




Actuarial Bid Training Introduction to Bidding

CMS Office of the Actuary
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This presentation is informational only and not a replacement for the BPT Instructions.

Welcome to the “Introduction to Bidding” Actuarial Training Session. It’s aimed at new users of CMS’ bid pricing tool for the Medicare Advantage and Part D programs, but returning users may find it useful also. The goal is to introduce and explain important basic concepts and terms used in the bidding process to prepare people to use CMS’s bid pricing tool (or BPT). A separate training session, called BPT101, elaborates on this session by describing the structure and content of the BPTs. This session provides an overview of the competitive bidding process reflecting data current for Contract Year (CY) 2026, beginning with elements that apply to both the Medicare Advantage and Part D programs, and proceeding to program-specific terms and concepts.



Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 (PL 108-173)

MMA

- Title I—Prescription Drugs—Part D
- Title II—Medicare Advantage—Part C
(Formerly Medicare+Choice)

In 2003, Congress enacted “The Medicare Prescription Drug, Improvement, and Modernization Act” commonly referred to as MMA. Title I of the Act created Medicare Part D, which established prescription drug coverage within Medicare. Title II of the Act defined the Medicare Advantage (or MA) program, which was previously called the Medicare-Plus-Choice Program. MMA also defined the bidding process that is described in this session. The Inflation Reduction Act (2022) and the Medicare Advantage and Part D Final Rule for Contract Year 2024 made changes to the Part D benefit with the intent of lowering the out-of-pocket cost for patients who pay for drugs. These changes began in contract year 2023 and will be completely reflected as of contract year 2025. See slides 16 to 20 for more information.



Competitive Bidding

It's an annual process that—

- Is used by MA and Part D programs
- Began in contract year (CY) 2006
- Includes—
 - Release of the MA rate book (April)
 - Initial bid submission (June)
 - Release of Part D and RPPO benchmarks (July)

The competitive bidding process established by the MMA applies to both the MA and Part D programs. It was first used for CY 2006. It is an annual process that encompasses the release of the MA rate book by early April, the bids that plans submit to CMS in early June, and the release of the Part D and RPPO benchmarks, which typically occurs by late July.



Competitive Bidding (cont.)

Each bid must—

- Present the estimated revenue requirements of the plan
- Be standardized with respect to risk
- Document methods and assumptions in compliance with—
 - Applicable ASOPs
 - CMS' bid instructions and guidance
 - Applicable laws and rules
- Be certified by a qualified actuary

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To be acceptable to CMS, each bid must—

- Present the estimated revenue requirements of the plan
- Ensure that bid amounts are standardized with respect to risk, and
- Adequately document the methods and assumptions used to develop the bid, in compliance with—
 - Any applicable Actuarial Standards of Practice;
 - The CMS bid instructions; and
 - All applicable laws and rules.
- The bid must also be certified by a qualified actuary.

In summary, each bid must include—a completed bid pricing tool, adequate documentation, and an actuarial certification.



Competitive Bidding (cont.)

Revenue requirement =

- Benefit expenses +
- Non-benefit expenses +
- Gain/loss margin

The plan's revenue requirement is equal to benefit expenses plus non-benefit expenses plus a gain or loss margin. This amount is reported on a PMPM basis in the BPT.



Risk Adjustment

- Bids must—
 - Reflect projected costs
 - Be standardized
 - Reflect—
 - A risk score of 1.000
 - The risk profile of the average Medicare beneficiary

Risk scores enable CMS to compare and view bid amounts on a standardized basis. Projected costs that are based on actual plan experience must reflect the risk profile of that plan's population. When these costs are divided by the plan's risk score, the costs become "standardized." Standardized costs have a risk score equal to one, which means that they reflect the risk profile of the average Medicare beneficiary.



Risk Adjustment (cont.)

- Risk scores are—
 - Used in bidding and plan payment processes
 - Based on—
 - Demographic characteristics
 - Health status/disease information
 - Separate risk models are used for the MA and Part D programs

Risk scores are based on a beneficiary's demographic characteristics, health status, and disease information. They are used to standardize bid amounts and to adjust payments to plans. Separate risk models are used for Medicare Advantage and Part D.



