Updated 5/1/12

Effective July 1, 2012

Administration Insurance Costs

Blue Shield of Northeastern New York- PPO:

Individual	2 Person	Family
$39.48 per pay	$100.38 per pay	$103.77 per pay

MVP:

Individual	2 Person	Family
$37.46 per pay	$76.67 per pay	$94.75 per pay

Delta Dental

Individual	2 Person	Family
$0 per pay	$11.03 per pay	$23.68 per pay

Vision

Coverage for employee only (no deductions per pay check)

Updated 5/1/12

Effective July 1, 2012

Teacher's Insurance Costs
(12 mo/21 pays)

<u>Blue Shield of Northeastern New York- PPO</u>: 12 month

Individual	2 Person	Family
$32.39 per pay	$84.51 per pay	$87.31 per pay

<u>MVP: Effective 7/1/2012:</u>

Individual	2 Person	Family
$30.72 per pay	$64.95 per pay	$79.87 per pay

<u>Delta Dental</u>

Individual	2 Person	Family
$0 per pay	$13.65 per pay	$29.31 per pay

<u>Vision</u>

Coverage for employee only (no deductions per pay check)

Updated 5/1/12

Effective July 1, 2012

Non-Aligned Insurance Costs

Blue Shield of Northeastern New York- PPO:

Individual	2 Person	Family
$26.32 per pay	$66.92 per pay	$69.18 per pay

MVP:

Individual	2 Person	Family
$24.97 per pay	$51.12 per pay	$63.17 per pay

Delta Dental

Individual	2 Person	Family
$0 per pay	$11.03 per pay	$23.68 per pay

Updated 5/1/12

Effective July 1, 2012

CSEA Insurance Costs
(12 mo/26 pays)

Blue Shield of Northeastern New York- PPO:

Individual	2 Person	Family
$23.84 per pay	$61.39 per pay	$63.64 per pay

MVP:

Individual	2 Person	Family
$19.85 per pay	$41.97 per pay	$51.61 per pay

Delta Dental:

Individual	2 Person	Family
$0 per pay	$11.03 per pay	$23.68 per pay

Updated 5/1/2012 **Effective July 1, 2012**

CSEA's Insurance Costs
(10 month employee - 21 pays)

Blue Shield of Northeastern New York- PPO:

Individual	2 Person	Family
$29.51 per pay	$76.01 per pay	$78.79 per pay

(If you make less than $17501.00 per year, your cost for the health coverage is $0.)

MVP:

Individual	2 Person	Family
$24.58 per pay	$51.96 per pay	$63.89 per pay

Delta Dental

Individual	2 Person	Family
$0 per pay	$11.03 per pay	$23.68 per pay

CAIRO-DURHAM CENTRAL SCHOOL DISTRICT *Business Office*

P.O. Box 780, Cairo, N.Y. 12413
(518) 622-8534 * FAX (518) 622-9566

Lissa Jilek
Business Manager

May 1, 2012

TO: All Eligible Employees

FROM: Lissa Jilek

RE: Open Enrollment Period – IRS Section 125 Flex (Cafeteria) Spending Plan

Please be advised that "Open Enrollment Period" for the IRS Section 125 Flex (Cafeteria) Spending Plan is **May 1, 2012 through May 31, 2012.**

During this period you may elect to do the following:
1. Change your position with the Health Insurance, Dental Insurance and Cash Buy-Out benefits offered by the district;
2. Change your position with the "Medical Care Reimbursement" plan using pretax salary dollars; and
3. Change your position with the "Dependent Care Assistance Reimbursement" plan using pre tax salary dollars.

At no other time during the year can you elect to make a change to these programs unless you qualify under the "Change of Status" requirements as established by federal regulations, and these "Change of Status" requirements are detailed in the plan's "Summary Plan Description".

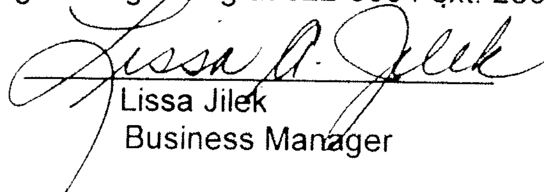
If you plan to retire anytime between July 1, 2011 and June 30, 2012, you are reminded that your insurance coverage at your time of retirement will be the same as provided on the last day of your employment. If you wish to make a change in that coverage, you will have to do so during this open enrollment period (05/01/12-05/31/12).

All changes to the plan will be effective **July 1, 2012**.

All eligible employees should have a copy of the "Summary Plan Description." If you wish to have another copy, please contact Georgia Houghtaling at extension #23060.

Enclosed is a copy of the "Election Form and Compensation Reduction Agreement." If you wish to make any changes different than your present status, please complete the appropriate pages and return the **signed** and **dated** form to the Business Office by **May 31, 2012**. **No action on your part is required if no changes are made**.

If you have any questions, please call Georgia Houghtaling at 622-8534 ext. 23060.



Lissa Jilek
Business Manager

Attachment

CAIRO-DURHAM CENTRAL SCHOOL DISTRICT

CAFETERIA PLAN

ELECTION FORM AND COMPENSATION REDUCTION AGREEMENT

Employer Name ____

Employee Name ____

Employee Address ____

____

Employee Social Security Number ____________________________

Plan year: **July 1, 2012 through June 30, 2013**

As an eligible employee in the above Plan, I acknowledge that I have received the Summary Plan Description. I have read the Summary Plan Description and understand the benefits available to me as well as the other rights and obligations which I have under the Plan.

Attention

PLEASE FILL OUT THIS APPLICATION AND RETURN IT TO THE DISTRICT OFFICE *ONLY* IF YOU WISH TO MAKE ANY CHANGE TO YOUR CURRENT STATUS OR TO ENROLL IN THE PLAN.

THANK YOU FOR YOUR COOPERATION.

ELECTION OF MEDICAL REIMBURSEMENTS

Please check this section if you would like to participate in the Medical Reimbursement Plan for this year and indicate the amount to be deducted.

