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Ron DeSantis, Governor

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ADDENDUM NO. 1 TO THE FOLLOWING REQUEST FOR PROPOSALS (RFP):

FULLY-INSURED MEDICARE ADVANTAGE AND PRESCRIPTION DRUG PLAN(S)

RFP NO.: DMS-18/19-054

Date: May 7, 2019

To: Prospective Respondents to RFP No.: DMS-18/19-054

From: Shannon Bagenholm, Procurement Officer

Subject: Revisions to RFP and Questions and Answers

The Request for Proposals, RFP No.: DMS-18/19-054, is hereby amended as follows:

1. Attachment A - Draft Contract, Attachment 2: Performance Guarantees, PG-5 is hereby revised as follows:

PG-5	Service Level / Average Speed to Answer	Inbound customer calls received by the customer service unit shall be answered by a live agent within the specified target time threshold. Target time threshold is measured from time the call is presented in the call queue for an agent and does not include any time used to navigate the automated system upon entering the call queue, if applicable.	Calls shall be answered within an average of thirty (30) seconds or less.	Quarterly	~~$2,000 per percentage point less than one hundred percent (100%)~~ $2,000 for each second over thirty (30) seconds

2. Attachment E - Paid Claims File, is hereby revised in accordance with the amendments set forth in the revised Attachment E - Paid Claims File.

The Department will send the revised Attachment E – Paid Claims File on CD-ROM by Federal Express overnight delivery to the Respondents that submitted Attachment F – Confidentiality and Non-Disclosure Agreement, and Attachment G – Notice of Intent to Submit a Proposal by the deadline indicated in subsection 1.6, Timeline of Events.

Enclosure:
Addendum No. 1: Questions and Answers Exhibit

Request for Proposals

Fully-Insured Medicare Advantage and Prescription Drug Plan(s)

RFP No.: DMS-18/19-054

Addendum No. 1: Questions and Answers Exhibit

The Department's responses to timely submitted questions are below.

Question Number	Section	Page Number	Question	Response
1			Whether companies from Outside USA can apply for this? (like, from India or Canada)	Refer to subsection 4.2.5 of Attachment A - Draft Contract and subsection 3.3, Mandatory Responsive Requirements of the RFP.
2			Whether we need to come over there for meetings?	Refer to subsection 6.5, Meetings/Conference Calls, of the RFP.
3			Can we perform the tasks (related to RFP) outside USA? (like, from India or Canada)	Refer to subsection 4.2.5 of Attachment A - Draft Contract.
4			Can we submit the proposals via email?	Refer to subsection 3.2, Receipt of Proposals of the RFP.
5	N/A	N/A	Can you please provide an updated member level RX claim file for all Medicare retirees for each RX plan. We will need one file that contains claim level information. The information should be provided in summary as well as in detail format. The detail format file should be in delimited text format, inclusive of a header row. The data should be provided for the Medicare eligible population we are quoting. Such as both Medicare eligible pre- and post-65's, including disableds. The File should include: a. Unique Member ID b. Pharmacy ID c. NDC-11 d. AWP e. Dispense Date f. Retail vs. Mail Indicator g. Days supply	The Department revised Attachment E - Paid Claims File to provide additional data fields. The Department is unable to provide all of the information requested. The Department will send the revised Attachment E – Paid Claims File on CD-ROM by Federal Express overnight delivery to the Respondents that submitted Attachment F – Confidentiality and Non-Disclosure Agreement, and

