to Response No. 47.

69. Page 19, Item 47 – Please clarify the reference to "stop loss." Is/Are any Agency(ies) not self-insured? Can you identify which Agency(ies)? Can additional information be provided to Respondents in order to quote on this basis (i.e., 2 years of claims experience)? Are we expected to quote on this at this time or will this be negotiated separately with that agency: If not, how do you anticipate that cost without having access to additional information?

Refer to Response No. 4.

70. Page 22, Item B6 – Please clarify what is meant by "provide the names contact people for technical questions (excluding marketing representative and account executives) within your organization able to answer technical and professional questions related to your RFP response". If the sales executive's name is provided as a single point of contact for all questions related to the RFP, will this suffice?

The sales/account executive can be the single point of contact. Respondents should also refer to Section I.B.1 (Cover Letter – Transmittal Letter) of the RFP.

71. Page 25, Question C14 – Are Agencies considering utilizing the medical card for the prescription benefit instead of having a stand-alone prescription card? If so, which Agencies and how many households is this being considered for? If possible, please specify the medical card providers for each agency requesting a "combined" medical and prescription card.

This information will be available at the time of contract negotiations.

72. Page 29 – For each agency, please clarify if the individual agency, medical carriers or other third-party administrators will provide eligibility to the Selected Respondent (for some agencies, there might be more than one source of eligibility).

The Agencies are the sole source of their eligibility, with the exception of one Agency that utilizes a medical administrator to pass the information to their PBM.

73. Page 32, Question J2 – Reference is made to PHSA. Who is PHSA? How many households are in this group? How many individuals?

Refer to Response No. 6. Enrollment varies among the Agencies.

74. Page 33 – Do all retail plan designs consist of a retail card component where only occasionally a member will submit a paper claim for reimbursement? Do any Agencies have a paper submit program where all members pay 100% at retail and submit a paper claim for reimbursement? If so, which Agencies have a paper-submit program and how many households are enrolled?

There will be occasional paper submissions for reimbursement.

75. Page 33, Question H5 – Though it states here that the Agencies expect to be billed no more frequently than monthly, it states on page 17, item 24 that Agencies will be billed no less frequently than monthly. Can you clarify?

Refer to Response No. 9.

76. Page 34, I1 – Prior Authorization: Please specify the following information by agency:

- What drugs require prior authorization?
- Who performs the prior authorizations (Agency, PBM, Carrier or other third-party)?
- How many prior authorizations are performed each year?
- Once a final decision has been made, how many are prior authorization's are appealed?

This information varies by Agency.

77. Page 36, Item K – Disease Management: Please specify the following by agency:

This question pertains to the following three questions.

78. What disease management programs are in place?

Disease Management programs include Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, Asthma, Diabetes, etc., but vary by Agency.

79. Are the programs educational in nature or do they provide member-specific case management?

Both may apply.

80. Who is the Disease Management vendor for each program in place?

Refer to Response No. 58.

81. Page 36, Item K – Pharmacy Case Management: Please specify what "Pharmacy Case Management" programs are in place for each agency.

Pharmacy Case Management programs include retrospective drug utilization review, drug utilization review, etc., but vary by Agency.

82. For each agency, is specialty pharmacy carved out of the prescription drug program and provided by other entities, or is specialty pharmacy to be provided by the selected Respondent?

Respondents should include any discussion of specialty pharmacies as part of their Proposal.

83. Page 39, Question M2 – Confirm that AWP 100 means the average wholesale price utilizing package size of 100. If the medication does not come in package size 100, what package size should be used? For example, items that are dispensed in milliliters. Do the agencies want only a listing of brands on the formulary or generics also? If generics are to be included, do the Agencies want all conceivable generic manufacturers and repackagers included? Please confirm that you want the AWP 100 for generics and not the applicable MAC price.

Refer to Responses No. 29 and No. 2.

84. Page 41, N3 – Please provide the DUR programs (Prospective, Concurrent, Retrospective) that are currently in place for each agency. Also specify if the DUR programs are in place for both mail and retail programs.

Refer to Response No. 81.

85. Page 43, Question O6 – Please confirm that AWP 100 means the average wholesale price for package size of 100. For what strength and form of the drug should Respondents supply the AWP? Also, some of the top 25-50 drugs are generics, and therefore each strength and form of the generic would have more than one AWP 100 associated with it. Should Respondents supply the AWP for the least expensive, most expensive or on what basis?