☐ I elect to receive medical reimbursements for the Plan Year.

Salary Reduction: The amount of compensation redirections will be $________ for the Plan Year.

Note: The annual plan limit which may be allocated to the medical reimbursement account is $2,500.00

I understand that:

Reimbursements will be available only for "Qualifying medical care expenses" generally, "qualifying medical care expenses" are those medical expenses normally deductible on any federal income tax return (without regard to the percentage of adjusted gross income limitations). I agree to notify the Employer if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense. I also agree to indemnify and reimburse the Employer on demand for any liability it may incur for failure to withhold federal, state or local income tax or Social Security tax from any reimbursement I receive of a non qualifying expense up to the amount of additional tax actually owed by me.

This section of the agreement will automatically terminate if the Plan is terminated or discontinued.

If I cease my employment with the Employer, my participation in the Plan will continue if I so elect.

If I elect to continue participation, my contributions will continue for the remainder of the Plan Year.

If I elect not to continue participation, no further contributions will be made to the Plan on my behalf. Although I may submit claims for expenses incurred prior to my date of termination.

I cannot seek reimbursement from this account for a medical expense which I intend on taking as a deduction or credit on my tax return.

DENTAL INSURANCE: If you need to make any changes, please come into the District Office to fill out a change form (this can only be done during open enrollment period).

ELECTION OF DEPENDENT CARE ASSISTANCE

Please check this section and the amount to be deducted if you would like to participate in the Dependent Care Plan.

☐ I elect to receive dependent care assistance for the Plan year.

Salary Redirection: The amount of compensation redirection will be $________ for the plan year.

I understand that:

Reimbursement will be available only for "qualifying dependent care expenses" as described in the Internal Revenue Code Section 129, the Plan Document and the Summary Plan Description. I agree to notify the Employer if I have reason to believe that any expenses for which I have obtained reimbursement is not a qualifying expense. I also agree to indemnify and reimburse the Employer on demand for any liability it may incur for failure to withhold federal, state, or local income tax of Social Security tax from any reimbursement I receive of a non qualifying expense, up to the amount of additional tax actually owed by me.

I agree to provide the Administrator with a statement from the service provider that includes the amount of the expense as proof that the expense has been incurred.

I agree to provide the Administrator with the name, address, and if applicable, the taxpayer identification number of the service provider.

This section of the agreement will automatically terminate if the Plan is terminated or discontinued. I will however, be entitled to be reimbursed for eligible expenses (to the extend funded) for the remainder of the Plan Year.

I will only be reimbursed for amounts up to the balance in my account at the time of my request.

I cannot claim a dependent care tax credit on amounts I receive as reimbursements under this dependent care assistance program.

DECLINATION OF HEALTH INSURANCE COVERAGE

Please check this section if you ***do not*** wish to have Health Insurance Benefits and would like to receive the cash buyout.

☐ I hereby decline coverage under the district's health insurance and accept in lieu this coverage cash payments as stipulated under the applicable collective bargaining agreement, or for nonunion employees as established by the district. Further, I hereby certify that I have health insurance coverage under another plan.

ELECTION OF OUTSIDE COVERAGE

Salary Redirection: The amount of compensation redirection will will be $N/A for the Plan Year.

I understand that I must furnish adequate proof of this coverage and that the Administrator must authorize this payment.

OTHER TERMS AND CONDITIONS

I understand that:

I cannot change or revoke any of my elections or this compensation reduction Agreement at any time during the Plan Year unless I have a change in status and my election in consistent with such change.

The Plan Administrator may reduce or cancel my compensation reduction or otherwise modify this agreement in the event he believes it advisable in order to satisfy certain provisions of the Internal Revenue Code.

The reduction in my cash compensation under this agreement shall be in addition to any reduction under other agreements or benefit programs maintained by my Employer.

Any amounts that are not used during a Plan Year to provide benefits will be forfeited and may not be paid to me in cash or used to provide benefits specifically for me in a later Plan Year.

Prior to the first day of each Plan Year, I will be offered the opportunity to change my benefit elections for the following Plan Year. If I do not complete and return a new election form at that time, I will be treated as having elected to continue my benefit elections then in effect for the new Plan Year. In addition this compensation reduction agreement will continue by its terms in the amount of the required contribution for the insured benefit option.

THIS AGREEMENT IS SUBJECT TO THE TERMS OF THE EMPLOYER'S CAFETERIA PLAN AS AMENDED FROM TIME TO TIME IN EFFECT, SHALL BE GOVERNED BY AND CONTTRUED IN ACCORDANCE WITH APPLICABLE LAWS, SHALL TAKE EFFECT AS A SEALED INSTRUMENT UNDER APPLICABLE LAWS, AND REVOKES ANY PRIOR ELECTION AND COMPENSATION REDUCTION RELATING TO SUCH PLAN.

______________________________________ Date ____________

Employee's Signature

Accepted and agreed to by the Employer's Authorized Representative

By: ___________________________________ Date ____________

PLEASE INCLUDE WHICH DEPENDENTS ARE LISTED ON YOUR CURRENT HEALTH INSURANCE AND DATE OF BIRTH:

888-411-4398

Benetech, Inc
One Dodge Street
North Greenbush, NY 12198

EMPLOYEE/EMPLOYER
ELECTION FORM/COMPENSATION
REDUCTION AGREEMENT
FLEXIBLE SPENDING ACCOUNT

EMPLOYEE INFORMATION
ADD ____ CHANGE* ____ EMPLOYEE TERMINATION* ____

(* Must provide reason on back of form and must be authorized by employer)

COMPANY/CLIENT NAME **Cairo-Durham CSD**	CLIENT # **Benetech Use Only**
EMPLOYEE NAME	DATE OF HIRE
SOCIAL SECURITY NUMBER	EMPLOYEE PHONE NUMBER
ADDRESS: STREET, CITY, STATE, ZIP	
EMAIL ADDRESS **(REQUIRED)**	

* Per Health Care Reform; effective January 1, 2011 over the counter medications will no longer be an eligible FSA item if not accompanied by a prescription

Premium under Certain Benefit Plans

- I may be eligible for certain health, dental, and/or vision insurance coverage's.
- Where I have enrolled for such plan(s), my premium contribution will be paid, if any, on a pre-tax basis, unless I complete an "Election Not To Participate" form available through my employer.

