



Schalmont Central School District



BUSINESS OFFICE

MEMORANDUM

TO: ADMINISTRATORS

FROM: Brenda Leitt – District Treasurer/Health, Vision & Dental Benefits

RE: Health Insurance Open Enrollment, Transfer and Opt-Out-Period

DATE: April 27, 2022

The open enrollment transfer and opt-out-period for current health plan participants and eligible employees will be through May 31, 2022. During this period employees may choose any of the health plans listed on the reverse side of this memo, including the optical benefit and dental plan. Since there are different eligibility criteria for each employee group, it is requested that you contact Brenda Leitt for more information. (355-9200 ext 4007 or bleitt@schalmont.net)

All health plan enrollment forms are available in the Business Office and must be returned by May 31, 2022 for coverage effective July 1, 2022. Deductions will begin with the payroll of September 16, 2022 and will continue for 21 pays through June 23, 2023.

Cc: T Reardon – Superintendent of Schools
J Karas – Asst. Supt. for Business

SCHALMONT CENTRAL SCHOOL DISTRICT
4 Sabre Drive
Schenectady, NY 12306

TO: All Administrators

FROM: Brenda Leitt – District Treasurer/Health, Vision & Dental Benefits

DATE: April 27, 2022

RE: Health Insurance Opt Out

Below you will find the policy regarding the health insurance buyout as negotiated in the contract followed by the Schalmont Administrators Association.

Please review this policy and, if you choose to opt out of the health insurance plan offered by the District, complete the opt-out form and return to the District Office no later than June 17, 2022.

OPT OUT

I hereby opt out of the Schalmont Health Insurance Program under the terms of the opt out policy and the Schalmont Administrators Association Agreement.

I stipulate that I am or will be covered under an alternate health plan during the opt out period and have attached a copy of my current health insurance card.

I understand that I may not re-enroll in the health plan until the next enrollment period with an effective date of July 1, 2023, unless I lose health coverage or have a change in family as defined in the opt out policy. **Applications for re-entry must be made within thirty-one (31) days of any change in status or loss of coverage.**

I have read and fully understand the above and opt out of the plan. Single employees are eligible for opt out of \$1,000, and family employees are eligible for opt out of \$4,000. Payment will be made pursuant to the opt out policy and the SAA Agreement.

***This opt out is for health insurance only and has no effect on your vision & dental coverage or lack thereof.*

Signature

Date

Health Insurance Rates July 1, 2022 - June 30, 2023									
Administrators		20%	Health Insurance						
		20%	Dental						
		20%	Vision						
22/23 Monthly Rates									
Name of Plan	Monthly Rate	Monthly District Share	Monthly Employee Share	Yearly Cost	Yearly District Share	Yearly Employee Share	21 PAYS 9/16/22 - 6/23/23		
							22/23 Deduction	22/23 Limit	
BS 815 - Individual	741.94	593.55	148.39	8,903.28	7,122.62	1,780.66	84.80	1,780.66	
BS 815 - 2 Person	1532.71	1,226.17	306.54	18,392.52	14,714.02	3,678.50	175.17	1,678.50	
BS 815 - Family	2101.34	1,681.07	420.27	25,216.08	20,172.86	5,043.22	240.16	5,043.22	
CDPHP 422 - Individual	836.30	669.04	167.26	10,035.60	8,028.48	2,007.12	95.58	2,007.12	
CDPHP 422 - 2 Person	1664.56	1,331.65	332.91	19,974.72	15,979.78	3,994.94	190.24	3,994.94	
CDPHP 422 - Family	2217.48	1,773.98	443.50	26,609.76	21,287.81	5,321.95	253.43	5,321.95	
Vision - Ind	21.22	16.98	4.24	254.64	203.71	50.93	2.43	50.93	
Vision - Family	49.43	39.54	9.89	593.16	474.53	118.63	5.65	118.63	
Dental - Individual 0%	51.93	41.54	10.39	623.16	498.53	124.63	5.94	124.63	
Dental - Family	158.16	126.53	31.63	1,897.92	1,518.34	379.58	18.08	379.58	

CAPITAL AREA SCHOOLS HEALTH INSURANCE CONSORTIUM (CASHIC)

12 Computer Drive West, Albany, NY 12205 enrollments@amsureins.com

GROUP NAME Schalmont CSD

SECTION A	Last Name	First	M.I.	Your Social Security No. _____ - _____ - _____
	Address			<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed Date of Marriage ____/____/____ Date of Divorce ____/____/____ Phone No.: (____) _____ (____) _____ Employment Status: <input type="checkbox"/> FT <input type="checkbox"/> PT Hrs/Weekly _____ <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> COBRA Hire Date ____/____/____ Status Chg Date ____/____/____
	County			EMPLOYER USE ONLY Effective Date ____/____/____ Retire Date ____/____/____ Grp No. _____ Loc. Code _____
City	State	Zip Code		