Refer to Response No. 83.

86. Page 44, Question O12 – There does not seem to be a group/copay indicator on the data file that could be used to drive the applicable copay deduction. Will the Agencies reissue the file with an indicator or can you identify one plan design/copy structure that Respondents should use to perform the analysis?

Refer to Response No. 8.

87. Page 44, Question O12B – A summary report is to be provided by plan of benefit yet there doesn't seem to be an indicator on the data that identifies which claims belong to which plan. Can the Agencies identify which claims on the CD belong to which plan?

Refer to Response No. 86.

88. Page 45, Question O12B – Please define "costs." Is cost total plan cost, total plan cost net of copays, total plan costs net of rebates and copays, etc. Can you provide the formula that would define "costs"?

Respondents should use the information provided and their own business knowledge to make recommendations and develop pricing proposals. Respondents should make appropriate assumptions and determinations as to NDC, strength, etc. and clearly document those assumptions and determinations for review by the Agencies. Respondents are also directed to refer to ***Revision No. 4****, by which Interrogative O.11 is replaced.*

89. Page 45, Question C – Respondents are asked to provide for each entity a report by therapeutic class. Please clarify if this is for each Agency's therapeutic class, or the Respondent's therapeutic class.

Refer to Response No. 8.

90. Page 45, Question O12E – Should the information requested be broken out between retail and mail? Or should it be provided in total?

Refer to Response No. 88.

91. Page 46-48, Pricing Grids – Can you clarify how these should be completed? If Respondents are proposing an integrated program, do they need to only complete the "Integrated" bid?

Refer to Response No. 13.

92. Page 46-48, Please clarify the definition of "member" as referenced throughout the RFP in the cost exhibit (pages 46-48). Is a "member" an individual (employee, retiree or dependent) or a family unit (household)?

Member refers to an individual.

93. Exhibit 1C – Page 6 of 10 seems to be missing. Can you provide?

Respondents are directed to refer to ***Revision No. 3****.*

94. Exhibit 2A/B stops at page 11. Exhibit 2C starts on page 13. Is this coincidental or is page 12 missing? If so, can you provide?

Exhibit 2A/B ends on page 11. Exhibit 2C starts on page 1 and not on page 13 of the published copies of the RFP.

95. Exhibit 6C stops at page 33. Exhibit 6D starts at page 35. Is this coincidental or is page 34 missing? Is so, can you provide?

Exhibit 6C ends on page 33. Exhibit 6D starts on page 35. There is no page 34 to this section of exhibits.

96. Exhibit 8C – No total was given for this segment. Should Respondents assume 571 employees/households for this agency?

Respondents are responsible for any assumptions.

97. Exhibit 9 contains data on the top 25-50 drugs. City Colleges and City Parks are both identified as Agency "F". Should one be identified as Agency "F" & the other as Agency "G", and if so which is which? Some columns are entitled "by Scrips" yet the "scrip" count does not seem to be in a descending order. Can you clarify how these lists are sorted? (See Agencies A, E (Retail), F). Are they assorted by Claims? If so, can these Agencies supply us with data sorted "by Scrips"? When sorted by claims, is that claim dollars?

The lists are sorted by the number of claims. Disregard the letter designation for any Agency.

98. Exhibit 11 – Are the copays for the City of Chicago Plan PPO plan design correctly stated or is there a typographical mistake? If correctly stated, it appears that the City is incenting non-formulary drugs. Can you provide you strategy for this design?

*Respondents are directed to refer to **Revision No. 1**, by which Exhibit 11 is replaced with Exhibit 11R.*

99. Exhibit 12 – For the Chicago Transit Authority and the Chicago Housing Authority, the total number of brand and generic prescriptions does not equal the number of Scrips identified in the first column. Can you clarify?

*Respondents are directed to refer to **Revision No. 2**, by which Exhibit 12 is replaced with Exhibit 12R.*

100. CD ROM README. TX Pricing Indicator – Please define "Provide Pass Through", "CPG", "Full Reported Ingredient Cost", and "Submitted Cost."

These are terms used by the incumbent PBM and are not necessary for the extraction of the information requested.