Question Number	Section	Page Number	Question	Response
			h. Quantity or Units Dispensed i. Duplicate records and originals/reversals should be removed j. Specific pharmacy plan indicator Can you please provide Rx member months for the same year claims have been provided (by month if possible). This should be provided for Medicare eligible members only and will be used to convert insured pricing to a PMPM basis.	Attachment G – Notice of Intent to Submit a Proposal by the deadline indicated in subsection 1.6, Timeline of Events.
6	N/A	N/A	Does the current Rx formulary include non-part D drugs (Example - Erectile Dysfunction drugs, vitamins and minerals, etc.)? If so please provide a listing of what is covered.	Yes. All federal legend drugs are covered if prescribed for a covered medical condition.
7	N/A	N/A	Can you please provide the latest 12-24 months of medical claims, including corresponding member counts by month for each product/plan, for Medicare eligible retirees only. (Claims should exclude under 65 spouses/dependents and non-Medicare eligible retirees)	Attachment E and revised Attachment E contains all of the medical claims data that can be provided by the Department.
8	N/A	N/A	Can you please provide member level risk score data for the members enrolled in a Medicare Advantage plan today that correspond to the paid claim data requested above?	The Department does not have this data.
9	N/A	N/A	Can you please provide member level risk score data for the members enrolled in a Medicare Advantage plan today that correspond to the paid claim data requested above?	The Department does not have this data.
10	N/A	N/A	For all of the Medicare Advantage medical claim files, what is the paid through date? Has a completion factor been applied?	No completion factor has been applied. See response to Question #7.
11	N/A	N/A	For all of the Medicare Advantage medical claim files, do the paid claims represent all claims or are there any additional claims such as non-FFS claims, vendor fees, provider bonuses, other rider costs, or capitation not included?	Yes, the data represents all paid medical claims.
12	N/A	N/A	Please confirm whether or not there were any benefit changes from the first year of provided claims to current year.	Effective July 1, 2017, occupational therapy benefits were added as covered benefits for all plans.
13	N/A	N/A	Is sequestration included in the CMS revenue payments for the Medicare Advantage plans?	Yes
14	N/A	N/A	Does the risk score information include an estimate for the midyear reconciliation done in December or final reconciliation done in July? If so, can you provide the estimated amount of each reconciliation?	Risk score information is not available and was not provided as part of this RFP solicitation.

Question Number	Section	Page Number	Question	Response
15	N/A	N/A	If the risk scores are MAPD combined, how are they combined? Is it the average of Medical and Rx, or is it the weighted average with weights being the MA revenue and Rx revenue?	See response to Question #14.
16	N/A	N/A	How is plan design eligibility determined? Do members have choice or are they mapped based on eligibility (retirement date, job listing, etc.)?	Eligible members will have a choice of a MA-PD plan(s), including the fully-insured HMO or the self-funded plan options currently available.
17	N/A	N/A	Can you please confirm the current coordination of benefits methodology with Medicare that applies to all the commercial Medical plans (2 self-funded PPO options, 1 fully-insured HMO option and 1 self-funded HMO style option) for Medicare eligible retirees; COB (coordination of benefits, retiree comes out whole), MOB (maintenance of benefits, also called Carve-out and Non-duplication) or Government Exclusion (also called Medicare exclusion) basis: ◦ COB - Coordination of benefits/ retiree comes out whole - Calculates what the plan would have paid as sole provider and adds what Medicare pays. If the total is more than 100% of the bill, the plan pays only enough to total 100%. The retiree often pays no deductible or coinsurance. ◦ MOB - maintenance of benefits or also called Carve-out and Non-duplication - Calculates the plan's payment as if there were no Medicare coverage, applies the deductibles, coinsurance and other plan limits and pays the remaining amount minus what Medicare pays. ◦ Government Exclusion (also called Medicare exclusion) - Determines the total expenses covered under the plan, reduces them by Medicare benefits and then applies the deductibles, coinsurance and other plan limits	The self-funded plans (PPO and HMO) most closely resemble the COB methodology for Medicare enrolled retirees. The fully-insured plan does not coordinate benefits with the State plan. For additional details, Plan designs are available on our website: https://www.mybenefits.myflorida.com/health/resources and https://capitalhealth.com/medicare/2019-chp-retiree-advantage-hmo-state-florida-members
18	N/A	N/A	Aetna provides Medicare Advantage MA-PD rates on a per member per month basis (PMPM) and not a tiered structure (Similar to Medicare I tier request). Because of this, how should we be filling out the tiered rate structure for Medicare II and III in C3a and C3b?	Refer to the instructions in Attachment C - Financial Proposal and Section 11 of the RFP.
19	N/A	N/A	Can you please provide detailed HMO plan designs for all HMO and HMO style plans offered to The State of Florida Medicare eligible retirees?	Plan designs are available on our website: https://www.mybenefits.myflorida.com/health/resources and