Bid Pricing Tool (BPT) vs. Actual Plan Pricing

- Plans model pricing outside the BPT
- The BPT has specific requirements, such as—
 - Reporting plan experience
 - Assigning credibility
- CMS has specific pricing considerations for calculating the gain/loss margin
 - Some flexibility is allowed
 - Specific requirements apply at both the bid and aggregate level

CMS understands that organizations do extensive pricing and analysis in their own business models before they fill out the bid pricing tool. The instructions for filling out the BPT are comprehensive and—in some areas—not very flexible. For example, bids must report plan experience and assign it an appropriate level of credibility. Achieving desired pricing results using assumptions that do not reflect expected values is not acceptable. Where the BPT does allow some flexibility is in the gain/loss margin. Recall that the gain/loss margin is added to benefit expenses and non-benefit expenses in calculating the plan's revenue requirement. While there is flexibility, CMS has specific pricing considerations and supporting documentation requirements for the gain/loss margin at both the bid level and aggregate level. See the Bid Instructions for more details about gain/loss margin. We now turn to concepts and terms associated with plans offered under the MA program.



MA—Plan Types

- Plans with county-based service areas
 - HMOs, PPOs, PFFS plans, etc.
 - Special needs plans (SNPs)
 - Other county-based plans
- Regional PPOs (RPPOs)
 - 26 MA regions defined by CMS
 - Region-based service areas

Medicare Advantage continues to offer Medicare beneficiaries an alternative to fee-for-service coverage under Medicare Parts A and B, namely beneficiaries may choose plan coverage under Medicare Advantage through a variety of plan types, including—HMOs, PPOs, private-fee-for-service plans, and others. MMA added a new type of plan called a Special Needs Plan, or “SNP”; these plans can target specific Medicare populations for enrollment, such as: 1) institutionalized beneficiaries; 2) people who are dually eligible for Medicare and Medicaid; and/or 3) individuals with severe or disabling chronic conditions. MMA also introduced a new plan type called a regional PPO (RPPO), and CMS defined 26 regions made up of individual states or groups of states; for these plans, the service area must be one of the 26 regions. All other MA plans (that is, non-RPPOs such as HMOs, PPOs, PFFS plans, and SNPs) can have service areas that are as small as one county but can include multiple counties.



MA—Plan Benefits

- Medicare Part A and Part B coverage—
 - Provides “basic” or “Medicare-covered” services
 - Is known as “Medicare A/B,” “Medicare FFS,” “Original Medicare,” and “Traditional Medicare”
- MA plans must offer all the items and services covered under Medicare Parts A and B
- MA plans may offer additional benefits
 - Mandatory Supplemental—for all plan enrollees
 - Optional Supplemental—purchased separately

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Since MA plans are an alternative to coverage under Parts A and B, Medicare Advantage plans **MUST**—cover all items and services that Medicare beneficiaries receive under Parts A and B. It is worth noting that Parts A and B are referred to in many ways, including—“basic” services, “Medicare-covered” services, “Medicare FFS,” “Original Medicare,” or “Traditional Medicare.”

Medicare Advantage plans **MAY**—and often do—cover additional benefits, that is, benefits **NOT** covered under the Traditional Medicare program. These fall into two categories.

Mandatory Supplemental Benefits are additional benefits that the plan covers for every person enrolled in the plan.

Optional Supplemental Benefits are additional benefits that enrollees may elect to purchase separately.



MA—Plan Benefits (cont.)

Mandatory Supplemental Benefits

- Reduced cost sharing—
 - Is known as FFS cost-sharing buydown
 - Applies when MA cost sharing is less than Medicare FFS cost sharing
- Additional benefits—
 - Include non-covered services
 - Extend the benefit limits of Medicare-covered services

Mandatory Supplemental Benefits can be provided in the form of reduced cost sharing or in the form of additional benefits.

Reduced cost sharing, is also called “FFS cost-sharing buydown.” It applies when cost sharing under the MA plan is less than cost sharing under traditional Medicare—for example, when an MA plan does not have a hospital deductible.

Additional benefits include coverage of non-covered services, which is anything not offered under Traditional Medicare, like routine dental benefits, for example. Additional benefits also include coverage of Medicare-covered services beyond the limits included in Traditional Medicare. For example, covering inpatient hospital days beyond the Medicare lifetime limit would be considered an additional benefit.