SECTION B	<input type="checkbox"/> Open Enrollment (complete Section D) <input type="checkbox"/> New Enrollment/Reinstatement (complete Section D) <input type="checkbox"/> Change Coverage to (check new coverage) <input type="checkbox"/> Cancel Coverage (check what applies) <input type="checkbox"/> Add/Delete Dependent (complete section D) <input type="checkbox"/> Information Change (complete Section A) <input type="checkbox"/> Waive Coverage (must provide proof of Insurance) <input type="checkbox"/> NYS Dependent Coverage up to Age 29	Carrier	Tier	SECTION C	Other Coverage? Is there coverage under any other group health plan available to you or any of your covered dependents? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes: Policyholder Name _____ Relationship <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child Social Security Number _____ Birth Date ____/____/____ Insurance Co. Name _____ Policy # _____ Plan Type <input type="checkbox"/> Self only <input type="checkbox"/> Self/Spouse <input type="checkbox"/> Self/Child(ren) <input type="checkbox"/> Fam Coverage Type <input type="checkbox"/> Health <input type="checkbox"/> Drug <input type="checkbox"/> Dental <input type="checkbox"/> Vision
	Indem/Blue Shield	<input type="checkbox"/> Ind <input type="checkbox"/> 2P <input type="checkbox"/> Fam <input type="checkbox"/> Mdcr			
	PPO/Blue Shield	<input type="checkbox"/> Ind <input type="checkbox"/> 2P <input type="checkbox"/> Fam <input type="checkbox"/> Mdcr			
	POS/Blue Shield	<input type="checkbox"/> Ind <input type="checkbox"/> 2P <input type="checkbox"/> Fam <input type="checkbox"/> Mdcr			
	CDPHP EPO	<input type="checkbox"/> Ind <input type="checkbox"/> 2P <input type="checkbox"/> Fam <input type="checkbox"/> Mdcr			
	MVP HMO	<input type="checkbox"/> Ind <input type="checkbox"/> 2P <input type="checkbox"/> Fam <input type="checkbox"/> Mdcr			
	Rx	<input type="checkbox"/> Ind <input type="checkbox"/> 2P <input type="checkbox"/> Fam <input type="checkbox"/> Mdcr			
	Dental	<input type="checkbox"/> Ind <input type="checkbox"/> 2P <input type="checkbox"/> Fam <input type="checkbox"/> Mdcr			
Other	<input type="checkbox"/> Ind <input type="checkbox"/> 2P <input type="checkbox"/> Fam <input type="checkbox"/> Mdcr				
Reason/Comments: _____					

LIST APPLICANT AND ALL ELIGIBLE DEPENDENTS * (See Dependent Verification Requirement Below)

SECTION D	ADD	DELETE	Relationship	Last	First	M.I.	Birth Date (mo/day/yr)	F/T Student	Social Security #	Medicare A & B Effective Date	Primary Care Physician (PCP)
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Self <input type="checkbox"/> M <input type="checkbox"/> F				____/____/____	n/a	____/____/____	____/____/____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spouse/DP <input type="checkbox"/> M <input type="checkbox"/> F				____/____/____	n/a	____/____/____	____/____/____	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Son <input type="checkbox"/> Daughter				____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	____/____/____	____/____/____	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Son <input type="checkbox"/> Daughter				____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	____/____/____	____/____/____	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Son <input type="checkbox"/> Daughter				____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	____/____/____	____/____/____	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Son <input type="checkbox"/> Daughter				____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	____/____/____	____/____/____	

SECTION E Do your dependents reside in your home? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, give address: _____ Do you have a disabled dependent beyond age 19? <input type="checkbox"/> Yes <input type="checkbox"/> No List name(s): _____	Full-time college students age 19 and over (Dental Only): List Names: _____ School Name and Address: _____ _____ _____	Dependent Verification* School District Representative (SDR) _____ (please initial) Date: _____ * The SDR by initialing above affirms that they have received and reviewed the required dependent verification documentation, and that the dependents for whom this applicant is requesting coverage meet the minimum standards for dependent coverage established by this district and the Capital Area Schools Health Insurance Consortium (CASHIC).
Applicant's Signature: _____ Date: _____	Employer's Signature: _____ Date: _____	



An Anthem Company

Schalmont CSD

Group Number : 300560

Enrollment Form

EMPLOYEE INFORMATION. Please verify the information below for accuracy. If incorrect, please contact your HR representative.

Name/Address _____ _____ _____	Date of Birth	Employee ID/SSN
	Division	Date of Hire
	Class 1	Annual Salary
	BillClass	SubGroup
	Effective Date	Gender

PLEASE PRINT IN BLACK OR BLUE INK. Read and complete all of this form. Please complete all grayed sections. If you need more space, attach a separate sheet of paper. Please use four digits for years (e.g. 1998, not 98).

