Schalmont Central School District

BUSINESS OFFICE

MEMORANDUM

TO: **ALL INSTRUCTIONAL STAFF**

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

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

DATE: April 29, 2024

The open enrollment transfer and opt-out period for current health plan participants and eligible employees will be through June 1, 2024. 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)

All health plan enrollment forms are available online under Staff Resources of the Schalmont website and must be returned by May 31, 2024 for coverage effective July 1, 2024. Deductions will begin with the payroll of September 20, 2024 and will continue for 21 pays through June 27, 2025.

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

Health Insurance Rates July 1, 2024 - June 30, 2025

Instructional

15%	Health Insurance
0%	Individual Employee Dental
20%	Family Dental = Family cost less Individual cost X 20%
5%	Individual or Family Vision

24/25 Monthly Rates

Name of Plan	Monthly Rate	Monthly District Share	Monthly Employee Share	Yearly Cost	Yearly District Share	Yearly Employee Share	21 PAYS 24/25 Deduction	21 PAYS 24/25 Limit
BS 815 - Individual	891.53	757.80	133.73	10,698.36	9,093.61	1,604.75	76.42	1,465.79
BS 815 - 2 Person	1,844.01	1,567.41	276.60	22,128.12	18,808.90	3,319.22	158.06	3,319.22
BS 815 - Family	2,528.92	2,149.58	379.34	30,347.04	25,794.98	4,552.06	216.77	4,552.06
CDPHP 422 - Individual	955.38	812.07	143.31	11,464.56	9,744.88	1,719.68	81.89	1,719.68
CDPHP 422 - 2 Person	1,903.22	1,617.74	285.48	22,838.64	19,412.84	3,425.80	163.14	3,425.80
CDPHP 422 - Family	2,535.97	2,155.57	380.40	30,431.64	25,866.89	4,564.75	217.37	4,564.75
Vision - Ind	21.22	20.16	1.06	254.64	241.91	12.73	0.61	12.73
Vision - Family	49.43	46.96	2.47	593.16	563.50	29.66	1.42	29.66
Dental - Individual 0%	51.93	51.93	0.00	623.16	623.16	0.00	0.00	0.00
Dental - Family	158.16	136.91	21.25	1,897.92	1,642.97	254.95	12.15	254.95

SCHALMONT CENTRAL SCHOOL DISTRICT
4 SABRE DRIVE
SCHENECTADY, NEW YORK 12306

TO: All Teachers

FROM: Brenda Leitt

RE: Advance Net Salary Payment

This is to advise you that the teacher net salary payment of $500, as outlined in the Schalmont Teachers Association Contract, Article VI, Section 8, is scheduled for September 13, 2024. This check will be for $500 with no deductions taken. This will Be a Direct Deposit.

Those opting for the advance payment will receive a bi-weekly check on September 16, 2022 for $500 less and will include tax withholdings for the $500.

If you wish to receive the advance payment you will need to sign and return this entire letter **BY August 1, 2024** to Payroll in the District Office.

I wish to receive the $500 net salary payment on September 13, 2024. I understand that the September 20, 2024 bi-weekly pay will be $500 less.

_____

Name Date

SCHALMONT CENTRAL SCHOOL DISTRICT

26 PAYS ELECTION FORM

ELECTION TO DEFER SCHOOL DISTRICT COMPENSATION FOR COMPLIANCE WITH U.S. TREASURY REGULATION SECTION 1.409a-2(A)(14)

(This election is effective 9/1/2024 and supersedes any prior election statement)

The election statement below is intended to meet the requirements of U.S. Treasury Regulations Section 1.409a-2(A)(14) and Article VI, Section 7d of the Schalmont Teachers' Association. If a school employee wishes to receive their salary spread over a 12-month period (26 pays September-June) versus receiving all total compensation during the regular school year (21 pays September-June), this election form must be completed. The election must be made before the beginning of the school year to which it applies.

DEFERRED PAYROLL ELECTION

I,_____(print name), elect to receive my school year compensation spread over a twelve (12) month period instead of only during the school year (21 pays September-June). I understand that my compensation will be divided by 26, with 21 pays occurring on a bi-weekly basis from September-June and the remaining 5 pays occurring in a separate paycheck before June 30th.

My election is effective the first (1st) day of September 2024 for the 2024-2025 school year and thereafter, until I revoke this election for a subsequent school year.

I understand that my election is irrevocable once the school year begins. It may only be changed after the entire school year is over for a subsequent school year. However, I further understand that my election will remain in place until I elect to change it. **If I want to change my election and begin to receive my entire compensation during the school year (21 pays September-June), I must notify the District in writing.** That change must be made before the beginning of the school year to which the change applies.

_____

Signature Date

SCHALMONT CENTRAL SCHOOL DISTRICT
4 Sabre Drive
Schenectady, NY 12306

TO: All Instructional Staff

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

DATE: April 29, 2024

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 Teachers' Association employees.

