Continuation of Health Care and Dental Coverage Notice
Effective July 1, 2023

You are receiving this Notice because your coverage under the RCAB Health and/or Dental Plan(s) will end due to one of the following:

- End of Employment
- Death of employee
- Entitlement to Medicare
- Reduction in hours of employment
- Divorce or legal separation
- Loss of dependent child status

This notice has important information about your right to continue your health and/or dental coverage under one of the RCAB Health Plans as well as other health coverage options that may be available to you. Please read the information in this notice very carefully before you make your decisions. If you choose to elect Continuation of Coverage (COC), you should use the enclosed Election Form.

The Health and Dental Plans of the Archdiocese of Boston Health Benefit Trust are church plans and as such are exempt from COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985). COBRA is a law that allows employees losing coverage due to a qualifying event to elect to continue their health and dental insurance coverage(s) through the employer's plan at group rates.

As a service to our staff members and their eligible dependents, the Archdiocese provides a form of continuation of coverage for a period of **up to 12 months**. If you were an employee and your coverage was extended past the month in which the termination event occurred, even if paid for by your former employer, the maximum period for your COC will be reduced. Please note that staff members who are eligible to enroll in Medicare are **not eligible** to elect continuation of Health Plan coverage. Staff members may be Medicare eligible for one of the following reasons: (1) they are **age 65 and over; or (2) they are under age 65 but have qualifying disabilities as determined by Medicare (ex. End Stage Renal Disease, ALS)**. For those who are age 64 and electing COC for their Health Plan, COC coverage will terminate on the last day of the month prior to the participant's 65th birthday. Regarding continuation of Dental Plan coverage, staff members may enroll in COC dental coverage regardless of age.

Coverage for eligible participants begins the first of the month following active employee coverage termination date. The Participant is responsible for payment of the unsubsidized monthly premium as set by the Trustees of the Plans.

Visit bostoncatholicbenefits.org/health/health.htm for information on the Health Plans or bostoncatholicbenefits.org/dental/dental.htm for information on the Dental Plan.

You may have other options available to you when you lose group health coverage.

You may be eligible to buy an individual plan through the Health Insurance Marketplace. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Please see the enclosed document titled **New Health Insurance Marketplace Options and Your Health Coverage** or visit HealthCare.gov or call 1-800-318-2596 for additional information. For Massachusetts residents, you can also visit mahealthconnector.org or call 1-877-MA-ENROLL (1-877-623-6765).

You should also explore additional coverage options you may have, including:

- Coverage through a spouse's or parent's plan (you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible, even if that plan generally doesn't accept late enrollees)
- Medicare and/or Social Security (medicare.gov or socialsecurity.gov)

If you wish to elect COC for the RCAB Health and/or Dental Plans:

- Complete the enclosed election form and Direct Debit Authorization Form and return them to the Benefits Office (contact information is listed below), **postmarked no more than 60 days after your active employee coverage termination date**. Please note that you cannot pay for COC premiums with Health Savings Account (HSA) funds.
- You (and your spouse, if enrolled) are not eligible to earn HSA dollars through participation in the RCAB Health Benefit Trust's Wellness Program **if enrolled in the HDHP under COC**.
- If you are currently enrolled in the individual plus one or family plan as an active employee, you have the option of enrolling in the individual plan for purposes of COC.
- You may elect to enroll in a different medical plan (Enhanced, Basic, HDHP) as long as you had medical coverage prior to coverage termination. Note, if you switch coverage to the HDHP on July 1, 2023 or later, you will lose any available HRA funds.
- Coverages cannot be changed, except for terminated, unless you have an approved qualifying life event or you are making a change during annual open enrollment (May/June).
- Payments will be debited per the Direct Debit Authorization Form on the 5th business day of each month for the current month's coverage. Payments rejected or not made in a timely manner will result in cancellation of coverage.
- If you wish to cancel your Health and/or Dental Plan coverage prior to exhausting the maximum continuation benefit period, please notify the Benefits Office in writing no later than the 25th of the month prior to your desired last month of coverage. For example, to cancel coverage as of September 1, notice must be provided in writing to the Benefits Office by August 25. If notice is not received by that date, you will be charged for coverage for the following month. Coverage will end at 11:59 pm on the last day of the month of coverage.

Note: Once your coverage has been terminated, reinstatement through COC will not be permitted.

Contact Information

Benefits Administration Office

Mailing Address: RCAB Lay Benefits Office, 66 Brooks Drive, Braintree, MA 02184
Phone Number: 617-746-5640
Fax: 617-779-4567
E-mail: benefits@rcab.org

For questions about this Notice or Continuation of Coverage options, please contact the RCAB Health Plan Administrator, Carol Gustavson, at (617) 746-5830 or cgustavson@rcab.org.

Continuation of Health Care and Dental Coverage
Election Form
Effective July 1, 2023

Name _____ Phone# _____

E-mail Address _____

Home Address _____

Most recent employer name and town: _____

Effective Date of New Coverage: _____ 1, 20____
(must be first of the month following end of active employee coverage)

By selecting one or more options and signing below, I acknowledge that I understand the Notice enclosed with this form and am aware of my rights concerning the election of continuation of the Archdiocese of Boston Health and/or Dental Plan coverage. I understand that if I terminate my Continuation of Coverage before the expiration of 12 months of coverage, reinstatement through Continuation of Coverage will not be permitted.