101. CD ROM README. TX – Group ID Indicator – Is this an indicator for the various benefit plans (PPO, POS, HMO)? If so, can the key to the indicator be provided?

Refer to Response No. 11.

102. Pharmacy Class – though there is an indicator for "Mail" and "Retail," all claims are coded R for "Retail." However, there are many claims that have greater than a 35 days supply. Should claims with greater than 35 days supply be considered Mail?

Yes.

103. Does the City of Chicago have approval from the State Department of Insurance to procure insurance service collectively?

The City of Chicago and its Agencies are self-funding their pharmacy requirements. Only a single Agency is requesting a specific aggregate "Stop Loss" contract.

104. Are the "Agencies" of the City of Chicago willing to work under one set of Terms and Conditions or will each agency need a separate contract?

Respondents are directed to review the second paragraph of Section I (General Invitation) of the RFP.

105. Will each agency need a separate set of signatures for each of the MBE, WBE and DBE contracts?

As indicated in Section I.B.3 (Deadline and Procedures for Submitting Proposals) of the RFP, Respondents must submit 1 original and 3 copies of their Proposal for each of the 7 Agencies. This requirement applies to all forms submitted by Respondents.

106. There appears to be pages missing or out of order in the RFP that was picked up from the Bid and Bond room. Is there an updated or electronic version of the RFP?

The only missing page noted was for Exhibit 1C, page 6, which is provided with this Addendum as indicated by ***Revision No. 3****. Other apparent numerical gaps in page numbering are coincidental and not an indication of missing pages.*

107. Will the current plan designs for all agencies also be the proposed plan designs?

Respondents are directed to refer to ***Revision No. 5****, regarding changes to plan design.*

108. Is it your intent to award one vendor for all agencies or can each agency select their own vendor?

Respondents are directed to review Section IV (Respondent Selection Process) of the RFP.

109. Please confirm if the agencies are looking to carve-in or carve-out this benefit.

Refer to Response No. 21.

110. Can you confirm lives currently under medical vendors – list broken out by carriers?

This information is not relevant to this process.

111. There are specific instructions for submitting proposals that are outlined in the exhibits (they vary by agency). Should we assume that the instructions in the RFP prevail?

*Respondents are responsible for any assumptions. Respondents are directed to review **Revision No. 7** for additional information on certain submittal requirements.*

112. Are current vendors in compliance with MBE/WBE requirements?

This information is not relevant to this process.

113. How are the estimates of MBE/WBE commitments evaluated? Do higher estimates get more "credit" in the evaluation process?

*Respondents are directed to refer to **Clarification No. 1** regarding M/W/DBE Commitment.*

114. Are the certified sub-contractors for the City of Chicago listed in the web site?

Information on firms certified by the City of Chicago is available on the City's website. Respondents are reminded that the M/W/DBE certifications and requirements vary among the Agencies.

115. If there is no administration fee, how is MBE/WBE calculated? How does each agency calculate the dollar value for the basis of the MBE/WBE requirement?

*Respondents are directed to refer to **Clarification No. 1** regarding M/W/DBE Commitment.*

116. Can we use as an indirect MBE/WBE a vendor who does services for a sister company?

Yes, if the M/W/DBE is appropriately certified by every Agency for which it is being utilized. However, Respondents (and Contractors, if a contract is awarded) may not count the same dollars spent with any certified M/W/DBE firm more than once toward meeting compliance requirements under all Agency contracts.

117. Regarding dollar amounts, what is the city's expectation of drug spending versus net fees? Drug spend may be millions of dollars, as opposed to a few thousand for net to the company. Where should we base our estimates?

*Respondents are directed to refer to **Clarification No. 1** regarding M/W/DBE Commitment.*

118. County of Cook MBE states 35% of "Total Dollar Amount" – Please Define

*Respondents are directed to refer to **Clarification No. 1** regarding M/W/DBE Commitment.*

119. Are there any significant changes between current (incumbent) contracts and what each City Entity has listed in the RFP?

Information regarding any incumbent contractors or providers is not relevant to this process.

120. Will census information (zip code data) be available in an electronic format?

Refer to Response No. 1.

121. Will all Chicago Area pharmacies be permitted to participate in the pharmacy network or will you allow a "restricted network"?

The Respondent(s) (and Contractor, if a contract is awarded) are responsible for pharmacy network development.