NUMBER OF PAYCHECKS RECEIVED ANNUALLY:

_____ Weekly (52x) ____ Bi-Weekly (26x) ____ Semi-Monthly (24x) ____ Monthly (12x) ____ Other

	$/Pay Period*		# of Pay Periods*		Annual Employee Election*		Annual Employer Contribution
___ Medical/Dental Reimbursement – Plan year maximum (per participant): $2,500							
	________	x	________	=	________	+	________
___ Dependent Care (Day Care) Reimbursement – *Plan Year Maximum (per participant): $2,500 if married and file separate Income Tax return; $5,000 if married and file joint Income Tax return.*							
	________	x	________	=	________	+	________

** In the event of a calculation discrepancy, the annual election will be the amount used, and the per pay period amount will be recalculated.*

I hereby elect to participate in the Employer's Flexible Spending Account for the Plan Year beginning _7/1/2012_, and ending _6/30/2013_. Any previous election and compensation reduction agreement relating to the same benefits is hereby revoked & I understand that election is required annually to participate. As a participant, I understand that:

- I cannot change or revoke this agreement at any date prior to the next plan year, unless I have a change in my family status as set forth in the Adoption Agreement and Summary Plan Description. Prior to my next Plan Year I will be offered the opportunity to change my benefit election for the following year.
- My pay will be reduced by the amount of my required contribution for the benefit option(s) I have elected, continuing for each succeeding pay period until this agreement is amended or terminated.
- The reduction in my cash compensation under this agreement will be in addition to any reductions under other agreements or benefit plans. If my required contributions change while this agreement is in effect, my pay reduction will automatically be adjusted to reflect that change.
- The Plan Administrator may change the amount of my reduction or otherwise modify this agreement, if he believes it is required to satisfy provisions of the Internal Revenue Code.
- The amount of my compensation reduction will be credited to the appropriate reimbursement account on my employer's books for payment of eligible expenses incurred within the plan year.
- Reimbursement will be available only for qualifying expenses as described in the attached form. I agree to notify the Employer if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense. I also agree on demand to indemnify and reimburse the Employer for any liability it may incur for failure to withhold income or FICA tax from any reimbursement I receive of a non-qualifying expense.
- If the amount in my reimbursement account at the end of the year exceeds the amount of my eligible expenses for the plan year, I will forfeit the excess amount.

The pay reductions will not be effective for any pay period that begins before you have signed this form and returned it to the Plan Administrator.

CHANGES/TERMINATIONS

Date of Event: ____/____/____

First paycheck date that change will be processed: ____/____/____.

___ Marriage/Divorce
___ Birth/Death of Spouse or Dependent
___ Spouse's employment commenced/terminated
___ Status change from full-time to part-time or part-time to full-time by employee or spouse
___ Unpaid leave of absence by employee or spouse
___ Open Enrollment

Employee Signature________________________________ Date______________

Employer Signature ________________________________ Date ______________

Reminder: Please advise your payroll service or payroll department of these employee deductions. Your employer will forward this form to Benetech, Inc.

HUMAN RESOURCES – OFFICE USE ONLY
(ALL FIELDS REQUIRED)

Highly Compensated ☐ Y ☐ N

Key Employee ☐ Y ☐ N

Officer ☐ Y ☐ N

Spouse or Dependent of Owner ☐ Y ☐ N

More than 5% Owner ☐ Y ☐ N

More than 1% owner with salary greater than $150,000 ☐ Y ☐ N

2

P.O. Box 348
Wynantskill, NY 12198
(518) 283-8500
Fax (518) 283-2393
800-698-4753
www.wedobenefits.com

Flexible Spending Account Direct Deposit Authorization Form

PARTICIPANT INFORMATION

Employer Name: ______________________________

____

Participant Full Name: ______________________________
(Exactly as it appears on the checking account.)

Participant Social Security Number: ______________________________
Participant Phone Number: ______________________________
Email address: ______________________________

ACCOUNT INFORMATION

Bank Name: ______________________________
Account Number: ______________________________
Routing Number: ______________________________

AGREEMENT

I hereby authorize Benetech to deposit applicable Flexible Spending Account reimbursements into the bank account listed above. I understand that I may discontinue this payment service at any time by notifying Benetech in writing.

Participant Signature: ______________________________ Date: ______________
(Must be an authorized signer on the checking account.)

***Participant must include a voided or cancelled check with the account information above to complete this authorization.**

GROUP INSURANCE PLANNING

benetech®

FLEXIBLE SPENDING ACCOUNTS

Exceptional benefits and savings for you using pre-tax dollars

Benetech®
One Dodge Street
North Greenbush, NY 12198
518.283.8500
800.698-4753
fax: 518.283.2393
www.wedobenefits.com

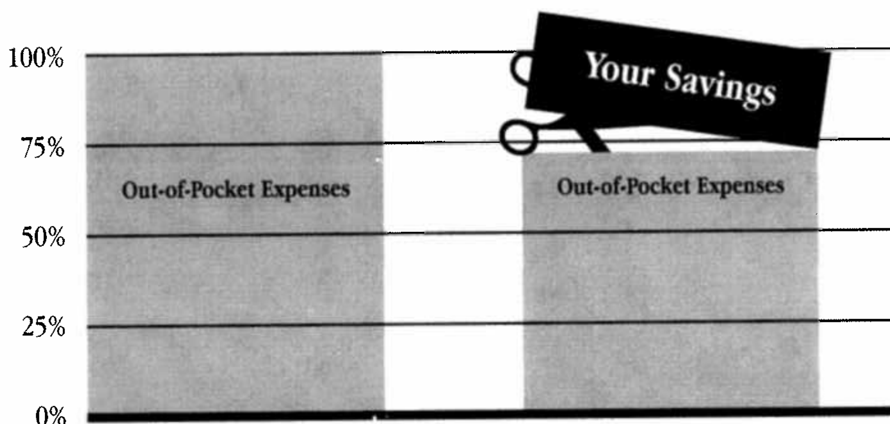
CHOOSE TO PAY FOR YOUR PAYROLL DEDUCTED INSURANCE COSTS WITH **FLEX!**

Pay your share of employer-sponsored medical, dental, vision, hearing, and drug insurance policies with pre-tax dollars.

