BID # SDOC-08-P-084-CJ

March 27, 2008

ADDENDUM NO.: 1
(To be attached and become a part of the RFP)

EMPLOYEE BENEFIT CONSULTING SERVICES

To be opened, **April 2, 2008** at 2:00 p.m., in the School District of Osceola County, Purchasing Department, 817 Bill Beck Boulevard, Kissimmee, Florida 34744.

During the Pre-Proposal Conference there were many questions, below are the questions submitted and their answers.

Question 1
Please clarify the scoring criteria. There appears to be slight discrepancies between the definitions under Section 4.0 Tab 3/4/5/6 and Section 5.0. They both add up to 100 points but, for example, Section 5.0 #3 references is 40 points but Tab 3 references is 20 points.
Answer: The difference is not a discrepancy, as Section 4 outlines the submittal evaluation and Section 5 outlines the presentation evaluation.

Question 2
Section 4.0 Tab # 1—the opening sentence requires "RFP submittal Letter signed by authorized agent of the business/corporation with proof of authorization from business" We are a publicly traded NY Stock Exchange company—please clarify what you are requesting so that we can be in compliance.
Answer: Include documentation that shows your firm's officers who are authorized to sign on behalf of your firm.

Question 3
Section 4.0 Tab #1 G—again, we are a publicly traded NY Stock Exchange company headquartered in Daytona Beach, Florida. Please clarify what we need to submit to be in compliance.
Answer: "For non-Florida businesses submit documentation from the state in which the business was formed and documentation from the State of Florida providing authorization to perform business in the state of Florida." This can be found on the State of Florida website.

Question 4
We (the incumbent) participate in the annual "Welcome Back" function and the open enrollment "Benefits Help Line". Does the district wish these services to continue to be provided?
Answer: Yes

Question 5
For the past 5 years we (the incumbent) have sponsored an annual Retiree Lunch And Learn seminar in August to communicate plan changes to the retiree population. We view this as one of our Core Services to the District. Last August there were over 150 retirees in attendance, and this number will only grow in the future. Does the District wish for this activity to continue for 2008 and beyond?
Answer: Yes

Question 6
We (the incumbent) designed and produced a flash based, audio-visual communications tool with animation for each product offered to the district employees. This information was designed to supplement the material in the printed enrollment guide. This information was made available on both a CD for viewing at individual work sites and via a web based distribution. Does the District wish to have this service for 2008 and beyond? If so, a web link can be provided by Risk and Benefits Management for viewing.
Answer: Not being used at this time, uncertain of future need.

Question 7
Please describe the current payment arrangement for the incumbent broker, Brown and Brown (formerly Wittner National Group), i.e. fee or commission. If it is fee, what is the annual amount paid to Brown and Brown. If commission, what is the percentage of commission that is paid by policy, (i.e. 5% on medical stop loss, 10% on life insurance, etc.) Is there an administrative fee that is paid by CIGNA to Brown and Brown that is part of the administrative invoice from CIGNA?
Answer: Commissions as Broker of Record includes 5% for CompBenefits Vision, 3% for Life Insurance, ASO fee includes $1/ee/month, 10% for CIGNA Dental and 15% for UNUM Disability

Question 8
If commission, please provide the approximate total commission dollars paid under the most recent 12 month period.
Answer: Not available.
Where there additional dollars paid to Brown and Brown under contingent or bonus commission programs offered by the carriers?
Answer: Yes, B&B qualified for additional compensation of $51,372 based on membership in our plans during 2005 (paid in 06/07).

Question 9
Does the District have a preference of fee vs. commission?
Answer: Responses to the RFP should be in the form of an Annual Fee.

Question 10
Are all medical plans under CIGNA self-insured?
Answer: Yes
The RFP lists four plans under CIGNA Healthcare with 9/30/08 termination dates. Are these different from the ASO and Stop Loss plans?
Answer: Yes, the ASO and Stop Loss agreements renew 07/01/08; the Plan Years all run 10/01 to 09/30.

Question 11
Please confirm that the CIGNA ASO and Stop Loss agreements are 7/1 anniversary dates. If so, please provide a brief description of why they are under a different anniversary date than the other benefit plans.
Answer: Yes, they are different. The District Budget year runs 07/01 to 06/30 as noted above the Plan Years run 10/01 to 09/30. ASO and Stop Loss are billed and paid monthly with the District Budget year.