MA—Benchmarks

- Non-RPPO benchmark amount
 - Weighted average of rate book values
 - Equal to the share of projected plan enrollment by county
- RPPO benchmark amount—a blend of two components
 - Statutory—based on rate book values
 - Plan bid—based on weighted average of bid amounts in each region

The bid process for a MA plan relies on two benchmarks amounts: one for regional plans and one for all other plans. The non-regional benchmark is a weighted average of county-specific rate book values, where the weights are each county's share of the total projected enrollment for the plan. For regional PPOs, the benchmark is a blend of two components: A statutory component, which is based on rate book values; and a plan bid component, which is based on plan bid amounts.



MA—Plan Payment

- The amount CMS pays depends on—
 - The beneficiary's risk score
 - The relationship between the bid amount and the MA benchmark
- If bid amount > benchmark
 - CMS pays the benchmark amount; and
 - The beneficiary pays the difference
- If bid amount < benchmark
 - CMS pays both the bid amount; and
 - The MA rebate amount, which is equal to the benchmark minus the bid

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The amount that CMS pays a plan to provide coverage to Medicare beneficiaries is always risk adjusted, i.e., it depends on the risk score of each beneficiary, but it also depends on the relationship between the plan's bid amount and the MA benchmark. If the bid amount is greater than the benchmark, CMS pays the benchmark amount, and the beneficiary pays the difference (i.e., the bid minus the benchmark). If the bid is less than the benchmark, CMS pays the bid amount plus the MA rebate amount which is equal to a percentage of the difference (i.e., the benchmark minus the bid amount). The percentage is between 50% and 70% and depends on the plan's quality rating.



MA—Plan Payment (cont.)

- Total payment from CMS = bid amount + rebate
- Bid amount funds Medicare-covered benefits
- Rebate funds supplemental benefits and premium and can be used to—
 - Reduce premiums (Part B or Part D)
 - Reduce cost sharing
 - Increase benefits
 - Expansion of Medicare-covered benefits
 - Provision of non-covered benefits

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It is instructive to consider the component parts of the total plan payment from CMS—the bid amount and the rebate—in terms of the benefits that they fund. The bid amount funds the Medicare-covered services included in the plan’s total benefits. The rebate funds all other benefits, usually called supplemental benefits, provided by the plan. Rebates, however, can be provided in different forms: they can be used to reduce premiums (for Part B or Part D benefits), they can be used to reduce cost sharing for Medicare-covered services, or they can be used to increase benefits. Note that increased benefits can be—either expansion of Medicare-covered benefit limits or offering benefits not offered under Traditional Medicare, such as vision benefits. Next, we consider plans offered under the Part D program.



Part D—Plan Types

Coverage is provided/administered by two types of private health plans:

- Medicare Advantage plans, which offer a prescription drug benefit (MA-PDs)
- Prescription Drug Plans (PDPs)
 - PDPs must cover an entire region
 - CMS has defined 39 Part D regions

Under the Part D program, drug coverage is provided and administered exclusively by private plans. Plan sponsors can offer prescription drug benefits in conjunction with an MA plan, which is then called an MA-PD, or they can offer a stand-alone Prescription Drug Plan (or PDP), which is region-based. CMS has defined 34 state-based regions and 5 regions that cover U.S. territories.



Defined Standard Benefit (2026 values)

Total Drug Spending	Beneficiary Spending	Beneficiary Pays	Plan Pays	Manufacturers Pay	Government Pays
\$0 - \$615	\$615	100%			
Deductible					
\$615 - OOP Max	\$1,485	25%	65% Applicable Drug Costs or Selected Drug Costs	10% Applicable Drug Costs	10% Selected Drug Costs
Initial Coverage Limit (ICL)			75% Non-applicable Drug Costs		
Catastrophic			60%	20% Applicable Drug Costs	20% Applicable Drug Costs 40% Non-applicable Drug Costs or Selected Drug Costs

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The table uses CY2026 benefit values for illustrative purposes. These values are indexed and updated by CMS every year. Under the Defined Standard Benefit, the amount that the plan pays varies as the amount spent on drugs reaches certain thresholds. For example, if total drug spending (shown in the first column) is less than or equal to the deductible amount of \$615, the beneficiary pays 100% of the cost. For drug spending more than the deductible but less than or equal to the catastrophic threshold, the beneficiary pays 25%, the plan pays 75% for Non-Applicable Drug costs and 65% for Applicable and Selected Drug costs, the manufacturers pays 10% for Applicable Drug costs, and the government pays 10% for Selected Drug costs. For catastrophic coverage, the beneficiary will have no cost sharing, the plan pays 60%, the manufacturers pay 20% for Applicable Drug costs, and the government pays 20% for Applicable Drug costs and 40% for Non-Applicable and Selected Drug costs. The amount the government pays in the Catastrophic phase is called “federal reinsurance.”