- **NO CHANGE** in current benefits
- Reduce your **TAXABLE** income
- Money deducted **PRE-TAX** in the exact amount of your contributions
- **SAVE** up to 30% or more
- **INCREASE** your take-home pay

OUT-OF-POCKET EXPENSES
Without FLEX, you pay 100% of your out-of-pocket costs

WITH FLEX, YOU CAN **SAVE UP TO 30%** OF OUT-OF-POCKET EXPENSES



CHOOSE TO USE FLEXIBLE SPENDING REIMBURSEMENT ACCOUNTS AND SAVE

Pay for eligible medical, dental, vision, dependent day care expenses, and private insurance premiums, with pre-tax dollars.

- Three separate accounts help you **save up to 30%** *(or more depending on your tax bracket)*
- Expenses for you, your spouse, and any dependents you claim on your Federal Income Tax Return, are eligible
- Enroll in any or all accounts that your employer offers
- Use Benetech's Worksheet (on the back cover) to help you calculate a Target Annual Election that you expect to spend on eligible expenses during your Plan Year
- Set aside money before taxes are taken out of your paycheck
- Submit claims for reimbursement as you incur eligible expenses

The Premium Expense Account

- Pay for health insurance premiums with **pre-tax** dollars
- COBRA premiums
- Disability Insurance *(not recommended – benefits become taxable when premiums are paid on a pre-tax basis)*

The Unreimbursed Medical Account

- Pay for medical and dental co-pays and/or deductibles with **pre-tax** dollars
- Pay for out-of-pocket costs including eligible expenses NOT covered by your insurance
- Immediate reimbursement up to your Target Annual Election

The Dependent Day Care Account

- Pay with **pre-tax** dollars for day care services that allow you and your spouse to work
- Expenses for children up to age 13, and expenses for disabled and elderly dependents are eligible

FREQUENTLY ASKED QUESTIONS AND ANSWERS

Q. What is the purpose of the Plan?

A. The purpose of the Plan is to permit eligible employees to elect to defer part of their salary on a pre-tax basis to defray their health insurance expenses and their unreimbursed medical expenses.

Q. What is the Premium Conversion Benefit?

A. The Premium Conversion Benefit allows you to pay your share of the health insurance premiums with pre-tax dollars. If you do not elect to receive the Premium Conversion Benefit, you still have to pay your share of the health insurance premiums under the health care program, but on an after-tax basis.

Q. How does the Medical Spending Account Benefit help me?

A. It is likely that you will have some medical expenses that you will have to pay in the coming year. For example, you or your family will have medical expenses that are subject to deductible or co-payment limits under your health plan, or you may incur expenses that are not reimbursed at all. Normally, you would pay for these expenses with after-tax income. Since taxes reduce the value of a dollar, you would have to earn more than $100 to pay for $100 of expenses.

The Medical Spending Account Benefit under the Plan permits eligible employees to contribute pre-tax income to a medical spending account on your behalf. The medical spending account will reimburse you on a pre-tax basis for your un-reimbursed medical expenses.

Q. How does the Medical Spending Account work?

A. Once you have determined your annual predictable medical expenses for the plan year *(or part thereof, if you first become eligible to participate in the middle of a plan year)*, you elect to defer a portion of your salary into a medical spending account maintained on your behalf. You should take into account your health insurance deductible and copayments, as well as uninsured medical and dental expenses, vision and hearing care. Generally, the expenses covered must be "medically necessary" as determined by a doctor. Do not take into account the premiums paid for health insurance coverage provided by the Company *(since this is covered under the Premium Conversion Benefit)*. Also, do not take into account other health insurance coverage, such as that of a spouse, or expenses for cosmetic surgery.

Q. What is an "eligible expense" under the Medical Spending Account?

A. An "eligible expense" means any items for which you can claim a medical expense deduction on an itemized federal income tax return, (i.e., an expense for which you have not otherwise been reimbursed from insurance or other source). Please review the list of eligible medical expenses provided on the back of this form for assistance in determining what is an "eligible expense".

Q. What happens to the money in my Spending Account should I terminate employment?

A. You must submit claims on expenses incurred before the date of your termination, up until three months (90 days) after you leave employment. If you elect continuation coverage through COBRA you may continue to use your Medical Spending Accounts.

Q. How long do I have after the Plan Year ends to submit my claims?

A. You will have three months (90 days) after the Plan Year ends to submit claims on expenses incurred in that Plan Year, unless you terminate your employment from the Company. A terminated employee has three months (90 days) from their date of termination to submit claims incurred in that Plan Year.

Q. What is the maximum amount of salary I can deposit per pay period to a Dependent Care Spending Account?

A. The maximum you may deposit to a Dependent Care Spending Account is $192 per bi-weekly pay, or $5,000 per Plan Year. If you are married and file separately, the maximums are $96 per bi-weekly pay, or $2,500 per Plan Year.

Q. Can I change my election during the Plan Year?

A. Generally, you may not change or vary your elections during the Plan Year. However, you may change your elections during the annual enrollment period for the coming Plan Year. The Plan Administrator will advise you when you may elect o change your elections for the upcoming Plan Year.

There is an important exception to this general rule: You may change or revoke your election at any time during the Plan Year if there is one or more of the following significant changes in your family status. Such changes include;

- Your marriage or divorce;
- Birth or adoption of your child;
- Death of your spouse or child;
- Termination of your spouse's employment;
- Change in the employment status of either you or your spouse from full-time to part-time or vice-versa;
- An unpaid leave of absence by you or your spouse, or
- A significant change in health coverage of you or your spouse attributable to your spouse's employment.