Question 12
Does Brown and Brown provide for the production and printing of the benefits enrollment guide? If so, is there a separate fee paid to Brown and Brown for this service?
Answer: No

Question 13
Does Brown and Brown provide for the design and on-going maintenance of the on-line benefits platform? If so, is there a separate fee paid to Brown and Brown for this service?
Answer: No

Question 14
How and when are they currently communicating required Medicare Part D notice? (I saw a brief reference to Medicare Part D in the Retiree section)
Answer: Notices are provided before the required November deadline. The District posts the notice on the email system for all active employees and mail

Question 15
In addition to the Benefits Guide, what other methods does the District use to educate employee?

- At OE: posters, postcards, flyers, newsletters, video, meetings, carrier materials, etc.?
  Answer: CIGNA Pre-enrollment Hotline, Welcome Back Event, Online Enrollment System, Benefits Help Line, Staff is available to attend meetings at sites upon request.

- New Employees: posters, video, carrier materials, etc.?
  Answer: Sign-up meetings held in conjunction with HR New Hire Sign-up, Online Enrollment System and District email system.

- Ongoing: newsletters, email blasts, carrier materials, etc.?
  Answer: Benefits Corner (District Email system)

- How does the District pay for their employee communications?
  Answer: Plan Trust Fund

Question 16
Since the Wellness program is an implementation: here are some questions:

- Does the District currently provide any wellness opportunities through vendors or health insurance carriers?
  Answer: Yes

- Is the District interested in a phased approach to wellness programs?
  Answer: Yes

- Does the District host a health fair now?
  Answer: This is our first year, we are holding four (4) throughout the District (1) Kissimmee, (1) St Cloud, (1) Poinciana, and (1) for Transportation Facility.

- Do the Districts medical plans offer incentives for health assessments, participating in carrier-sponsored programs?
  Answer: 10/01/07 offered $100 in FSA to all employees who completed the Health Risk Assessment available on myCIGNA.com. 10/01/08 in order to receive the $100 incentive employees will have to update the HRA, receive an Annual Physical from their PCP or OB/Gyn and attend at least (1) one of the (4) four Health Fairs offered this year.

- Does the District have a smoking cessation incentive, policy, etc. in place at this time?
  Answer: No

- How will the District fund a wellness program?
  Answer: We were one of 4 Districts in the State to receive Grant Funding from the Department of Health for $75,000. CIGNA has also committed $30,000 a year for the next three years to help fund our Wellness Program.

Question 17
Please provide a breakdown of the current compensation paid to Wittner/Brown & Brown by product and/or fee for service.
Answer: See response to 7, 8 & 9 above.

Question 18
Is it anticipated that the consultant selected will become the agent of record for all lines of coverage, e.g., dental, vision, life, disability?
Answer: No.
Will commissions on these products be available to serve as an off-set to consulting fees?
Answer: May be considered.

Question 19
Describe any expenses currently absorbed by Wittner/Brown & Brown, e.g., COBRA administration, Flexible Spending Accounts, enrollment.
Answer: None

Question 20
How many Requests for Proposals, and for which benefits, do you anticipate will go out over the next twelve months?
Answer: At this point in the year, the District anticipates that it be closer to the end of the next twelve months before decisions will be made about additional RFP's. We already have renewal offers for both Life Insurance and Disability for 10/01/08.

Question 21
Scope Item D includes the monitoring of administrators' actuarial and renewal assumptions under the self-insured program. This suggests the establishment of rates for the self-insured program is outside the scope of this RFP. Who currently sets the self-insured rates and handles the filing with the State?
Answer: The District currently sets the rates. 112.08 filing is completed by the Actuary firm of Wakely & Associates with a copy being sent to the Consultant, (outside the scope of this RFP).

Question 22
Regarding Scope Item F, please describe the current appealed claims process.
Answer: See Attached, Attachment A.

Question 23
Scope Item P suggests the School District does not currently have a Wellness program in place. If so, is it the School District's intent to establish and run its own wellness program, or contract with a third-party vendor (i.e. outside the scope of this RFP)? Please describe how the School District envisions the communications to employees and retirees being developed and distributed (in particular, the role(s) of the School District, the consultant, and any third party wellness vendors).
Answer: See 16 above.

Question 24
Will the consultant be required to attend the monthly District Insurance Committee meetings, or will it merely be necessary to be available as needed?
Answer: Yes

Question 25
Please provide a copy of the most recently available Annual Stewardship Report for the District.
Answer: See Attached. Attachment B

Question 26
The RFP lists a requirement for Cyber Liability coverage. We do not currently have this coverage and do not see any required services in the scope of services that would require such coverage. Can this requirement be waived for the bid?
Answer: Yes
(If the scope of services is expanded to include services requiring this coverage, we would agree to make sure the appropriate coverage was in force.)

