



## Halfmoon Township

Board of Supervisors  
Mark J. Stevenson, Chairman  
Andrew G. Merritt, Vice-Chairman  
Benjamin P. Pisoni, Supervisor  
Barbara H. Spencer, Supervisor  
Todd Kirsten, Supervisor

100 Municipal Lane  
Port Matilda, PA 16870  
(814)692-9800  
Fax (814) 692-7585

Susan Steele  
Manager

**TO: Interested Insurance Carriers**

**RE: Request For Group Health Insurance Proposals  
RFP 2012-003  
Halfmoon Township, PA**

January 26, 2012

Insurance Carriers:

I am writing to your company on behalf of Halfmoon Township, PA, hereinafter referred to as the "Planholder", requesting that you prepare a proposal reflecting your charges for group health insurance. We have not reviewed our present health plan with Geisinger Health Plan in some time and therefore to ascertain if the Township is receiving comparable benefits at a comparable price, we are in the process of reviewing our current health plan.

Halfmoon Township employs 4 full time employees, one part time, 6 elected officials, and around 25 seasonal employees. Only the fulltime employees and Township Supervisors (5) are eligible to participate in the Township's health plan. Currently all four full time employees participate in the Township's present health plan. The Township presently pays the entire cost of the health premium for the **full time employee only**.

**Submission of Proposals: Three (3) copies of all proposal documents, exhibits and answers to specific questions shall be sealed and submitted no later than June 16, 2012, at 4:00 p. m. to:**

**Susan Steele, Township Manager  
Halfmoon Township  
100 Municipal Lane  
Port Matilda, PA 16870**

**MARK ENVELOPE: "RFP NO. 2012-003 HEALTH INSURANCE"**

Late proposals will not be accepted.

**Selection: Recognizing the fact that there are very important considerations involved in selecting an insurance carrier, the Planholder is not bound to accept the lowest proposal.** The Planholder reserves the right to reject any or all proposals or to accept any proposal deemed advantageous to the Planholder. The award of the contract shall be made to the responsible offerer whose proposal is determined to be relatively priced, offerers' health care providers accepting said plan against what providers' the present employees are using, comparable benefits, and other evaluation factors set forth in the Request for Proposals. Proposals will be evaluated based on the following criteria and in the following order (with #1 being the most important):

1. Will employees need to change present health care providers if Township changes to new provider?
2. Offerer's benefits and deductibles
3. Offerer's ease of claim transmission and payment
4. Offerer's gross premium
5. Offerer's availability of local medical providers, specialists, and facilities
6. Offerer's qualifications/experience
7. Offerer's support/services provided

8. Offerer's retention charges
9. Offerer's other municipal or public clientele

Please complete and return the enclosed forms, which include: Proposal form including declaration of compliance, questionnaire and references.

**Upon submittal, the proposals will be reviewed at the staff level. The top three Offerers will be contacted by the Township Manager and be asked to conduct two presentations. One to the staff and one to the Board of Supervisors to address any questions either entity may have. The Township Manager will review both elected official and staff comments as well as proposals and then make a recommendation to the Board of Supervisors. The Board of Supervisors shall have the right to approve the Manager's recommendation, table the recommendation, or approve a different Offerer.**

#### PLAN ADMINISTRATION QUALIFICATIONS

##### Planholder Responsibility

The Planholder will provide for payment of the premiums, and payroll deductions if any, for premiums and advise the carrier of additions/deletions from the coverage. The Planholder will assist in the logistics of the enrollment process.

##### Selected Carrier Responsibility

The carrier will provide claim instructions, forms, employee identification cards, employee booklets outlining the benefits and instructions on filing a claim electronically or in written form, enrollment and orientation materials, and other appropriate communication materials deemed necessary by the Planholder as well as provide a Policyholder staff member, if requested by Planholder, to orient and address employee questions.

