

# Schalmont Central School District

## BUSINESS OFFICE

## MEMORANDUM

TO: ALL SUPPORT STAFF

FROM: Laurie Kapfer – District Treasurer/Health, Vision & Dental Benefits

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

DATE: April 28, 2023

The open enrollment transfer and opt-out period for current health plan participants and eligible employees will be through June 1, 2023. During this period employees may choose any of the health plans offered by Schalmont CSD, including the vision and dental plans. Since there are different eligibility criteria for each employee group, it is requested that you contact Laurie Kapfer for more information. (518-355-9200 x4007 or [lkapfer@schalmont.net](mailto:lkapfer@schalmont.net))

All health plan enrollment forms are available online under Staff Resources of the Schalmont website and must be returned by May 31, 2023 for coverage effective July 1, 2023. Deductions will begin with the payroll of September 15, 2023 and will continue for 21 pays through June 21, 2024.

CC: T. Reardon - Superintendent of Schools  
B. Leitt - School Business Administrator

**SCHALMONT CENTRAL SCHOOL DISTRICT**  
**4 Sabre Drive**  
**Schenectady, NY 12306**

TO: All Non-Instructional Staff

FROM: Laurie Kapfer – District Treasurer/Health, Vision & Dental Benefits

DATE: April 27, 2023

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 School Related Professionals Association.

Please review this policy and, if you choose to opt out of the health insurance plan offered by the district, complete this opt out form and return to the District Office no later than June 16, 2023.

**OPT OUT**

I hereby opt out of the Schalmont Health Insurance Program under the terms of the opt out policy and the Schalmont School Related Professional Association Collective Bargaining 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 next enrollment period with an effective date of July 1, 2024, 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 (30) days of any change in status or loss of coverage.**

I have read and fully understand the above opt out of the plan. Single employees are eligible for opt out of \$1,000, and family employees are eligible for opt out of \$2,500. Payment will be made pursuant to the opt out policy and SSRPA Collective Bargaining 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, 2023 - June 30, 2024 |              |   |        |                        |             |                |        |                       |                   |          |  |
|---|--------------|---|--------|------------------------|-------------|----------------|--------|-----------------------|-------------------|----------|--|
| Support Staff<br>Hired prior to 7/1/2016            | 12.50%       | Health Insurance  |        |                        |             |                |        |                       |                   |          |  |
|   | 10%          | Individual Employee Dental  |        |                        |             |                |        |                       |                   |          |  |
|   | 20%          | Family Dental = Family cost less Individual cost X 20% + Ind cost X 10% |        |                        |             |                |        |                       |                   |          |  |
|   | 10%          | Individual Employee Vision  |        |                        |             |                |        |                       |                   |          |  |
|   | 20%          | Family Vision = Family cost less Individual cost X 20% + Ind cost X 10% |        |                        |             |                |        |                       |                   |          |  |
| 23/24 Monthly Rates                                 |              |   |        |                        |             |                |        |                       |                   |          |  |
| Name of Plan  | Monthly Rate | Monthly   |        | Monthly Employee Share | Yearly Cost | Yearly         |        | Yearly Employee Share | 21 PAYS           |          |  |
|   |              | District Share  | Share  |                        |             | District Share | Share  |                       | 9/16/23 - 6/23/24 | 23/24    |  |
| BS 815 - Individual                                 | 814.33       | 712.54  | 101.79 | 9,771.96               | 8,550.47    | 1,221.50       | 58.17  | 1,221.50              | 58.17             | 1,221.50 |  |
| BS 815 - 2 Person                                   | 1,684.18     | 1,473.66  | 210.52 | 20,210.16              | 17,683.89   | 2,526.27       | 120.30 | 2,526.27              | 120.30            | 2,526.27 |  |
| BS 815 - Family                                     | 2,309.67     | 2,020.96  | 288.71 | 27,716.04              | 24,251.54   | 3,464.51       | 164.98 | 3,464.51              | 164.98            | 3,464.51 |  |
| CDPHP 422 - Individual                              | 930.14       | 813.87  | 116.27 | 11,161.68              | 9,766.47    | 1,395.21       | 66.44  | 1,395.21              | 66.44             | 1,395.21 |  |
| CDPHP 422 - 2 Person                                | 1,853.24     | 1,621.59  | 231.66 | 22,238.88              | 19,459.02   | 2,779.86       | 132.38 | 2,779.86              | 132.38            | 2,779.86 |  |
| CDPHP 422 - Family                                  | 2,469.48     | 2,160.80  | 308.69 | 29,633.76              | 25,929.54   | 3,704.22       | 176.40 | 3,704.22              | 176.40            | 6,704.22 |  |
| Vision - Ind  | 21.22        | 19.10   | 2.12   | 254.64                 | 229.18      | 25.46          | 1.22   | 25.46                 | 1.22              | 25.46    |  |
| Vision - Family                                     | 49.43        | 41.67   | 7.76   | 593.16                 | 500.04      | 93.12          | 4.44   | 93.12                 | 4.44              | 93.12    |  |
| Dental - Individual                                 | 51.93        | 46.74   | 5.19   | 623.16                 | 560.84      | 62.32          | 2.97   | 62.32                 | 2.97              | 62.32    |  |
| Dental - Family                                     | 158.16       | 131.72  | 26.44  | 1,897.92               | 1,580.64    | 317.28         | 15.11  | 317.28                | 15.11             | 317.28   |  |