HOW DOES FLEX WORK?

	Using After Tax Dollars	Using Pre-tax Dollars
Gross Annual Income	$ 40,000.	$ 40,000.
Eligible Expenses	$ 0.	$ 2,000.
Taxable Income	$ 40,000.	$ 38,000.
Estimated Taxes	$ 11,200.	$ 10,640.
Income After Taxes	$ 28,800.	$ 27,360.
Eligible Expenses	$ 2,000.	$ 0.
Take Home Pay	$ 26,800.	$ 27,360.
Annual Savings	N/A	$ 560.

EXAMPLES OF ELIGIBLE EXPENSES

Please call Benetech® to verify eligibility of an expense prior to the start of your plan year.

Examples of Eligible Medical Expenses

Acupuncture
Alcoholism treatment
Ambulance services
Artificial limbs
Braille books
Chiropractors
Contact lenses and supplies
Contraceptives *(by prescription)*
Co-pays
Crowns, bridges and dentures
Crutches
Deductibles
Dental cleanings
Dermatologists
Eye examinations
Fillings
Glasses
Hearing aids and batteries
Home health care
Home improvements for medical purposes
Hospital bills
Insulin and syringes
Laboratory fees
Lasik surgery
Mammography
Mental health care
Nursing (RN/LPN)
OB/GYN Examinations
Orthodontia
Orthopedic shoes and braces
Physicals
Physical therapy
Prescriptions, including many over-the-counter drugs*
Psychiatric services
Seeing eye dogs and upkeep
Sterilizations and reversals
Substance abuse treatment
Surgical expenses
Telephone equipment for the deaf
Transportation for medical purposes
Well-child care
Wheelchairs
X-rays

Examples of Eligible Dependent Day Care Expenses

Babysitters *(daytime only)*
Before/After school programs
Day care
Elder care centers
Nursery school
Summer day camps

Examples of Eligible Privately Held Insurance Premium Expenses

COBRA
Dental
Disability *(not recommended – benefits become taxable when premiums are paid on a pre-tax basis)*
Supplemental health
Vision

If a specific item or service is not listed, please contact Benetech® for verification of eligibility at 518.283.8500 or 800.698.4753.

*if accompanied by a prescription

YOUR FLEXIBLE SPENDING ACCOUNT WORKSHEET

This worksheet will help you determine your annual out-of-pocket costs for each account.

Unreimbursed Medical Account	Annual		Annual	Dependent Day Care Account	Annual	Premium Expense Account	Annual
Deductible(s)	$________	Check-up/exam	$________	Day babysitters	$________	Health*	$________
Co-pays	$________	Orthodontia	$________	Day care centers	$________	Vision*	$________
Co-insurance	$________	Monthly treatments	$________	Elder care	$________	Dental*	$________
Prescription drugs	$________	Dentures	$________	Day camp	$________	COBRA premiums	$________
Special equipment	$________	Bridgework	$________	After-school programs	$________	Other	$________
Physicals	$________	Partial plates	$________	Nursery school	$________		
Medical travel costs	$________	Eye exams	$________	Other	$________		
Hearing aids	$________	Contacts and supplies	$________				
Other	$________						

*Amount deducted from your pay

Accepted Over-The-Counter Items*

Antiseptics
- Antiseptic wash or ointment for cuts or scrapes
- Benzocaine swabs
- Boric Acid powder
- First aid wipes
- Hydrogen Peroxide
- Iodine tincture
- Rubbing Alcohol
- Sublimed Sulfur powder

Asthma Medications
- Bronchodilator/Expectorant tablets
- Bronchial asthma inhalers

Cold, Flu, and Allergy Medications
- Allergy medications
- Cold relief syrup
- Cold relief tablets
- Cough drops
- Cough syrup
- Flu relief tablets or liquid
- Medicated chest rub
- Nasal decongestant inhaler
- Nasal decongestant spray or drops
- Nasal strips to improve congestion
- Sinus & allergy homeopathic nasal spray
- Sinus medications
- Vapor patch cough suppressant

Diabetes
- Diabetic lancets
- Diabetic supplies
- Diabetic test strips
- Glucose meters

Ear/Eye Care
- Airplane ear protection
- Ear drops for swimmers
- Ear water-drying aid
- Ear wax removal drops
- Homeopathic earache tablets
- Contact lens solutions

Health Aids
- Antifungal treatments
- Denture adhesives
- Diuretics and water pills
- Hemorrhoid relief
- Incontinence supplies
- Lice control
- Medicated bandages
- Motion sickness tablets
- Respiratory stimulant ammonia
- Sleeping aids

Pain Relief
- Arthritis pain reliever
- Bunion and blister treatments
- Itch relief
- Orajel
- Pain relievers, aspirin and non-aspirin
- Throat pain medications

Personal Test Kits
- Cholesterol tests
- Colorectal cancer screening tests
- Home drug tests
- Ovulation indicators
- Pregnancy tests

Skin Care
- Acne mediations
- Anti-itch lotion
- Bunion and blister treatments
- Cold sore and fever blister medications
- Corn and callus removal medications
- Diaper rash ointment
- Eczema cream
- Medicated bath products
- Wart removal medications

Stomach Care
- Acid reducers
- Antacid gum
- Antacid liquid
- Antacid tablets
- Anti-diarrhea medications
- Gas prevent food enzyme dietary supplement
- Gas relief drops for infants and children
- Ipecac syrup
- Laxatives
- Pinworm treatment
- Prilosec
- Upset stomach mediations

Not Acceptable*

- Aromatherapy
- Baby bottles and cups
- Baby oil
- Baby wipes
- Breast enhancement system
- Cosmetics
- Cotton swabs
- Dental floss
- Deodorants
- Facial care
- Feminine care
- Fragrances
- Hair regrowth
- Low "carb" foods
- Low calorie foods
- Oral care
- Petroleum jelly
- Shampoo and conditioner
- Skin care
- Spa salts
- Sun tanning products
- Tooth brushes

Dual use - requires doctor letter*

- Adhesive or elastic bandages
- Blood pressure meter
- Cold or hot compresses
- Eye drops
- Foot spa
- Gauze and tape
- Gloves and masks
- Herbs
- Leg or arm braces
- Massagers
- Minerals
- Multivitamins
- Saline nose drops
- Special supplements
- Special teeth cleaning system
- Thermometers
- Vitamins

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*Plan restrictions may apply.
Check with your plan administrator.