#### GENERAL INFORMATION AND INSTRUCTIONS

1. All proposals must be received at the designated location by the deadline shown. Proposals received after the deadline shall be considered void and unacceptable. Halfmoon Township is not responsible for non-delivery of mail, carrier, etc.
2. Proposals are anticipated to provide a 12 month rate guarantee, with a contract period of September 26, 2012 through September 25, 2013, and three optional 12 month periods beginning September 26, 2013 and extending through September 25, 2016. However, the Planholder reserves the right to accept a guarantee of less than or more than 12 months if it is in the Planholder's interest. Premium rates proposed must be firm and not subject to change based upon enrollment.
3. The Planholder reserves the right to reject any and all proposals and to accept any proposal deemed advantageous to the Planholder. Since there are important considerations involved in selecting a carrier, in addition to rates, the Planholder will not be required to accept the lowest proposal. In addition to cost, service will also serve as a basis for award of the contract.
4. The Carrier must submit evidence of ability to service the group without undue requirements of the Planholder's employees. Each Carrier should list as references municipal or public entity groups that is services in the State of Pennsylvania.
5. Your proposal must conform in all respects to the specifications outlined in this letter and attached exhibits. If your company's practice prohibits you from submitting a proposal on the same basis as outlined in the specifications, you may submit a proposal on a basis that is in accordance with your practice. Please state clearly, in detail, any deviation from the specifications outlined in this letter with complete reference to the provision from which the deviation is being made.
6. Proposals must be based on benefits similar to the current plan however all options for health coverage will be considered. (Plan of current benefits provided). The current plan with Geisinger Health Plan is not through an agent a proposal submitted to provide health benefits may be through an agent or directly with a provider.
7. HIPAA Compliance with Privacy and Confidentiality guidelines will be required.
8. Proposals shall include coverage on all eligible full time employees and Board of Supervisors and with optional coverage available for dependent coverage. Fulltime is defined as 40 hours or more per week. Dependent is defined as the employees' or supervisors' spouse and/or children from birth to age 26. Adopted children, stepchild(ren) or foster child(ren) who are in a legal parent-child relationship are also classified as eligible dependents. Children who

are currently disabled will be covered as long as they are totally disabled and dependent upon the support from their parents.

9. Waiting period: Newly hired employees and their dependents must complete at least a 90 day waiting period before becoming eligible for coverage.
10. Currently the employer pays 100% of the employee premium for the coverage for FULL TIME EMPLOYEES ONLY, 0% of the dependent premium for any plan coverage. There is no retiree coverage. The employer currently pays 0% of the supervisors premium.
11. Please complete the appropriate enclosed proposal forms.
12. The Township does not need to provide a five year history due to the size of the eligible employees under PA law.

ATTACHMENTS:

Attachment A is the form to provide your information.

Attachment B is the form for your insurance costs quotation

Attachment C is the form to provide a comparison of the plan benefits submitted in the proposal to provide a comparison to current plans.

Attachment D is the form to provide information on references

In preparing your premium quotations, please use the forms provided.

We look forward to receiving your proposal. This letter provides you with the information necessary for you to submit a proposal, which includes complete and carefully prepared information for consideration by the Planholder.

If you have any questions, please direct all inquiries to: Susan Steele, Township Manager, Halfmoon Township, 100 Municipal Lane, Port Matilda, PA 16870, via email to [manager@halfmoontwp.us](mailto:manager@halfmoontwp.us) prior to June 2, 2012.

Sincerely,

Susan E. Steele  
Township Manager  
Halfmoon Township

ATTACHMENT A  
**VENDOR INFORMATION**

Name of Organization: \_\_\_\_\_

Date Founded: \_\_\_\_\_

Name of Contract Person: \_\_\_\_\_

Title: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Email: \_\_\_\_\_

Fax Number: \_\_\_\_\_

ATTACHMENT B

**PROPOSAL FORM**

The undersigned, does hereby declare that they have read the specifications for Group Health for the Planholder employees, and with full knowledge of the requirements, does hereby agree to furnish the administrative services in full accordance with the specifications and requirements. The undersigned also agrees to duplicate present coverage and if not, will attach itemized detail of any differences.

Please provide monthly health care costs in the table below.

|                                  | Proposed Plan 1 | Proposed Plan 2 | Proposed Plan 3 |
|----------------------------------|-----------------|-----------------|-----------------|
| Employee/Supervisor only         |                 |                 |                 |
| Employee/Supervisor and spouse   |                 |                 |                 |
| Employee/Supervisor and children |                 |                 |                 |
| Employee/Supervisor and family   |                 |                 |                 |

Health Plan Carrier: \_\_\_\_\_

Address: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Title: \_\_\_\_\_ Date: \_\_\_\_\_