| Health Insurance Rates July 1, 2023 - June 30, 2024 |   |                |                |             |                |           |                       |                   |             |  |
|---|---|----------------|----------------|-------------|----------------|-----------|-----------------------|-------------------|-------------|--|
| Support Staff<br>Hired 7/1/2016 or later            | 15% Health Insurance  |                |                |             |                |           |                       |                   |             |  |
|   | 10% Individual Employee Dental  |                |                |             |                |           |                       |                   |             |  |
|   | 20% Family Dental = Family cost less Individual cost X 20% + Ind cost X 10% |                |                |             |                |           |                       |                   |             |  |
|   | 10% Individual Employee Vision  |                |                |             |                |           |                       |                   |             |  |
|   | 20% Family Vision = Family cost less Individual cost X 20% + Ind cost X 10% |                |                |             |                |           |                       |                   |             |  |
| 23/24 Monthly Rates                                 |   |                |                |             |                |           |                       |                   |             |  |
| Name of Plan  | Monthly Rate  | Monthly        |                | Yearly Cost | Yearly         |           | Yearly Employee Share | 21 PAYS           |             |  |
|   |   | District Share | Employee Share |             | District Share | Deduction |                       | 9/16/23 - 6/23/24 | 23/24 Limit |  |
| BS 815 - Individual                                 | 814.33  | 692.18         | 122.15         | 9,771.96    | 8,306.17       | 1,465.79  | 69.80                 | 1,465.79          |             |  |
| BS 815 - 2 Person                                   | 1,684.18  | 1,431.55       | 252.63         | 20,210.16   | 17,178.64      | 3,031.52  | 144.36                | 3,031.52          |             |  |
| BS 815 - Family                                     | 2,309.67  | 1,963.22       | 346.45         | 27,716.04   | 23,558.63      | 4,157.41  | 197.97                | 4,157.41          |             |  |
| CDPHP 422 - Individual                              | 930.14  | 790.62         | 139.52         | 11,161.68   | 9,487.43       | 1,674.25  | 79.73                 | 1,674.25          |             |  |
| CDPHP 422 - 2 Person                                | 1,853.24  | 1,575.25       | 277.99         | 22,238.88   | 18,903.05      | 3,335.83  | 158.85                | 3,335.83          |             |  |
| CDPHP 422 - Family                                  | 2,469.48  | 2,099.06       | 370.42         | 29,633.76   | 25,188.70      | 4,445.06  | 211.67                | 4,445.06          |             |  |
| Vision - Ind  | 21.22   | 19.10          | 2.12           | 254.64      | 229.18         | 25.46     | 1.22                  | 25.46             |             |  |
| Vision - Family                                     | 49.43   | 41.67          | 7.76           | 593.16      | 500.04         | 93.12     | 4.44                  | 93.12             |             |  |
| Dental - Individual                                 | 51.93   | 46.74          | 5.19           | 623.16      | 560.84         | 62.32     | 2.97                  | 62.32             |             |  |
| Dental - Family                                     | 158.16  | 131.72         | 26.44          | 1,897.92    | 1,580.64       | 317.28    | 15.11                 | 317.28            |             |  |