Cairo-Durham Central School District

www.cairodurham.org

DISTRICT OFFICE
(518) 622-8534
FAX 622-9566
Post Office Box 780
Cairo, NY 12413

Sally M. Sharkey
Superintendent

Lissa A. Jilek
Business Manager

HIGH SCHOOL
(518) 622-8543
FAX 622-8857
Post Office Box 598
Cairo, NY 12413

Anthony J. Taibi
Principal

Imran A. Abbasi
Assistant Principal
Middle/High School

MIDDLE SCHOOL
(518) 622-0490
FAX 622-0493
Post Office Box 1139
Cairo, NY 12413

Kerry A. Overbaugh
Principal

CAIRO ELEMENTARY
(518) 622-3231
FAX 622-9060
Post Office Box 1090
Cairo, NY 12413

Scott L. Richards
Principal

Daniel E. Packard
Assistant Principal

DURHAM ELEMENTARY
(518) 239-8412
FAX 239-5925
4099 Rt. 145
Durham, NY 12422

Kristen E. Reno
Principal

SPECIAL EDUCATION & PUPIL PERSONNEL SERVICES
Linda Wistar
Director
(518) 622-0261
FAX 622-2948

TRANSPORTATION
(518) 622-2236

MEMORANDUM

TO: Employees, Retirees and their Dependents

FROM: Georgia Houghtaling, Health Benefits Clerk

SUBJECT: Redistribution of COBRA General Information Notices

The Consolidated Omnibus Reconciliation Act (COBRA) requires that employees, retirees and dependents who are enrolled in our district's health benefits plans be informed of their rights to continued coverage.

We are therefore sending you this COBRA notice for your information.

It is the obligation of the health insurance participant to notify the school district of any change in family status.

If you have any further questions, please do not hesitate to contact me at 518-622-8534 ext. 2306.

VERY IMPORTANT NOTICE

YOUR RIGHTS TO CONTINUED HEALTH BENEFITS COVERAGE UNDER FEDERAL LAW

Introduction

Federal law requires that most employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end. This notice is intended to inform you, in a summary fashion, of your rights and obligations under the benefit continuation law.

Both you and your spouse should take the time to read this notice carefully.

Who is Eligible for Continued Coverage

If you are an employee covered by the district's group health plan, you have a right to choose continuation coverage if you lose your group health coverage because of a reduction in work hours or termination of your employment for reasons other than gross misconduct on your part.

If you are the spouse of an employee covered by the group health plan, you have the right to choose continuation coverage for yourself if you lose group health coverage under the district's plan for any of the following reasons:

1. The death of your spouse;
2. A reduction in your spouse's work hours or termination of his or her employment for reasons other than gross misconduct;
3. Divorce or legal separation from your spouse; or
4. Your spouse becomes covered under Medicare.

In the case of a dependent child of an employee covered by the district's group health plan, he or she has the right to continuation coverage if coverage is lost for any of the following reasons:

1. The death of a parent;
2. A reduction in the parent's work hours or termination of his or her employment with the district for reasons other than gross misconduct;
3. The divorce or legal separation of the parents;
4. A parent becomes covered under Medicare; or
5. The dependent ceases to be a dependent child under the provisions of the group health plan.

District Responsibilities

By law the district has the responsibility to notify the continuation of benefits administrator of an enrolled employee's death, termination of coverage or Medicare entitlement. The administrator will send out more detailed information to the employee and his or her family describing their continuation rights and options.

Traditional Blue

BlueShield of Northeastern New York

Traditional Blue PPO 812
Prepared for: Cairo-Durham CSD

What makes the Traditional Blue PPO 812 Plan stand out? How about:

- The freedom to use any provider
- $10 office visit co-pays
- 100% coverage for inpatient hospital services at participating providers
- No claim forms when using participating providers
- Coast-to-Coast coverage through the Blue Card Program

Dependents covered to age 26. Students covered to age 26.

Out of Network features ⇨

Upfront Deductible:
$250 individual
$500 family

Coinsurance: 20%

Out of Pocket Maximum:
$2,500 individual
$5,000 family

Maximum Benefit:
Unlimited

	In-Network
Doctor's office visits	
Office visits • pediatrics • internal medicine • family practice • specialists	$10 co-pay
Routine physical – 1 per year (*no coverage out of network*)	Covered in full
Routine eye exam – 1 every 2 years (*no coverage out of network*)	Covered in full
Well child visits and immunizations (up to age 19)	Covered in full
Women's services	
Gynecological office visits	Covered in full
Pap smears	Covered in full
Mammograms	Covered in full
Maternity care (Prenatal & post-natal care)	Covered in full after $10 co-pay for initial visit
Medical care	
Physical, speech & occupational therapy (60 visits aggregate)	$10 co-pay
Chiropractic care	$10 co-pay
Diagnostic x-rays, lab services & MRIs	Covered in full
Outpatient hospital care	
Chemotherapy • radiation therapy • hemodialysis	$10 co-pay
Cardiac rehabilitation (24 visits per year)	$10 co-pay
Outpatient surgery (facility) • ambulatory facility	Covered in full
Preadmission testing (within 7 days of admission)	Covered in full
Inpatient hospital care	
Semi-private room (unlimited days)	Covered in full
Physical rehabilitation (60 days)	Covered in full
Skilled nursing facility – non custodial (120 days)	Covered in full
Maternity admissions	Covered in full
Emergency care	
Emergency room visit	$35 co-pay
Emergency ambulance service	Covered in full
Mental health care	
Inpatient care (unlimited per medical necessity)	Covered in full
Outpatient care (unlimited per medical necessity)	Covered in full
Substance abuse treatment	
Inpatient treatment for chemical dependency (unlimited per medical necessity)	Covered in full
Outpatient treatment (unlimited per medical necessity)	Covered in full
Other services	
Home health care (100 visits)	$10 co-pay
Diabetic supplies, equipment, education, insulin	$10 co-pay
Hospice (210 days)	Covered in full
Durable medical equipment	Covered in full
Infusion therapy	Covered in full
Prosthetics & orthotics	Covered in full
Prescription drugs (Managed triple option)	$5/$10/$25