Question Number	Section	Page Number	Question	Response
				https://capitalhealth.com/medicare/2019-chp-retiree-advantage-hmo-state-florida-members
20	N/A	N/A	Can you please provide detailed Rx plan designs for all Rx plans offered to The State of Florida Medicare eligible retirees?	See response to Question #19.
21	5.1	29	On page 29 5.1 states "Respondent will provide fully-insured HMO MA-PD coverage on a full replacement basis". On the same page 5.3 states "Respondent's Proposal is not contingent upon being the only plan offered in a service area and does not include any minimum participation or employee contribution requirements." Can you please clarify what you mean above when you say full replacement if multiple plans could be awarded.	The term "full replacement" is to indicate that the awarded plan(s) will provide medical and Rx coverage to eligible Medicare retirees. The Program will continue to offer self-insured PPO and HMO health plans to Medicare retirees, as well as the MA-PD plan offered by Capital Health Plan.
22	4.3.3	27	On page 27 of the RFP it states for carriers to provide "one (1) proposed plan design with an actuarial value of at least eighty-nine percent (89%) ("Plan Design A") and one (1) proposed plan design with an actuarial value of at least seventy-eight percent (78%) ("Plan Design B"). Do these actuarial values take into account the coordination of benefits with Medicare or are the actuarial values estimated on the active plan?	This RFP is for fully-insured MA-PD coverage. The actuarial values must be based on plan designs submitted by Respondents. Attachment H – Covered Benefits represents the actuarial values for the active State of Florida employee population.
23	4.3.3	27	The RFP states "Respondents must provide two (2) proposed MA-PD plan designs". If the current commercial PPO plans coordinate with Medicare on a "coordination of benefits" basis, the member is usually left with no out of pocket costs. Per page 27 in the RFP, we are asked to quote one plan design with a minimum actuarial value of 89% and the other at 78% which will leave the member with OOP costs. Can you please clarify if the intent of the RFP is to provide leaner plans than what members are enrolled in today or to match plans dependent on how they coordinate with Medicare?	Refer to subsections 4.3.2, 4.3.3, and 4.4 of the RFP and the instructions in Attachment C - Financial Proposal.
24	N/A	N/A	In order to provide a comprehensive MAPD solution while also controlling costs, would the State consider a Medicare Advantage care-coordinated plan with a broad, national network of providers and hospitals that accept Medicare assignment, coupled with the same	Refer to the RFP document and all of its attachments.

Question Number	Section	Page Number	Question	Response
			care management services and cost-containment as is provided under an HMO-style arrangement? This enables us to provide the State of Florida retirees with one national plan with a single cost sharing tier regardless of where the member may reside.	
25	N/A	N/A	Are carriers able to provide tiered rates based on different membership enrollment assumptions? This would account for whether The State decides to offer these Medicare Advantage plans on a full replacement or slice basis dependent on what is most advantageous to The State.	Refer to the RFP, including the instructions in Attachment C - Financial Proposal, Section 5, Minimum Qualifications, and Section 11, Financial Proposal.
26	N/A	N/A	In "Attachment D - CENSUS FILE" there are about ~38,000 members enrolled in Medicare Tier I, Tier II and Tier III plans. This is much greater than the ~30,000 Medicare eligible members described on page 9 of the RFP. After analyzing the census we assumed that children and spouses on Medicare tier II plans should be removed as only one member in this tier should be eligible for Medicare. We also assumed that anyone who was tier III eligible was already duplicated for dual membership in the census provided. Our assumption for total Medicare eligible membership in this RFP is about 36,000 lives. Can you please confirm that this assumption of 36,000 members is accurate as it is about 6,000 greater than what was shown in the chart on page 9 of the RFP? Please see tier justification below. **Tier I - One eligible Member** Chart Enrollment Assumption (PPO & HMO combined) = 21,227 Census Enrollment = 21,248 **Tier II - One Eligible Member plus an ineligible member** Chart Enrollment Assumption (PPO & HMO combined) = 1,518 Census Enrollment (After removing children and spouses) = 1,520 **Tier III - Two eligible Members** Chart Enrollment Assumption (PPO & HMO combined) = 7,007 Census Enrollment (Assuming membership in chart is duplicated for 2 eligible members) = 14,048	The chart included in the RFP was only enrollee data. Census data includes all Medicare Tier members, including retroactive members.
27	N/A	N/A	Can you please confirm if there are Medicare eligible members enrolled in spouses plans or in the individual market that are eligible for the group plan during open enrollment? If so, how large is this population of members?	The question is unclear. State of Florida retirees must meet the eligbility requirements as provided in statutes and Florida Administrative Code.