Question 27
How many of the 7,000 employees we mention in the RFP are full time and how many are part-time?
Answer: Full-Time Employee Count as of February 29, 2008 was 6,669.

Question 28
Does the Consultant participate in the union negotiations when they are due?
Answer: No

Acknowledgement of Addendum #1 by Vendor:

This addendum shall be completed by Vendor and returned with the RFP Package. If the RFP package has already been submitted, this addendum must be submitted to the above address in a sealed envelope, which is marked on the outside Addendum to RFP, RFP title and number.

This is to acknowledge receipt of this addendum, which will become part of the RFP document.

AUTHORIZED NAME (TYPED)	TITLE
AUTHORIZED SIGNATURE	COMPANY NAME

Attachment A

PART 9 — CLAIMS PROCEDURES AND ADMINISTRATION

9.1 The Third Party Administrator shall be CIGNA HealthCare. A new Third Party Administrator may be named from time to time by the Employer. Covered Persons will receive notice of such change within ten (10) days of its effective date.

9.2 The Employer shall pay to or for the benefit of Covered Persons the benefits described in Part 3. All claims will be submitted to, processed by, and, if approved, paid by CIGNA within thirty (30) days of receipt. Claims should be submitted no later than forty-five (45) days after Covered Expenses have been incurred for terminated employees. Covered Persons must submit claims within 12 months of date of service.

9.3 If any claims for benefits under this Plan are denied in whole or in part, the claimant shall be furnished written notice promptly by CIGNA:

1. Setting forth the reason for the denial;
2. Describing any additional material or information needed from the claimant and why; and
3. Explaining the claim review procedure set forth herein.

If CIGNA fails to respond to a claim within sixty (60) days after the denial of any claim for benefits under this Plan, the claimant may request in writing a review of the denial from CIGNA. Any claimant seeking a review hereunder is entitled to examine all pertinent documents and to submit issues and comments in writing. CIGNA shall render a decision on review of a claim no later than sixty (60) days after receipt of request for review hereunder. The decision shall be in writing and shall state the reason for the decision, referring to the Plan provisions upon which it is based. Should this decision be unsatisfactory the claimant may appeal under the Grievance Procedures as established by the Trustees.

9.4 INSTRUCTIONS FOR SUBMISSION OF CLAIMS

Customarily, claims will be submitted by the provider of care. In the rare instance that you submit the claim, be sure the bills submitted include all of the following:

1. Employee’s name, social security number and home address.
2. If claim is made for a dependent, name, Employer and age.
3. Employer’s name and group number: **School District of Osceola County, #3198508**
4. Name and address of the Physician or Hospital.
5. Physician’s diagnosis.
6. Itemization of charges.
7. Date the injury or illness began.

These items are REQUIRED in order to accurately pay claims. Certain claims may require additional information before being processed.

All payments will be issued directly to the provider of the service unless receipted bills showing payment has been made are submitted. In the event of the Covered Person's death, direct payment will continue to be made to the provider.

Please direct all claims and any questions regarding claims to:
CIGNA Claims
P.O. Box 182223
Chattanooga, Tennessee 37422-7223
800-244-6224

Every attempt will be made to help Covered Persons understand their benefits; however, any statement made by an employee of CIGNA or the Employee will be deemed a representation and not a warranty. Actual benefit payment can only be determined at the time the claim is submitted and all facts are presented in writing. All benefit payments are governed by the provisions of the Plan Document.

If a definite answer to a specific question is required, please submit a written request, including all pertinent information, and a statement from the attending Physician (if applicable), and a written reply (which will be kept on file) will be sent.

WHEN YOU HAVE A COMPLAINT OR AN APPEAL

For the purposes of this section, any reference to "you," "your," or "Member" also refers to a representative or provider designated by you to act on your behalf, unless otherwise noted.

We want you to be completely satisfied with the care you receive. That is why we have established a process for addressing your concerns and solving your problems.

Start with Member Services

We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, or contractual benefits, you can call the toll-free number on your Benefit Identification card, explanation of benefits, or claim form and explain your concern to one of our Member Services representatives. You can also express that concern in writing.

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, but in any case within 30 days.

If you are not satisfied with the results of a coverage decision, you can start the appeals procedure.

Appeals Procedure

CIGNA has a two-step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request for an appeal in writing to CIGNA within 365 days of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask CIGNA to register your appeal by telephone. Call or write us at the toll-free number on your Benefit Identification card, explanation of benefits, or claim form.