122. Is there a difference between direct & indirect participation from a MBE/DBE, WBE etc.? Would direct participation be more responsive toward the contract award?

In general, direct participation is the subcontracting of goods and/or services specifically required in the performance of the contract. Indirect participation is the subcontracting of goods and/or services not specifically related to the performance of the contract that could be used in conducting daily business activities. Respondents are advised to review each Agency's exhibit regarding M/W/DBE policies and requirements. Respondents are also directed to refer to ***Clarification No. 1*** *regarding M/W/DBE Commitment.*

123. What has the City done to ensure that their primary vendors select or seek direct participation first, oppose to just satisfying MBE/WBE participations.

Respondents are directed to refer to ***Clarification No. 1*** *regarding M/W/DBE Commitment and to review each Agency's exhibit regarding M/W/DBE policies and requirements*

124. What is the preferred rebate structure (ie. Per RX, per formulary brand) for the agencies? Will it differ by agency?

Refer to Response No. 88.

125. Where should the respondents address any deviations or comments to each agency's contract/general conditions?

Respondents should address any such issues in their Proposals. Respondents are reminded that any material exception taken to the terms and conditions set forth in each Agency's exhibit may result in the Respondent being deemed non-responsive by the respective Agency.

126. Re Exhibit 11: Please confirm the City of Chicago PPO Plan is as communicated below. Please clarify if it should/should not be $15 non-formulary/$5 formulary and $20 non-formulary/$10 formulary?

Respondents are directed to refer to ***Revision No. 1****, by which Exhibit 11 is replaced with Exhibit 11R.*

April 11, 2003

Addendum No. 1

to

REQUEST FOR PROPOSALS ("RFP") FOR PRESCRIPTION DRUG PHARMACY NETWORK AND PRESCRIPTION DRUG MAIL ORDER PROGRAM SERVICES

For: City of Chicago, Board of Education of the City of Chicago, City Colleges of Chicago, Chicago Transit Authority, Chicago Housing Authority, Chicago Park District and County of Cook (collectively, "Agencies")

Consisting of Section I (Notice of Postponement of Proposal Due Date); Section II (Revisions to the RFP); Section III (Clarifications); Section IV (Questions and Responses); and this Acknowledgment.

ACKNOWLEDGMENT

I hereby acknowledge receipt of Addendum No. 1 to the RFP named above, and further state that I am authorized to execute this Acknowledgment on behalf of the company listed below.

_____	_____
Signature of Authorized Individual	Title
_____	_____
Name of Authorized Individual (Type or Print)	Company Name
	_____
	Business Telephone Number

Complete and Return this Acknowledgment by facsimile to:
312-744-7679, Attn: Gail Borenstein

Exhibit __11R (Revised 3/14/03)
Coalition For Health Care Purchases
Plan Design Information

	Plans	Mail-Co-pays	Generic	Formulary	Non-formulary	Retail 30-34 days	Generic	Formulary	Non-formulary
City of Chicago	PPO	**90-day supply**	$5	$15 $5 *	$10 $20 $10*		$10	$20	$35
* Member is responsible for	POS		$20	$40	$70		$10	$20	$35
paying the generic rate plus the	HMO		$18	$34	$54		$9	$17	$27
cost difference between the name brand and the generic medication.	HMO		$18	$34	$54		$9	$17	$27
City Colleges of Chicago			$8	$12	n/a		$8	$12	n/a
Cook County	BC/BS	**100-day supply**		$0	n/a		$5	$10	n/a
Chicago Board of Education	PPO	**90-day supply**	$2	$10	n/a		20% of drug Costs	20% of drug Costs	n/a
Chicago Transit Authority	PPO	**90-day supply**	$6	$10	$30		$3	$5	$15
	HMO		$6	$10	$30				
Bus Drivers* **			$0	$0			$3.50	$3.50	
Chicago Housing Authority	PPO	**90-day supply**	$10	$20	$40		$10	$20	$40
	HMO		$10	$30	$70		$5	$15	$35
Chicago Park District	PPO						$5	$5	