# CAPITAL AREA SCHOOLS HEALTH INSURANCE CONSORTIUM (CASHIC)

12 Computer Dr West, Albany, NY 12205 - (518) 689-1555, emorrisette@amsure.net

GROUP NAME

Schenectady

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

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

| LIST APPLICANT AND ALL ELIGIBLE DEPENDENTS * (See Dependent Verification Requirement Below) |                          |              |      | MVP/HMO & BS POS ONLY |      |                        |  |                   |                               |                              |
|---|--------------------------|--------------|------|-----------------------|------|------------------------|--|-------------------|-------------------------------|------------------------------|
| AD  | DEF                      | 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"/> | Self         |      |                       |      |                        | n/a  |                   |                               |                              |
| <input type="checkbox"/>  | <input type="checkbox"/> | Spouse/DP    |      |                       |      |                        | n/a  |                   |                               |                              |
| <input type="checkbox"/>  | <input type="checkbox"/> | Son          |      |                       |      |                        | <input type="checkbox"/> Yes <input type="checkbox"/> No |                   |                               |                              |
| <input type="checkbox"/>  | <input type="checkbox"/> | Daughter     |      |                       |      |                        | <input type="checkbox"/> Yes <input type="checkbox"/> No |                   |                               |                              |
| <input type="checkbox"/>  | <input type="checkbox"/> | Son          |      |                       |      |                        | <input type="checkbox"/> Yes <input type="checkbox"/> No |                   |                               |                              |
| <input type="checkbox"/>  | <input type="checkbox"/> | Daughter     |      |                       |      |                        | <input type="checkbox"/> Yes <input type="checkbox"/> No |                   |                               |                              |
| <input type="checkbox"/>  | <input type="checkbox"/> | Son          |      |                       |      |                        | <input type="checkbox"/> Yes <input type="checkbox"/> No |                   |                               |                              |
| <input type="checkbox"/>  | <input type="checkbox"/> | Daughter     |      |                       |      |                        | <input type="checkbox"/> Yes <input type="checkbox"/> No |                   |                               |                              |

|   |  |   |  |
|---|--|---|--|
| SECTION D<br>Do your dependents reside in your home? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If No, give address: _____<br>Do you have a disabled dependent beyond age 19? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>List name(s): _____<br>Applicant's Signature: _____<br>Date: _____ |  | SECTION E<br>Full-time college students age 19 and over (Dental Only):<br>List Names: _____<br>School Name and Address: _____<br>School District Representative (SDR) _____ (please initial)<br>Date: _____<br>* 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). |  |
|---|--|---|--|



An Anthem Company

Enrollment Form

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

|                              |                |                 |
|------------------------------|----------------|-----------------|
| Name/Address<br><br><br><br> | Date of Birth  | Employee ID/SSN |
|                              | Division       | Date of Hire    |
|                              | Class<br>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<br>(XXX-XX-XXXX) | Sex  | Date of Birth<br>(XX-XX-XXXX) | Age | Relationship<br>(spouse/domestic partner or child) |
|-----------------------------|----------------------|--|-------------------------------|-----|--|
|                             | - -                  | <input type="checkbox"/> M<br><input type="checkbox"/> F | / /                           |     | Spouse/Domestic Partner                            |
|                             | - -                  | <input type="checkbox"/> M<br><input type="checkbox"/> F | / /                           |     | Child  |
|                             | - -                  | <input type="checkbox"/> M<br><input type="checkbox"/> F | / /                           |     | Child  |
|                             | - -                  | <input type="checkbox"/> M<br><input type="checkbox"/> F | / /                           |     | Child  |
|                             | - -                  | <input type="checkbox"/> M<br><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 materials 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 ningun 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<br><input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated | Is dependent employed<br><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?<br><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?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |   |
| If yes, what is the name of the school attended prior to the medical leave?  | What is the date the medical leave began?     |

*(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 |
|-------------------------|------|

*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)."*



# Schalmont Central School District

## BUSINESS OFFICE

## MEMORANDUM

TO: ADMINISTRATORS

FROM: Laurie Kapfer – District Treasurer/Health, Vision & Dental Benefits

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

DATE: April 28, 2023

The open enrollment transfer and opt-out period for current health plan participants and eligible employees will be through June 1, 2023. During this period employees may choose any of the health plans offered by Schalmont CSD, including the vision and dental plans. Since there are different eligibility criteria for each employee group, it is requested that you contact Laurie Kapfer for more information. (518-355-9200 x4007 or [lkapfer@schalmont.net](mailto:lkapfer@schalmont.net))

All health plan enrollment forms are available online under Staff Resources of the Schalmont website and must be returned by May 31, 2023 for coverage effective July 1, 2023. Deductions will begin with the payroll of September 15, 2023 and will continue for 21 pays through June 21, 2024.

CC: T. Reardon - Superintendent of Schools  
B. Leitt - School Business Administrator