Enhancements to Part D after the MMA

- The Inflation Reduction Act (2022)
- Medicare Advantage and Part D Final Rule for Contract Year 2024

There have recently been several recent changes to the Part D benefit with the intent of lowering the out-of-pocket cost for patients who pay for drugs.



The Inflation Reduction Act (2022)

- Effective 2023
 - Limits monthly insulin cost sharing to no more than \$35 and no deductible
 - Requires that adult vaccines be covered at no cost
 - Consistent with coverage of vaccines under Medicare Part B, such as the flu and COVID-19 vaccines

The Inflation Reduction Act of 2022 has provisions to lower prescription drug costs for people with Medicare. Beginning in 2023, the act limits monthly cost sharing for insulin products to no more than \$35 and no deductible, both Part D and Part B. The act also requires that adult vaccines covered under Medicare Part D and recommended by the Advisory Committee on Immunization Practices be covered at no cost, which makes coverage of vaccines under Medicare Part D consistent with coverage of vaccines under Medicare Part B, such as the flu and COVID-19 vaccines.



The Inflation Reduction Act (cont.)

- 2024
 - Cap out-of-pocket spending
 - Eliminated the 5% beneficiary coinsurance requirement above the catastrophic coverage threshold
- 2025
 - A hard cap on out-of-pocket spending of \$2,000
- 2026
 - Hard cap increases to \$2,100
 - Introduction of Maximum Fair Price drugs and Selected Drug subsidy

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Beginning 2024, The Inflation Reduction Act of 2022 capped out-of-pocket spending for Medicare Part D enrollees and eliminated the 5% beneficiary coinsurance requirement above the catastrophic threshold, effectively capping out-of-pocket costs at approximately \$3,250 that year.

Beginning 2025, there was a hard cap on out-of-pocket spending of \$2,000, indexed in future years to the rate of increase in per capita Part D costs. The act also required drug companies to pay rebates to Medicare if prices rise faster than inflation for drugs used by Medicare beneficiaries, beginning in 2023.

Beginning in 2026, the hard cap on out-of-pocket spending will increase to \$2,100. Additionally, CMS will begin negotiating prices for some drugs covered under Medicare Part B and Part D and will start paying for 10% of these selected drug costs in the initial coverage phase in the form of a “Selected Drug” subsidy and 40% reinsurance for these selected drugs above the catastrophic threshold.



Medicare Advantage and Part D Final Rule for CY 2024

- Effective in 2024, patients pay the “lowest possible out of pocket cost” for a Part D drug
- Part D plans to include all pharmacy price concessions in the pharmacy price at the point of sale
- All anticipated manufacturer and pharmacy discounts to lower the drug cost for the patient at the pharmacy

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The Medicare Advantage and Part D Final Rule for Contract Year 2024 requires Part D plans to apply all pharmacy rebates to the point-of-sale (POS) price starting January 1, 2024. POS rebates are passed to the patient when the prescription is filled so the result should be a reduced cost sharing to the patient if they are paying a coinsurance (a percentage of the drug's cost). Prior to this rule the “rebate” lowered the premium cost for all enrollees without affecting the cost for beneficiaries that pay for drugs.



Part D—Plan Benefit Types

- **Defined Standard (DS) plans**
 - 2025, hard cap on out-of-pocket spending of \$2,000
 - 2026, out-of-pocket spending cap increases to \$2,100
 - No cost sharing in catastrophic coverage
- **Actuarially Equivalent (AE) plans—**
 - May vary cost-sharing requirements
 - Must pass one actuarial equivalence test

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There are four Benefit Types for Part D plans. The first is the “Defined Standard,” which offers the Standard Benefit package summarized on the previous slide. The second benefit type is “Actuarially Equivalent.” Actuarially Equivalent plans can vary the cost-sharing requirements; for example, by instituting co-pays. These plans must pass an actuarial equivalence test in the bid pricing tool.



Part D—Plan Benefit Types (cont.)