Are you actively at work? Yes No

Are you retired? Yes No

Marital status: Single Married Widowed Divorced

Occupation: _____

Phone: _____

Hours per week working for this employer: _____ Email Address: _____

BENEFIT SELECTION. Check the boxes that apply along with the appropriate coverage level.

Voluntary Dental

Regular dental check-ups can help in the detection of other health related issues. Gum and tooth disease have been linked to major health conditions like heart disease and stroke. That's why dental coverage is more important than ever.

Coverage level

Accept Decline

Employee

Employee + Spouse

Employee + Child(ren)

Employee + Family

Voluntary Vision

Consider how important good vision is to everyday activities like driving, shopping or watching a movie. Taking care of your vision is essential to your overall health and well-being. Did you know that having regular eye exams can reduce the risk of more serious, long-term diseases?

Coverage Level

Accept Decline

Employee

Employee + Spouse

Employee + Child(ren)

Employee + Family

DEPENDENT DESIGNATION

(Complete all details for individuals applying for coverage: list names of all dependents.)

Last name, First name, M.I.	SSN (XXX-XX-XXXX)	Sex	Date of Birth (XX-XX-XXXX)	Age	Relationship (spouse/domestic partner or child)
	- -	<input type="checkbox"/> M <input type="checkbox"/> F	/ /		Spouse/Domestic Partner
	- -	<input type="checkbox"/> M <input type="checkbox"/> F	/ /		Child
	- -	<input type="checkbox"/> M <input type="checkbox"/> F	/ /		Child
	- -	<input type="checkbox"/> M <input type="checkbox"/> F	/ /		Child
	- -	<input type="checkbox"/> M <input type="checkbox"/> F	/ /		Child

List address of all dependents if different from the applicant, including temporary address, e.g. college student.

Name/Address: _____ / _____

Name/Address: _____ / _____

ELIGIBILITY AND AUTHORIZATION

Employee Confirmation

My signature certifies that I (1) Apply for the coverages designated for which I am eligible under my employer's plan with the carrier. (2) Understand if coverages have been refused, I am not entitled to benefits under those coverages and that if I want to apply later, I must furnish at my own expense proof of good health to the carrier. (3) Authorize any required deductions from my earnings. (4) Designate the beneficiary named on this application to receive any benefits payable in the event of death. (5) Represent that all of the information on this application is complete, correct and true to the best of my knowledge and belief. (6) Understand that I must be actively at work the number of hours specified in the policy/participation agreement to remain insured.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Employee Signature _____ Date _____ / _____ / _____

Premium calculations above may differ slightly based on rounding rules and other system factors, but will not vary significantly. Every effort has been made to match your premiums to the penny.

New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

Services provided by Empire HealthChoice HMO, Inc. and/or Empire HealthChoice Assurance, Inc., licensees of the Blue Cross and Blue Shield Association, an association of Independent Blue Cross and Blue Shield plans. The Blue Cross names and symbols are registered marks of the Blue Cross and Blue Shield Association.

Si usted necesita ayuda en Español para entender este documento, puede solicitarlo sin ningún costo adicional llamando al número de servicio al cliente que se encuentra en este documento.

Student Coverage Questionnaire



MEMBER INFORMATION

Member's identification number

DEPENDENT'S INFORMATION

Last name	First name	MI	Date of birth
Relationship to member		Is dependent <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated	Is dependent employed <input type="checkbox"/> Yes <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> No

List any other group insurance or pre-payment program the dependent is covered under

DEPENDENT'S SCHOOL INFORMATION

Is the dependent a full-time student? <input type="checkbox"/> Yes <input type="checkbox"/> No	School name
Type of school (college, trade, etc.)	School address
Expected date of graduation	Expected date of full-time course completion?

Was the dependent a full-time student at an accredited school who is now on a leave of absence from the school due to illness or injury?
 Yes No

If yes, what is the name of the school attended prior to the medical leave?	What is the date the medical leave began?
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(You must also attach a letter from the student's doctor which documents his/her illness or injury and certifies to the medical necessity of the leave of absence from the school)

I HEREBY CERTIFY THAT THE ABOVE IS CORRECT TO THE BEST OF MY KNOWLEDGE

Signature of subscriber	Date
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I understand that any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

WHEN FORM IS COMPLETE

Return to Brenda Leitt
Schalmont CSD District Office

Please note: For contracts issued or renewed on or after October 9, 2009, health plans are required by federal law to continue coverage for students who begin a medically necessary leave of absence from a post secondary institution or who experience a change in enrollment status as a result of a serious illness or injury during that plan year. If your dependent is a dependent under your plan and meets the requirements for a medical leave of absence, your dependent's coverage will be extended to the earlier of (i) 12 months from the date the medical leave (or change in enrollment status due to serious illness or injury) began or (ii) the date on which the coverage would otherwise terminate under the terms of your plan. To be eligible for this continued coverage, the dependent must be enrolled in the plan on the basis of being a student immediately before the medical leave begins and the treating physician must certify in writing as to the medical necessity of the leave of absence (or other change of enrollment)."