Exhibit 12R (Revised 3/14/03)
Coalition for Health Care Purchases - Pharmacy

For the Calendar year January 1, 2001 through December 31, 2001
please provide the following information:

		scrips @ mail	*scrips @ Retail*		
example:	*# of Scrips 2,500,000*	*Mail 1,300,000*	*Retail 1,200,000*	*Brand 1,250,000*	*Generic 1,250,000*
Chicago Transit Authority	*385,515*	*19,088*	*366,427*	*252,448*	*133,067*
City of Chicago	*916,745*	*327,363*	*589,382*	*573,015*	*343,730*
Chicago Park District	*35,084*	*408*	*34,676*	*20,864*	*14,220*
Chicago Public Schools	*506,284*	*22,009*	*484,275*	*322,369*	*183,915*
City Colleges	*56,546*	*6,888*	*49,658*	*6,888*	*49,658*
Chicago Housing Authority	*9,636*	*922*	*8,714*	*5,440*	*4,196*
County of Cook and Annuity & Benefit Group incl Cobra	*618,495*	*90,430*	*528,065*	*390,839*	*227,656*
Totals	***2,528,305***	***467,108***	***2,061,197***	***1,571,863***	***956,442***

For all notifications required to be made by bidders/proposers, in situations where the Chief Procurement Officer has determined that time is of the essence, documented telephone contact may be substituted for letter contact.

5. Procedure To Determine Bid Compliance

The following Schedules and described documents constitute the bidder's MBE/WBE proposal, and must be submitted in accordance with the guidelines stated:

A. Schedule C-1: Letter of Intent from MBE/WBE to Perform as Subcontractor, Supplier and/or Consultant.
A Schedule C-1 executed by the MBE/WBE (or Schedule B/Joint Venture Subcontractor) must be submitted by the bidder/proposer for each MBE/WBE included on their Schedule D-1 and must accurately detail the work to be performed by the MBE/WBE and the agreed rates and prices to be paid.

If any fully completed and executed Schedule C-1 is not submitted with the bid/proposal, it must be received by the Contract Administrator within ten (10) days of the bid/proposal opening. (All post bid/proposal submissions must have original signatures on all documents). Failure to submit a completed Schedule C-1 in accordance with this section shall entitle the City to deem the bid/proposal non-responsive and therefore reject the bid/proposal.

B. Letters of Certification.

A copy of each proposed MBE/WBE firm's current Letter of Certification from the City of Chicago must be submitted with the bid/proposal.
All Letters of Certification issued by the City of Chicago include a statement of the MBE/WBE firm's Area of Specialty. The MBE/WBE firm's scope of work, as detailed by their Schedule C-1, must conform to their stated Area of Specialty.

C. Joint Venture Agreements.

If the bidder's/proposer's MBE/WBE proposal includes the participation of a MBE/WBE as joint venture on any tier (either as the bidder/proposer or as a subcontractor), the bidder/proposer must provide a copy of the joint venture agreement and a Schedule B.

In order to demonstrate the MBE/WBE partner's share in the ownership, control, management responsibilities, risks and profits of the joint venture, the proposed joint venture agreement must include specific details related to: (1) contributions of capital and equipment; (2) work responsibilities or other performance to be undertaken by the MBE/WBE; and (3) the commitment of management, supervisory and operative personnel employed by the MBE/WBE to be dedicated to the performance of the contract. The joint venture agreement must also clearly define each partner's authority to contractually obligate the joint venture and each partner's authority to expend joint venture funds (e.g., check signing authority).

D. Required Schedules Regarding DBE/MBE/WBE Utilization.

Bidders must submit, together with the bid, a completed Schedule D-1 committing them to the utilization of each listed MBE/WBE firm.

Except in cases where the bidder/proposer has submitted a request for a complete waiver of or variance from the MBE/WBE commitment in accordance with Section IV herein, the bidder/proposer must commit to

ATTACHMENT 4

EXHIBIT 2A RIDER

The "General Terms and Conditions" of the Board of Education of the City of Chicago in Exhibit 2A are minimum contracting requirements of the Board, and the Board reserves the right to revision of such and to require additional contract provisions, pursuant to, without limitation, any local, state, and/or federal laws or regulations, and/or Board policy and/or any other determinations on behalf of Board. In addition, any Proposer must warranty that they will be compliant with all such laws, regulations, policies and any other governmental requirements; including but not limited to the Health Insurance Portability and Accountability Act of 1996 (HIPAA.), as may be from time to time be amended.