Coverage Type	Monthly Premium
☐ Blue Cross **Enhanced** Individual Health Plan	$ 832.53
☐ Blue Cross **Enhanced** Individual + One Health Plan (please see page 2)	$1,872.59
☐ Blue Cross **Enhanced** Family Health Plan (please see page 2)	$ 2,330.31
☐ Blue Cross **Basic** Individual Health Plan	$ 707.80
☐ Blue Cross **Basic** Individual + One Health Plan (please see page 2)	$ 1,592.03
☐ Blue Cross **Basic** Family Health Plan (please see page 2)	$ 1,981.19
☐ Blue Cross **HDHP** Individual Health Plan	$ 607.76
☐ Blue Cross **HDHP** Individual + One Health Plan (please see page 2)	$ 1,366.98
☐ Blue Cross **HDHP** Family Health Plan (please see page 2)	$ 1,701.14

Please note that you (and your spouse, if enrolled) are not eligible to earn HSA dollars through the RCAB Health Benefit Trust Wellness Program if enrolled in the HDHP under COC. In addition, you cannot pay for COC premiums with HSA funds.

☐ Individual Dental	$ 48.32
☐ Family Dental (please see page 2)	$ 110.64

The cost for Plan coverage is subject to change. The Archdiocese of Boston Health Benefit Trust and the Plan Administrator retain the right, in its/their sole discretion, to change, amend, or discontinue these benefits.

If enrolling dependents, please complete the dependent section below.

Participant Signature _____ Date _____

In order to activate your coverage, mail or fax a completed Election Form and Direct Deposit Authorization Form to the address below. **The Forms must be postmarked no later than 60 days after your active employee coverage termination date.** For retroactive enrollments, outstanding payments will be debited per the Direct Deposit Authorization Form on the 5th business day of the month following receipt.

Archdiocese of Boston Lay Benefits Office
66 Brooks Drive, Braintree, MA 02184
Phone Number: 617-746-5640 Fax: 617-779-4567 benefits@rcab.org

Please complete the below if enrolling in Individual + One or Family Coverage for Medical and/or Dental.

Dependents to be Enrolled:

Relationship	Name

RCAB Health Benefit Trust Continuation of Coverage
Direct Debit Authorization Form

To enroll in Continuation of Coverage, all participants must complete this form and attach a voided check. Participant should also confirm with their bank that the account is set up for debit EFT/ACH transactions. All premiums will be pulled on the 5th business day of each month. Please ensure that sufficient funds are available in the account prior to this date each month.

Participant Information
Former Employee Name: _____

Banking Information
Name on Bank Account: _____

Routing Number: _____

Bank Account Type Checking ☐ Savings ☐

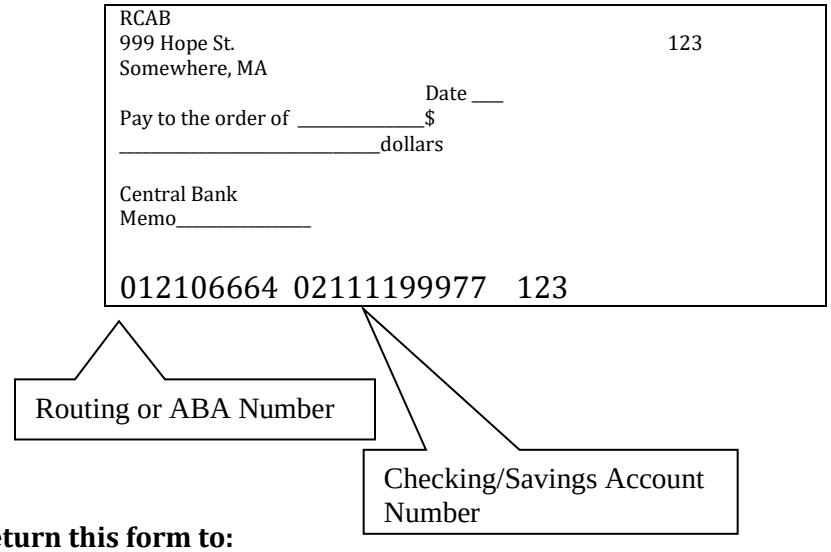
Bank Name: _____

Bank Account Number: _____

By my signature below, I hereby authorize the Roman Catholic Archdiocese of Boston and/or its Benefit Trusts to debit my account in the amount(s) denoted on my Continuation of Coverage (COC) Election Form for all months for which I have COC coverage.

Signature of Authorized Signer _____

Routing Number – this is the first group of 9 numbers on the bottom left part of the check
Bank Account Number – this is the group of numbers immediately after the routing number
Bank Name - as it appears on the check



Please return this form to:
RCAB Lay Benefits Office, 66 Brooks Drive, Braintree, MA 02184
Fax: 617-779-4567