MVP Preferred EPO $10

MVP℠ HEALTH CARE

Summary of Benefits

New York

SERVICE CATEGORY[1]	COVERAGE INFORMATION[2]
Annual Deductible per Contract Year	Not Applicable
Coinsurance	Not Applicable
Lifetime Maximum Benefit Payable	No Maximum
Annual Out-of-Pocket Maximum	Not Applicable
Preventive & Well Care Services[3] Well Baby, Child Care & Immunizations Adult Physical (One Routine Physical/Contract Year) Mammography & Prostate Cancer Screening Annual Pap Test & Ob/Gyn Exam Immunizations for Adults Colonoscopy & Sigmoidoscopy Screening for Adults Bone Density Tests **Laboratory Services** **Hospital** (Inpatient Services) **Physician Inpatient Care** (Medical/Surgical) **Maternity** Physician Pre/Postnatal Care Office Visits[4] Inpatient Services (Facility/Physician) Initial Newborn Exam **Ambulance** **Skilled Nursing Facility** (60 Days/Contract Year)	Covered in Full
Emergency Room (ER) Visit	$35 Copay/Visit
Physician Office Visits **Office Surgery** **Hospital** (Outpatient Surgery) **Diagnostic X-ray & Other Imaging Services**[5] (Office/Outpatient Setting) **High Tech Imaging Services**[5] (MRI, MRA, CT, etc.) **Urgent Care Center** **Home Health Care** (60 Visits/Contract Year) **Physical/Occupational/Speech Therapy** (Outpatient Setting) (Combined 30 Visits per Member per Contract Year)	$10 Copay/Visit
Mental Health & Substance Abuse	
Inpatient (Covered services only)	Covered in Full
Outpatient/Office Visits	$10 Copay/Visit
Durable Medical Equipment	50% Copay
Diabetic Supplies & Equipment (Items limited to a 31 day supply)	$10 Copay/Item

[1]Some services are subject to Notification or Prior Authorization requirements. See your Certificate of Coverage under *How This Policy Works* for details.

[2]A network provider must deliver all care.

[3]This represents a partial list of preventive services covered under this Plan. MVP will also cover all preventive services as required under the Patient Protection and Affordable Care Act of 2010 (PPACA). For a full listing of the PPACA preventive services, including any applicable limitations, please visit **www.healthcare.gov.**

[4]A Copay applies for the first office visit. Other services are covered as noted.

[5]X-rays usually require two providers' services, one for taking the X-ray, the other for interpreting results. Payments for each may apply and are based on where the work was done.

This Summary of Benefits chart is intended to provide a general outline of coverage. In the event of any conflict between this document and your Certificate of Coverage, Schedule and any applicable Rider(s), your Certificate of Coverage, Schedules and Rider(s) will be controlling. For details, please call 1-800-825-5687, option #2.

Continued on back

Rensselaer-Columbia-Greene Health Insurance Trust Enrollment Application

EMPLOYER USE ONLY

Group Name

Group No. | Sub Group #

Effective Date Requested ____ / ____ / ____

SECTION 1

Your Last Name | First | M.I.

Your Social Security No. ____________

Address

❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Date of Marriage ____ / ____ / ____ Date of Divorce ____ / ____ / ____

City | State | Zip Code

Phone No.: (____) ____________

Employment Status: ❑ Full-time ❑ Part-time ❑ Active ❑ Retired ❑ COBRA

Date of Employment ____ / ____ / ____ Date of Retirement ____ / ____ / ____

SECTION 2

❑ New Enrollment/Reinstatement (complete Section 4)

❑ Change Coverage from __________ to __________ (check new coverage)

❑ Cancel Coverage: (check those that apply)

❑ Add or Delete Dependent: (complete Section 4)

❑ Change Enrollee's Information:

REASON: ____________

Type	Plan Code(s)	Individual	2 Person	Family	Complement to Medicare
BSNENY Indemnity		❑	❑	❑	❑
BSNENY PPO		❑	❑	❑	❑
BSNENY POS		❑	❑	❑	❑
HMO		❑	❑	❑	❑
Dental		❑	❑	❑	❑
Vision		❑	❑	❑	❑
Drug		❑	❑	❑	❑

SECTION 3

OTHER COVERAGE?

Is there coverage under any other group health plan available to you or any member of your family? ❑ No ❑ Yes

If Yes: Policyholder Name | Relationship ❑ Self ❑ Spouse ❑ Child

Social Security Number | Birthdate ____ / ____ / ____

Insurance Co. Name | Policy #

Address

Plan Type ❑ Self Only ❑ Self and Family Coverage Type ❑ Health ❑ Drug ❑ Dental ❑ Vision

SECTION 4

LIST APPLICANT AND ALL ELIGIBLE DEPENDENTS

Copy of Medicare card required

FOR HMO OR POS ENROLLMENT ONLY

ADD	DELETE	Relationship	DEPENDENT NAME Last	First	M.I	Birthdate	Full-Time Student	Social Security#	Medicare A & B Effective Date	Disabled?	Primary Physician - OB/GYN	Existing Patient ✓
❑	❑	Self ❑ M ❑ F				__/__/__		___-___-___	__/__/__ __/__/__	❑ Yes ❑ No	PCP OB/GYN	
❑	❑	❑ Husband ❑ Wife				__/__/__		___-___-___	__/__/__ __/__/__	❑ Yes ❑ No	PCP OB/GYN	
❑	❑	❑ Son ❑ Daughter				__/__/__	❑ Yes ❑ No	___-___-___	__/__/__ __/__/__	❑ Yes ❑ No	PCP OB/GYN	
❑	❑	❑ Son ❑ Daughter				__/__/__	❑ Yes ❑ No	___-___-___	__/__/__ __/__/__	❑ Yes ❑ No	PCP OB/GYN	
❑	❑	❑ Son ❑ Daughter				__/__/__	❑ Yes ❑ No	___-___-___	__/__/__ __/__/__	❑ Yes ❑ No	PCP OB/GYN	

SECT. 5

Do your dependents reside in your home? ❑ Yes ❑ No If No give address:

List names	School Name and Address	Expected Graduation

AGREEMENT: I HAVE READ AND AGREE TO THE AUTHORIZATION ON THE REVERSE SIDE OF THIS FORM.