Question Number	Section	Page Number	Question	Response
28	N/A	N/A	Is it the intent of the RFP to match the two Rx plans provided in Attachment H but on a part-D basis? Are we able to provide a lower cost option if advantageous to The State?	Refer to subsections 4.3.2 and 4.3.3 of the RFP and the instructions in Attachment C - Financial Proposal. Refer also to Section 10 of the RFP and Attachment H - Covered Benefits ("The covered benefits are being provided as a reference only. Neither "Plan Design A" nor "Plan Design B" are required to match the listed covered benefits or applicable copayment and deductible amounts shown.").
29	6.6 (a)	32	Since it will be offered as an option, in addition to the 24 benefit fairs, will Respondent have an opportunity to begin marketing the MA-PD plan to retirees, following selection by the State?	Awarded Respondents will be able to market MA-PD plans to retirees with prior approval from the Department.
30	Attachment B – Reporting and Deliverables	Separate Exhibit	Is this document sent for informational purposes only on the format and timing of requested reports?	No, Attachment B will be incorporated into the Contract document in accordance with subsection 2.2 of Attachment A – Draft Contract.
31	3.4 Format of Proposal – Tab 9	24	Should we place forms 2-5 in Tab 9 of our RFP submission?	Respondents may place those forms in Tab 9.
32	3.4 Format of Proposal	23-24	Can we create a Tab 10 to provide any additional information that may not have a specific place holder in the requested TOC format?	Yes
33	N/A	N/A	Is there a page numbering requirement for this RFP? If so, does it need to be consecutively numbered or can we number pages by Tab section?	There are no page numbering requirements. Refer to subsection 3.4 of the RFP.
34	1.3	9	What is the average year of service For Medicare-eligible retirees receiving HIS? Is there any other state subsidy of premium in addition to the HIS?	The only premium subsidy available to retirees through the State is the HIS. Average years of service for retirees receiving the HIS is 21 years.
35	Section 10 – Plan Designs Proposal	47	Which of the following services are included in the actuarial value calculation: Medicare covered services, prescription drug, wigs,	This RFP is for fully-insured MA-PD coverage. The actuarial values should be based on plan

Question Number	Section	Page Number	Question	Response
			acupuncture, dental services, eye glasses, contacts, hearing test, weight loss services, manipulative services?	designs submitted by Respondents. Refer also to Attachment H - Covered Benefits and Section 10 of the RFP. See also answer to Question #28.
36	1.1	6	In lieu or in addition to the HMO product/plan designs, can a PPO product be offered for consideration?	No
37	Attachment H, Eye Glasses or Contacts 80% of Allowed Amt after CYD	3	Please confirm what the allowance or annual amount is.	The allowance or annual amount is marked as trade secret/confidential.
38	Attachment H, Dental Services	3	Please confirm dental Services - 80% of Allowed Amt after CYD or what is covered.	This question is unclear. See response to Question #37.
39	Section 11 – Financial Proposal	48	In the future, would DMS consider replacing the current PPO with a national Medicare Advantage PPO?	This question is outside the scope of this RFP.
40	Attachment D		When was the census file created?	February 2019.
41	Attachment D		What is the DOB for each member? If this information is not available, what is the "Age as of date" for each member?	The year of birth is included in Attachment D - Census File.
42	Attachment D		In the census file, we noticed the 4,140 Early Retiree/Family Plan Coverage Desc members. Do all of these members have Medicare as their primary coverage? If so, should any or all be included in this proposal?	Only members with a plan coverage tier listed as Medicare I, Medicare II, or Medicare III in Attachment D have Medicare as primary.
43	Attachment D		Are all the members under the age of 65 with Plan Coverage Desc Medicare I, II, and III, disabled and/or Medicare eligible? If not, can you identify which members aren't eligible?	Medicare II tier includes retirees in a family plan where at least one member is Medicare eligible. Medicare I is only available to single Medicare-eligible members. Medicare III includes more than one member all of which are Medicare-eligible.
44	Attachment D		Are we quoting the membership currently enrolled with Aetna, AvMed, and UHC (2,415 members) with Plan Coverage Desc Medicare I, II, and III?	The question is unclear. The RFP does not request Respondents to quote membership.