- Basic Alternative (BA) plans and Enhanced Alternative (EA) plans—
 - May vary cost-sharing requirements
 - Must pass four actuarial equivalence tests
 - Charge a supplemental premium (EA plans only) to cover the cost of supplemental Part D benefits

The third and fourth types of plans are called alternative plans: one is the Basic Alternative plan and the other is the Enhanced Alternative plan. Alternative plans MAY reduce the deductible and MAY vary the cost-sharing requirements below the catastrophic threshold. With more complex benefit offerings, these alternative plans must pass four actuarial equivalence tests in the BPT. Enhanced Alternative plans offer supplemental benefits by—reducing cost sharing, or by covering non-covered Part D drugs, or both. Enhanced Alternative plans charge a supplemental premium that covers the value of the supplemental benefits, non-benefit expenses and any gain/loss margin.



Part D—Benchmarks

- The national average monthly bid amount (NAMBA)—
 - Is based on bid amounts in a contract year
 - Excludes any supplemental premiums
 - Is typically released by CMS in July
- The base beneficiary premium (BBP) = 25.5% of the NAMBA
 - Adjusted for reinsurance, capped at a 6% increase from prior year
- The basic Part D premium = bid – NAMBA + BBP

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The Part D national average monthly bid amount (NAMBA) and the base beneficiary premium (BBP) are used to determine the premium payment for each plan. The NAMBA is a weighted average of bids submitted to CMS excluding any supplemental premiums, and it is typically released by CMS by late July. The BBP is equal to 25.5 percent of the national average, after an adjustment for reinsurance. Any increase value is capped at a 6% increase from prior year. The Part D basic premium is set equal to the plan bid amount minus the NAMBA plus the BBP.



Part D Payment

- Direct Subsidy
- Federal Reinsurance Subsidy
- Risk Sharing
- Low-income Subsidy (LIS)

Next, we'll discuss the components of Plan Payment under Part D, which include the Direct Subsidy, the Federal Reinsurance Subsidy, Risk Sharing, and the Low-income Subsidy, or "LIS".



Part D Payment (cont.)

- The direct subsidy—
 - Funds the portion of the DS Benefit paid by the plan
 - 75% of non-applicable drug costs and 65% of applicable and selected drug costs between the deductible and catastrophic threshold
 - 60% of drug costs beyond the catastrophic threshold
 - Risk adjusted for health status
 - Net of beneficiary premiums
 - Calculated using standardized bid amount

The direct subsidy funds the portion of the Defined Standard Benefit paid by the plan. It is based on 75% of non-applicable drug costs and 65% of applicable and selected drug costs incurred between the deductible and the catastrophic threshold as well as 60% of drug costs incurred beyond the catastrophic threshold. The direct subsidy is based on the standardized bid amount, is risk adjusted for health status, and is net of beneficiary premiums. Federal reinsurance provides periodic payments during the year, and these are reconciled after the end of the contract year.



Part D Payment (cont.)

- Reinsurance—
 - Provides interim payments with reconciliation at year's end
 - Reimburses the plan for costs beyond the catastrophic threshold
 - 20% for applicable drug costs
 - 40% for non-applicable drug costs
 - 40% for selected drug costs

Federal Reinsurance provides periodic payments during the year, which are reconciled after the end of the contract year. The federal government reimburses the plan for drug costs beyond the catastrophic threshold; 20% for applicable drug costs, 40% for non-applicable drug costs, and 40% for selected drug costs.



Part D Risk Sharing

- Risk sharing limits exposure to unexpected drug costs not predicted in the bid
- The plan sponsor and government share profit and loss through risk corridors
- Payments and retentions are based on the plan's target amount

Risk sharing limits the plan's and the government's exposure to unexpected expenses not included in the reinsurance subsidy or accounted for through risk adjustment. The federal government and plan share in experience that differs from that projected in the bids in the form of risk corridors. Risk corridors are symmetrically structured around the Plan's target amount.



Part D Risk Sharing (cont.)

- The target amount = direct subsidy + beneficiary premium + A/B rebate applied to premium – administrative cost ratio
- Reconciliation determines the difference between the target amount and allowable risk corridor costs

Target amount = direct subsidy + beneficiary premium + A/B rebate applied to premium – administrative cost ratio. Reconciliation of risk sharing involves determining the difference between the Plan's target amount and actual allowable costs excluding administrative expenses.