Applicant's Signature ____________ Date ____________

Employer's Signature ____________

Date ____ / ____ / ____

Enrollment/ Change Form

Delta Dental of New York

One Delta Drive
Mechanicsburg, PA 17055
(800) 932-0783
TTY/TDD (888) 373-3582
www.deltadentalins.com

Please check the applicable box or boxes.

- ☐ New enrollment
- ☐ COBRA
- ☐ Coverage change
- ☐ Name change
- ☐ Address change
- ☐ Change of dependents
- ☐ Termination
- ☐ Decline Coverage

Please check the applicable box or boxes.

- ☐ Delta Dental Premier®
- ☒ Delta Dental PPO℠
- ☐ Delta Dental PPO plus Premier
- ☐ DeltaCare® USA

Primary Enrollee Social Security Number

Last Name | First Name | MI | Date of Birth | Gender ☐ Male ☐ Female

Alternate Identification Number *(if applicable)*

Address (Is this a change of address? ☐ Yes ☐ No) Street | City | State | Zip Code

Group Number: 10254

Sublocation

Group Name: Cairo-Durham CSD

DeltaCare USA Primary Care Dentist *(required for DeltaCare USA enrollees)*

DeltaCare USA Primary Dental Office ID No. *(required for DeltaCare USA enrollees)*

Change of Coverage

New Coverage: | Former Coverage:

Name Change

From | To:

Dependent Change

Please check one of the boxes: ☐ Add dependent(s) listed below ☐ Delete dependent(s) listed below

Do you or your dependents have other dental coverage?

☐ Yes ☐ No *If yes, please complete the following:* Carrier Name and Address: Group Number:

Last name (if different)	First Name	MI	Gender	Date of Birth	Social Security Number
Spouse			M F		
Children			M F		
			M F		
			M F		
			M F		
			M F		

Date of Hire: | Effective Date: | Primary Enrollee Signature

Any person who knowingly and with intent to defraud any insurance company or any 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 be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

DENTAL REFUSAL FORM

I hereby decline the Delta Dental Insurance as offered at this time by the Cairo-Durham Central School District.

______________________________ ______________________________

Signature *Date*

Medicaid and the Children's Health Insurance Program (CHIP) Offer Free Or Low-Cost Health Coverage To Children And Families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.**

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of January 31, 2012. You should contact your State for further information on eligibility –

ALABAMA – Medicaid	**COLORADO** – Medicaid
Website: http://www.medicaid.alabama.gov Phone: 1-855-692-5447	Medicaid Website: http://www.colorado.gov/ Medicaid Phone (In state): 1-800-866-3513 Medicaid Phone (Out of state): 1-800-221-3943
ALASKA – Medicaid	
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	
ARIZONA – CHIP	**FLORIDA** – Medicaid
Website: http://www.azahcccs.gov/applicants Phone (Outside of Maricopa County): 1-877-764-5437 Phone (Maricopa County): 602-417-5437	Website: https://www.flmedicaidtplrecovery.com/ Phone: 1-877-357-3268
	GEORGIA – Medicaid
	Website: http://dch.georgia.gov/ Click on Programs, then Medicaid Phone: 1-800-869-1150

IDAHO – Medicaid and CHIP	MONTANA – Medicaid
Medicaid Website: www.accesstohealthinsurance.idaho.gov Medicaid Phone: 1-800-926-2588 CHIP Website: www.medicaid.idaho.gov CHIP Phone: 1-800-926-2588	Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Phone: 1-800-694-3084
INDIANA – Medicaid	**NEBRASKA** – Medicaid
Website: http://www.in.gov/fssa Phone: 1-800-889-9948	Website: http://dhhs.ne.gov/medicaid/Pages/med_kidsconx.aspx Phone: 1-877-255-3092
IOWA – Medicaid	**NEVADA** – Medicaid
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562 **KANSAS** – Medicaid Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900
KENTUCKY – Medicaid	**NEW HAMPSHIRE** – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: www.dhhs.nh.gov/ombp/index.htm Phone: 603-271-5218
LOUISIANA – Medicaid	**NEW JERSEY** – Medicaid and CHIP
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447 **MAINE** – Medicaid Website: http://www.maine.gov/dhhs/OIAS/public-assistance/index.html Phone: 1-800-572-3839	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 1-800-356-1561 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK** – Medicaid
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA** – Medicaid and CHIP
Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone: 1-800-657-3629	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA** – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604

OKLAHOMA – Medicaid and CHIP	UTAH – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://health.utah.gov/upp Phone: 1-866-435-7414
OREGON – Medicaid and CHIP	**VERMONT**– Medicaid
Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-877-314-5678	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA** – Medicaid and CHIP
Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462	Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647
RHODE ISLAND – Medicaid	**WASHINGTON** – Medicaid
Website: www.ohhs.ri.gov Phone: 401-462-5300	Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm Phone: 1-800-562-3022 ext. 15473
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA** – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability
SOUTH DAKOTA - Medicaid	**WISCONSIN** – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING** – Medicaid
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: http://health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531

To see if any more States have added a premium assistance program since January 31, 2012, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Ext. 61565

OMB Control Number 1210-0137 (expires 09/30/2013)