**ATTACHMENT C**

**PLAN DESIGN/PROPOSED PLAN**

| <b>PLAN DESIGN</b>  | <b>PRESENT PLAN<br/>IN-NETWORK<br/>Copayment</b> | <b>PRESENT PLAN<br/>OUT OF NETWORK<br/>Copayment</b> | <b>PROPOSED PLAN<br/>IN NETWORK<br/>Copayment</b> | <b>PROPOSED PLAN<br/>OUT OF NETWORK<br/>Copayment</b> |
|---|--|--|---|---|
| Cardiac Rehab (up to 36 sessions per year)                            | \$0  | No Coverage  |   |   |
| Diabetic Drugs  | 50%  | No Coverage  |   |   |
| Diabetic Foot Ortho   | \$0  | No coverage  |   |   |
| Diabetic medical equip  | \$0  | No coverage  |   |   |
| Blood Glucose test strips (copayment per 100 strips)                  | \$50   | No coverage  |   |   |
| Diabetic eye exam   | \$25 per visit                                   | No coverage  |   |   |
| Diagnostic and other outpatient facility services                     | \$0  | No coverage  |   |   |
| Durable medical equipment (\$2,500 limit per member per year)         | \$0  | No coverage  |   |   |
| ER Room if not admitted   | \$75.00  | \$75.00  |   |   |
| ER Room if admitted   | \$0  | Same until can be moved to in-network                |   |   |
| External Feeding  | \$0  |  |   |   |
| Primary Care Physician Visits   | \$15   | No coverage  |   |   |
| Specialist Visits   | \$25   | No coverage  |   |   |
| Other professional visits   | \$0 per day per service                          | No coverage  |   |   |
| Inpatient primary care physician services                             | \$0  | No coverage  |   |   |
| Inpatient hospital facility services                                  | \$0 per admission                                | No coverage  |   |   |
| Inpatient hospital specialist services                                | \$0  | No coverage  |   |   |
| Outpatient ambulatory surgical center And facility services           | \$0  | No coverage  |   |   |
| Outpatient ambulatory surgical center and hospital physician services | \$0  | No coverage  |   |   |
| Outpatient ambulatory surgical center and hospital surgery services   | \$0  | No coverage  |   |   |
| Implanted devices (contraception)                                     | 50%  |  |   |   |
| Implanted devices (all other)   | \$0  |  |   |   |
| Injectables   | \$0  |  |   |   |
| Post mastectomy reconstructive surgery                                | \$0  |  |   |   |
| Breast Prothesis  | \$0  |  |   |   |
| Individual Mental Health Therapy Services (up to 30 per               | \$25 per visit                                   |  |   |   |

|  |                                   |  |  |  |
|--|-----------------------------------|--|--|--|
| year)  |                                   |  |  |  |
| Group Mental Health Therapy Services   | <b>\$10 per visit</b>             |  |  |  |
| MRI/CAT, PET, Nuclear Cardiology   | <b>\$0</b>                        |  |  |  |
| Orthotic devices   | <b>50%</b>                        |  |  |  |
| Ostomy Supplies  | <b>\$0</b>                        |  |  |  |
| Diagnostic Services/Procedures   | <b>\$0</b>                        |  |  |  |
| Preventive Services  | <b>\$0</b>                        |  |  |  |
| Prosthetic Devices (Limit to \$5,000 per member per year)                      | <b>\$0</b>                        |  |  |  |
| Pulmonary Rehab  | <b>\$0</b>                        |  |  |  |
| Physical Therapy (45 days per year)  | <b>\$25 per day</b>               |  |  |  |
| Speech Therapy (45 days per year)  | <b>\$25 per day</b>               |  |  |  |
| Occupational therapy (45 days per year)  | <b>\$25 per day</b>               |  |  |  |
| Select Injectable Drugs  | <b>\$75 copayment</b>             |  |  |  |
| Skilled Nursing Facility   | <b>\$0</b>                        |  |  |  |
| Substance Abuse Inpatient (7 days limit)                                       | <b>\$0</b>                        |  |  |  |
| Short Term Acute Outpatient Substance Abuse (one uninterrupted 4 month period) | <b>\$15 per visit</b>             |  |  |  |
| Transportation Services  | <b>\$0</b>                        |  |  |  |
| Morbid obesity surgery   | <b>\$2,000 facility copayment</b> |  |  |  |
| Urgent Care Facility Services  | <b>\$25</b>                       |  |  |  |
| Urological Supplies  | <b>\$0</b>                        |  |  |  |
| Well Child Office Visits (0-21)  | <b>\$0</b>                        |  |  |  |
| RX   | <b>\$10-\$20-\$30</b>             |  |  |  |
|  |                                   |  |  |  |
| Premiums:  |                                   |  |  |  |
| Employee   | <b>\$463.55 per month</b>         |  |  |  |
| Employee & Child   | <b>\$648.97 per month</b>         |  |  |  |
| Employee & Spouse  | <b>\$1,112.52 per month</b>       |  |  |  |
| Employee & Children  | <b>\$927.10 per month</b>         |  |  |  |
| Family   | <b>\$1,254.60 per month</b>       |  |  |  |

**ATTACHMENT D**

**REFERENCES**

**Company Name:** \_\_\_\_\_

**Contract Person:** \_\_\_\_\_ **Title:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Phone number:** \_\_\_\_\_ **email:** \_\_\_\_\_

**Company Name:** \_\_\_\_\_

**Contract Person:** \_\_\_\_\_ **Title:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Phone number:** \_\_\_\_\_ **email:** \_\_\_\_\_

**Company Name:** \_\_\_\_\_

**Contract Person:** \_\_\_\_\_ **Title:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Phone number:** \_\_\_\_\_ **email:** \_\_\_\_\_

**Company Name:** \_\_\_\_\_

**Contract Person:** \_\_\_\_\_ **Title:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Phone number:** \_\_\_\_\_ **email:** \_\_\_\_\_