Part D Risk Sharing (cont.)

- Allowable risk corridor costs are actual paid costs under the DS Benefit less—
 - Direct and indirect remuneration (DIR)
 - EA cost-sharing amounts
 - Federal reinsurance and low-income cost-sharing payments
 - Beneficiary cost sharing
 - Induced utilization, if applicable

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Allowable risk corridor costs are equal to actual plan paid costs for covered Part D drugs under the Defined Standard Benefit, excluding direct and indirect remuneration (DIR), enhanced alternative cost-sharing amounts, federal reinsurance payments, low-income cost-sharing subsidy payments, and beneficiary cost sharing. If a plan offers supplemental benefits, the insurance effect of supplemental coverage (referred to as induced utilization) is excluded.



Part D Risk Sharing (cont.)

- The risk corridors for 2026 are—

Risk Corridor	Government's Share	Plan's Share
0% to 5%	0%	100%
5% to 10%	50%	50%
10% or more	80%	20%

- If the difference is—
 - A gain, the plan pays the government
 - A loss, the government pays the plan

Risk corridors determine how the plan and the government share gains and losses that arise when actual plan costs differ from the plan costs projected in the bid. The applicable risk corridors for contract year 2026 are as follows. The plan retains 100% of the difference if it is less than 5%. If the Difference is between 5% and 10%, it is shared equally between the plan and the government. And if the difference is greater than 10%, the plan retains 20% and the government retains 80%. Note that when the difference results in a gain (i.e., actual costs are less than projected costs) the plan pays the government; whereas, if the difference results in a loss, (i.e., the actual costs are greater than the projected costs) then the government pays the plan.



Low-Income Premium Subsidy Amount (LIPSA)

- LIPSA is the amount paid to plans by the government for low-income subsidy (LIS) beneficiaries
- It is equal to the lesser of—
 - The Part D basic premium for the plan
 - The low-income regional benchmark
- If the plan premium is greater than LIPSA, the low-income beneficiary pays the difference

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The Low-Income Premium Subsidy is the amount paid to plans by the government for LIS beneficiaries. The subsidy is equal to the lesser of:

- The Part D basic premium for the plan, and
- The Low-Income regional benchmark.

However, if the lowest PDP premium in the region is greater than the Low-Income regional benchmark, it must replace the Low-Income regional benchmark in the determination of the subsidy. When LIS beneficiaries enroll in plans where the plan premium is greater than the subsidy, they are required to pay the difference.



LIPSA (cont.)

- Low-income premium benchmarks—
 - Are based on submitted plan premiums
 - Are typically released by CMS in July
- Benefits for low-income beneficiaries include—
 - A reduced or eliminated deductible
 - Reduced cost sharing
 - A reduced or eliminated premium
 - No late enrollment penalty

The Low-Income Premium Benchmarks that are used in the determination of the subsidy are based on submitted plan premiums. These benchmarks are typically released by CMS by late July.

Low-income beneficiaries benefit from:

- A reduced or eliminated deductible
- Reduced cost-sharing
- A reduced or eliminated premium
- No late enrollment penalty



Low-Income Cost-Sharing (LICS) Subsidy

- Beneficiaries who qualify pay reduced cost-sharing amounts
- The LICS subsidy—
 - Funds the difference between—
 - The cost-sharing amounts paid by LIS beneficiaries; and
 - The cost-sharing amounts paid by plans for non-LIS beneficiaries
 - Is paid prospectively based on bid values
- Reconciliation is based on actual cost sharing

LIS beneficiaries pay reduced cost-sharing amounts for Part D coverage. The low-income cost sharing subsidy funds the difference between cost sharing amounts actually paid by LIS beneficiaries and the plan's cost sharing amounts for non-LIS beneficiaries. It is paid prospectively to the plan sponsor based on estimated amounts submitted in the bid. During reconciliation there is a true-up for the actual amount.



In Conclusion

For more guidance, consult—

- BPT 101
- BPT instructions, located at—
<https://www.cms.gov/medicare/payment/medicare-advantage-rates-statistics/bid-forms-instructions>

This concludes the “Introduction to Bidding” training session. For further guidance please view the “BPT101” Bidder Training Session. You will then be well prepared to read the Bid instructions, which can be found at the website listed on this slide.