Question Number	Section	Page Number	Question	Response
45	Attachment D		For members with Plan Coverage Desc Medicare II, can you identify which members aren't Medicare eligible? Based on the Tier II totals illustrated on Page 9 of the RFP vs the member counts on the census for PPO and HMO, there appears to members included that may not to be Medicare eligible.	The Department does not have the ability to indicate the members not eligible for coverage under the Medicare II tier. The chart included on page 9 of the RFP was enrollee only data. Census data includes all Medicare Tier members, including retroactive members. Please see response to Question #26 for additional information.
46	Attachment C	C-3a and C-3b	Why does the Medicare contract totals by tier and county differ when comparing Plan Design A with Plan Design B?	The totals differ based upon current enrollment in our current "Standard" plans (Plan design A) or the high deductible health plan (Plan Design B).
47	Attachment E		The 2017 and 2018 medical and drug claims data provided in Attachment E is not sufficient for rating proposes. There is no financial data included in the information (Medicare Allowed, Plan Paid, Member Paid, or COB Cost). The Rx data also didn't include enough information to estimate prescription costs. In order to price appropriately, we need the following information in items #13-16	See revised Attachment E - Paid Claims File. See also response to Question #5.
48	Attachment E		We need monthly medical claims for the most recent 24 months for members and dependents who have Medicare as their primary coverage for the Standard PPO, HDHP, Capital Health HMO plans. Please provide monthly member counts that tie with the experience period. All data needs to be separate by plan/carrier option.	See response to Question #7.
49	Attachment E		For members with Capital Health, please provide the most recent risk scores and/or MMR for the MA population. Please note the month or time period of the risk score and if it is paid or accrued. If accrued, please note if it includes mid-year or final payments.	The requested information is not available.
50	Attachment E		We need incurred monthly Rx claims for the most recent 24 months for Medicare eligible subscribers & dependents on the Standard PPO and HDHP plans including either monthly member count or PMPM. Also, please indicate whether the claims are net of rebates and member cost share.	See revised Attachment E - Paid Claims File. See also response to Question #5.

Question Number	Section	Page Number	Question	Response
51	Attachment E		We need incurred and paid monthly Rx claims for the most recent 24 months for Medicare eligible subscribers & dependents on the Capital Health plan including either monthly member count or PMPM. Are the drug claims net of Pharma discount, Rebates, reinsurance, member cost share and LIS. If not, please provide these amounts separately.	See revised Attachment E - Paid Claims File. See also response to Question #5.
52	Attachment D		Humana can provide more accurate prescription drug pricing with a detailed pharmacy claims file for calendar year 2017 and 2018. Please see the attached Excel file for the detailed pharmacy claims file layout.	Attachment E and revised Attachment E contains all of the medical claims and Rx data that can be provided by the Department.
53	Mandatory Response Requirements	23	The RFP indicates to include a letter from at least one (1) public sector client confirming our experience in providing MAPD plans valued at $25 million or more. Where should this letter be placed within the Table of Contents?	Respondents must include the letter in the Proposal. Respondent should indicate the page number of the letter on Form 6. Respondents may include the letter in Tab 9 of Proposal.
54	Mandatory Response Requirements	23	Please provide instruction as to where Attachment C should be placed within the Table of Contents.	See subsection 3.2, Receipt of Proposals, item b of the RFP.
55	Form 2	52	Please provide instruction as to where Form 2 should be placed within the Table of Contents.	Respondents may include in Tab 9 of Proposal.
56	Form 3	53	Please provide instruction as to where Form 3 should be placed within the Table of Contents.	Respondents may include in Tab 9 of Proposal.
57	Form 4	54	Please provide instruction as to where Form 4 should be placed within the Table of Contents.	Respondents may include in Tab 9 of Proposal.
58	Form 5	55	Please provide instruction as to where Form 5 should be placed within the Table of Contents.	Respondents may include in Tab 9 of Proposal.
59	11.1 Historical Claims Data	48	Attachment E: Request for additional details. Integral to UHC 'New to Medicare Advantage' best practices during plan design and benefit implementation phases, line-level claim data is requested for the prior plan year (12 months). The inpatient, outpatient and physician claim data elements requested are: Unique identifier for Members/ Subscribers; Plan/ Group ID; Claim Type Code (Inpatient, Outpatient, Professional); Claim Number; Claim Line Number; Principal Procedure	See response to Question #7.