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 17, 2024.

OPT OUT

I hereby opt out of the Schalmont Health Insurance Program under the terms of the opt out policy and the STA 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, 2025, 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. Employees are eligible for opt out of $4,000. Payment will be made pursuant to the opt out policy and STA 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

CAPITAL AREA SCHOOLS HEALTH INSURANCE CONSORTIUM (CASHIC)

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

GROUP NAME Schalmont CSD

SECTION A

Last Name | First | M.I.

Address | County

City | State | Zip Code

Your Social Security No. ___ ___ ___ – ___ ___ – ___ ___ ___ ___

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Date of Marriage ___/___/___ Date of Divorce ___/___/___

Phone No.: (___)___ (___)___

Employment Status: ☐ FT ☐ PT Hrs/Weekly___ ☐ Active ☐ Retired ☐ COBRA

Hire Date ___/___/___ Status Chg Date ___/___/___

EMPLOYER USE ONLY

Effective Date ___/___/___

Retire Date ___/___/___

Grp No.___

Loc. Code___

SECTION B

☐ Open Enrollment (complete Section D)

☐ New Enrollment/Reinstatement (complete Section D)

☐ Change Coverage to (check new coverage)

☐ Cancel Coverage (check what applies)

☐ Add/Delete Dependent (complete section D)

☐ Information Change (complete Section A)

☐ Waive Coverage (must provide proof of Insurance)

☐ NYS Dependent Coverage up to Age 29

	Carrier	Tier
Indem/Blue Shield		☐ Ind ☐ 2P ☐ Fam ☐ Mdcr
PPO/Blue Shield		☐ Ind ☐ 2P ☐ Fam ☐ Mdcr
POS/Blue Shield		☐ Ind ☐ 2P ☐ Fam ☐ Mdcr
CDPHP EPO		☐ Ind ☐ 2P ☐ Fam ☐ Mdcr
MVP HMO		☐ Ind ☐ 2P ☐ Fam ☐ Mdcr
Rx		☐ Ind ☐ 2P ☐ Fam ☐ Mdcr
Dental		☐ Ind ☐ 2P ☐ Fam ☐ Mdcr
Other		☐ Ind ☐ 2P ☐ Fam ☐ Mdcr

Reason/Comments:

SECTION C

Other Coverage?

Is there coverage under any other group health plan available to you or any of your covered dependents?

☐ Yes ☐ No

If Yes; Policyholder Name | Relationship ☐ Self ☐ Spouse ☐ Child

Social Security Number | Birth Date

___/___/___ ___/___/___

Insurance Co. Name | Policy #

Plan Type ☐ Self only ☐ Self/Spouse ☐ Self/Child(ren) ☐ Fam

Coverage Type ☐ Health ☐ Drug ☐ Dental ☐ Vision

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 #	Copy of Medicare card required: Medicare A & B Effective Date	MVP HMO & BS POS ONLY: Primary Care Physician (PCP)
☐	☐	**Self** ☐ M ☐ F		___/___/___	n/a	___/___/___	___/___/___ ___/___/___	
☐	☐	**Spouse/DP** ☐ M ☐ F		___/___/___	n/a	___/___/___	___/___/___ ___/___/___	
☐	☐	☐ Son ☐ Daughter		___/___/___	☐ Yes ☐ No	___/___/___	___/___/___ ___/___/___	
☐	☐	☐ Son ☐ Daughter		___/___/___	☐ Yes ☐ No	___/___/___	___/___/___ ___/___/___	
☐	☐	☐ Son ☐ Daughter		___/___/___	☐ Yes ☐ No	___/___/___	___/___/___ ___/___/___	
☐	☐	☐ Son ☐ Daughter		___/___/___	☐ Yes ☐ No	___/___/___	___/___/___ ___/___/___	

SECTION E

Do your dependents reside in your home? ☐ Yes ☐ No

If No, give address:___

Do you have a disabled dependent beyond age 19? ☐ Yes ☐ 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:___

White Copy – AMSURE Yellow Copy – EMPLOYER Pink Copy – EMPLOYEE

Empire BlueCross
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.

Accept	Decline	Coverage level
☐	☐	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?

Accept	Decline	Coverage Level
☐	☐	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)
	- -	☐ M ☐ F	/ /		Spouse/Domestic Partner
	- -	☐ M ☐ F	/ /		Child
	- -	☐ M ☐ F	/ /		Child
	- -	☐ M ☐ F	/ /		Child
	- -	☐ M ☐ 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

Empire BlueCross BlueShield

MEMBER INFORMATION

Member's identification number

DEPENDENT'S INFORMATION

Last name	First name	MI	Date of birth

Relationship to member	Is dependent ☐ Single ☐ Married ☐ Divorced ☐ Separated	Is dependent employed ☐ Yes ☐ Full-time ☐ Part-time ☐ 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? ☐ Yes ☐ 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?

(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 of 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)."