Level One Appeal

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional.

For level one appeals, we will respond in writing with a decision within 15 calendar days after we receive an appeal for a required preservice or concurrent care coverage determination, and within 30 calendar days after we receive an appeal for a postservice coverage determination. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

You may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum functionality or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves non-authorization of an admission or continuing inpatient Hospital stay. CIGNA's Physician reviewer, in consultation with the treating Physician will decide if an expedited appeal is necessary. When an appeal is expedited, CIGNA will respond orally with a decision within 72 hours, followed up in writing.

Level Two Appeal

When a problem cannot be satisfactorily resolved through the preceding steps, the issue may be referred to the Trustees of the SDOC Employee Benefit Trust for an administrative review. After review of the information compiled relative to the grievance, the Trustees shall either support the decision of the Level One Appeal, or direct the Plan Administrators to take other action to resolve the dispute. The Trustees shall be the final authority with regard to any SDOC Employee Benefit Trust disputes. The decision of the Trustees will be communicated to the Covered Person within 60 days.

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific plan provisions on which the determination is based; (3) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; (4) a statement describing any voluntary appeal procedures offered by the plan (5) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgement for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit.

Relevant Information

Relevant information is any document, record or other information which: (a) was relied upon in making the benefit determination; (b) was submitted, considered or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; (c) demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or (d) constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

9.5 Payment of Benefits

To Whom Payable

All Medical Benefits are payable to you. However, at the option of CIGNA, all or any part of them may be paid directly to the person or institution on whose charge claim is based.

Medical Benefits are not assignable unless agreed to by CIGNA. CIGNA may, at its option, make payment to you for the cost of any Covered Expenses received by you or your Dependent from a Non-Participating Provider even if benefits have been assigned. When benefits are paid to you or your Dependent, you or your Dependent is responsible for reimbursing the Provider. If any person to whom benefits are payable is a minor or, in the opinion of CIGNA, is not able to give a valid receipt for any payment due him, such payment will be made to his legal guardian. If no request for payment has been made by his legal guardian, CIGNA may, at its option, make payment to the person or institution appearing to have assumed his custody and support.

If you die while any of these benefits remain unpaid, CIGNA may choose to make direct payment to any of your following living relatives: spouse, mother, father, child or children, brothers or sisters; or to the executors or administrators of your estate.

Payment as described above will release CIGNA from all liability to the extent of any payment made.

Time of Payment

Benefits will be paid by CIGNA when it receives due proof of loss.

Recovery of Overpayment

When an overpayment has been made by CIGNA, CIGNA will have the right at any time to: (a) recover that overpayment from the person to whom or on whose behalf it was made; or (b) offset the amount of that overpayment from a future claim payment.

Calculation of Covered Expenses

CIGNA, in its discretion, will calculate Covered Expenses following evaluation and validation of all provider billings in accordance with:

- The methodologies in the most recent edition of the Current Procedural terminology.
- The methodologies as reported by generally recognized professionals or publications.

Attachment B

TRUST FUND ANALYSIS - 06/30/2007

BEGINNING FUND BALANCE 07/01/2006			$ 6,722,931.69	
REVENUE				
JULY	$	76,047.21		
AUGUST	$	1,601,975.45		
SEPTEMBER	$	3,358,574.76		
OCTOBER	$	3,450,769.83		
NOVEMBER	$	3,485,041.09		
DECEMBER	$	3,496,472.56		
JANUARY	$	3,547,863.45		
FEBRUARY	$	3,538,785.43		
MARCH	$	3,581,229.25		
APRIL	$	3,586,908.83		
MAY	$	4,515,325.37		
JUNE	$	1,042,137.06	$35,281,130.29	Year End Projection
EXPENDITURES				
JULY	$	2,653,481.85		
AUGUST	$	2,915,698.85		
SEPTEMBER	$	3,079,912.33		
OCTOBER	$	3,174,737.16		
NOVEMBER	$	3,821,432.07		
DECEMBER	$	3,464,577.29		
JANUARY	$	3,299,383.77		
FEBRUARY	$	3,343,032.39		
MARCH	$	3,747,149.81		
APRIL	$	2,925,507.52		
MAY	$	3,448,097.52		
JUNE	$	4,115,587.05	$39,988,597.61	Year End Projection
ANNUAL OPERATING GAIN/(LOSS)			$ (4,707,467.32)	
ENDING FUND BALANCE 06/30/2007			$ 2,015,464.37	