Question Number	Section	Page Number	Question	Response
			Code; Procedure Code Modifier; Revenue Code; Diagnosis Code 1; Diagnosis Code 2; Diagnosis Code 3; Service Start Date; Service End Date; Place of Service Code; Billing Provider Tax ID; Billing Provider Specialty; Billing Provider NPI; Billing Provider Name; Billed Amount; Non-Covered Amount; Copayment Amount; Deductible Amount; Coinsurance Amount; Paid Amount; Amount Covered by a Third Party or Medicare; Approval or Denial Code; Denial Reason Code; Denial Reason Description.	
60	ATTACHMENT D – CENSUS FILE	5	Attachment D Census File - Regarding Retirees classified as Medicare Tier II (one eligible member plus an ineligible member). Both members are shown on the census as Medicare without a differentiator indicating which member is ineligible. Please provide an updated census indicating which member is Medicare eligible, or ineligible.	The Department does not have an indicator for eligibility under Medicare Tier II.
61	11.1 Historical Claims Data	48	For medical, is it possible to get a monthly roll-up of the following items: enrollment, Medicare allowed, plan paid, and member paid? We would like to see for the last two full calendar years if possible. For pharmacy, is it possible to get a monthly roll-up of the following items: enrollment, pharmacy allowed, member paid and plan paid? Also for pharmacy, would it be possible get the following data added to the details claims file: NDC, fill date, days' supply, quantity dispensed, NABP or NPI and mail vs. retail indicator?	See responses to Question #5 and Question #7.
62	9.4.b	43	Can the State provide copies of all formularies utilized by the retiree population?	See response to Question #19.
63	Attachment A; Attachment 2; PG-5	41 (of sample contract document)	The requested PG penalty appears to be based on a service level percentage but the specific language of the PG itself refers to average speed to answer. If the State wants a PG measured by percentage of calls answered within 30 seconds, we would need a target service level percentage. If the State prefers an average speed metric, we would need a penalty based on the number of seconds greater than 30. We suggest language of "$2,000 per second more than 30 seconds." Please clarify.	See item #1 of this addendum.
64	1 INTRODUCTION	8	Will the existing PPO and HMO plans be terminated and all members be required to enroll in one of the two HMO plans through the outsourced human resource administrator?	See response to Question #16.
65	1 INTRODUCTION	8	Please confirm that drug coverage should be included in an integrated plan that covers both medical and prescription drug coverage, and that a closed, managed formulary may be utilized.	Confirmed

Question Number	Section	Page Number	Question	Response
66	1 INTRODUCTION	13	Do the census file and paid claims file contain sufficient details (e.g., gender, ESRD status, hospice status, Low Income Status, diagnosis codes) to calculate a risk score or will a file be supplied containing risk score for current enrollment? Relatedly, will that data contain a tag so that a member's current plan can be identified?	Refer to subsection 1.8 of the RFP. The Department does not have risk score information.
67	1 INTRODUCTION	13	Will paid data contain allowed/contracted amounts, or, assuming paid claims data will reflect current contracting, will information be provided to help convert that to allowed amounts?	Refer to subsection 1.8 of the RFP.
68	3.3.8 Mandatory Responsive Requirements	23	Will proposals that include a letter from a public sector client that is valued less than, but close to, $25 million in annual earned premium be considered?	No
69	5 MINIMUM QUALIFICATIONS	29	Is the intention to award the contract to one or multiple Medicare Advantage Organizations (MAOs) in a given service area?	Refer to subsection 4.4 of the RFP.
70	5 MINIMUM QUALIFICATIONS	29	Please clarify Minimum Requirement 5.2 (Respondent will provide fully-insured HMO MA-PD coverage on a full replacement basis for Members beginning January 1, 2020.) given the proposal allows for specific counties to be selected.	See response to Question #21.
71	5 MINIMUM QUALIFICATIONS	29	Would the State consider a proposal that offers an HMO in the Florida service area and only PPO options for outside of Florida?	No
72	10 PLAN DESIGNS PROPOSAL	47	In addition to actuarial values what other product requirements exist?	The question is unclear. See RFP for requirements.
73	10 PLAN DESIGNS PROPOSAL	47	Should the proposed plans include supplemental benefits (e.g., vision, dental)?	Refer to Section 10 of the RFP.
74	10 PLAN DESIGNS PROPOSAL	47	Is it preferred for supplemental benefits to be included as a buy up or as mandatory supplemental benefits?	Refer to Section 10 of the RFP.
75	Attachment C Financial Proposal	tab/ C-3b Plan Design B	Please confirm that the membership by county in Attachment C reflects the actual membership to be used for proposal development	The question is unclear. Refer to data made available in RFP and its attachments.

FAILURE TO FILE A PROTEST WITHIN THE TIME PRESCRIBED IN SECTION 120.57(3), FLORIDA STATUTES, OR FAILURE TO POST THE BOND OR OTHER SECURITY REQUIRED BY LAW WITHIN THE TIME ALLOWED FOR FILING A BOND SHALL CONSTITUTE A WAIVER OF PROCEEDINGS UNDER CHAPTER 120, FLORIDA STATUTES.