RCAB Health Plan Frequently Asked Questions

Updated 7/1/2020

Section A: RCAB Health Plans in General

A1. What changes were made to the Health Plan effective July 1, 2020?

- The Health Plan has changed to a Preferred Provider Organization (PPO) plan design. Employees and family members will no longer need referrals to see other providers, including specialists. In addition, the Blue Cross PPO network is national, and enrolled family members who live outside of New England will enjoy expanded access to in-network care.

- The Health Benefit Trust now offers an Individual +1 Tier. Employees enrolled in the Family tier who had only one enrolled dependent were automatically moved to the Individual + 1 tier, effective July 1, 2020. This tier is a less expensive option than the Family tier and provides coverage for an employee plus a spouse (or dependent child, up to age 26).

- Diagnostic Lab and X-ray services are no longer subject to a deductible and co-insurance. Enrolled employees and family members are only responsible for an office visit co-pay, at the same level charged for an office visit with their PCP ($25 Enhanced, $30 Basic).

- The Health Plans include coverage for up to 12 acupuncture visits each Plan Year for enrolled employees and dependents. The office visit co-pay is the same level charged for an office visit with a PCP.

A2. Is the requirement that employees work 1,000+ hours/year still in place? Will this change in the future?

The minimum 1,000 hour per year requirement (sometimes expressed as minimum 20 hours per week for employees who work year-round/24 hours per week for employees who work 10 months per year) will remain in effect through at least June 30, 2021. The Trustees may decide to increase the required annual hours in future Plan years, consistent with applicable laws. Any changes made by the Trustees will be communicated in advance so that employees have an opportunity to make decisions about health plan coverage well in advance of an effective date.

Section B: Enrollment

B.1. Can I choose from more than one Health Plan?

Yes, the RCAB Health Benefit Trust offers the choice of two Health Plan options: Enhanced and Basic. The Plans have different deductibles, co-insurance, and co-payments. You can view the differences

between these two Plans in the Summary of Benefits and Coverage documents located at www.catholicbenefits.org/health/healthplan_info.htm.

B2. What are the rules for making a benefit election outside the annual Open Enrollment period?

The rule for changing coverage due to "life events," also sometimes known as "qualifying events," is that an employee must make a request for a change in coverage (adding or dropping dependents, adding or dropping coverage, etc.) within 30 days of a life event, such as marriage, birth of a child, loss of other coverage, etc. These requests are handled through the MyEnroll system.

Due to the COVID-19 pandemic, however, the 30-day requirement has been extended for elections to **enroll** in the Archdiocese Health Plans after a qualifying life event. More information about the extension can be found at www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/covid-19.pdf.

B3. I am enrolling in the Health Plan for the first time. When will I receive an ID card from Blue Cross ?

ID cards are usually issued by Blue Cross within 10 business days of enrollment. If care is scheduled before an ID card is received, please contact the Benefits Office at (617) 746-5640 or benefits@rcab.org to obtain your Blue Cross ID number.

B4. How much will I pay on a per paycheck basis for the Enhanced Plan? For the Basic Plan?

Payroll deductions for the Enhanced and Basic Plans are set by each location. You can log in to MyEnroll during Open Enrollment each year to see the deduction amounts for each Plan.

Section C: Physicians, Hospitals, Other Providers, and Treatment in Process

C1. How can I determine if the physician/hospital/other providers my family and I currently see are part of the Blue Cross network?

The best way to determine if a provider is part of the Blue Cross network is to search the provider database at www.bluecrossma.org/myblue. Select "Find Care" and then "Find a Doctor." Select "PPO or EPO" in the dropdown menu before entering a provider name into the Search box. A detailed Guide on how to search the Blue Cross provider database is available at www.catholicbenefits.org/newplans/findaprovider.pdf.

C2. Can I see a health care provider virtually rather than in person?

Yes, so long as you have an internet connection and a smartphone, tablet, or computer with webcam, you can visit medical and mental health providers for minor medical and behavioral health care through Well Connection, the Blue Cross telehealth medicine platform. Co-payments are less than co-payments

for a PCP office visit. You simply download the Well Connection app to use these services 24 hours a day, 7 days per week. These providers can look up your medical history, diagnose and treat your symptoms, and prescribe medication if necessary.

To help reduce the spread of the COVID-19 virus, employees and family members enrolled in the Archdiocese of Boston Blue Cross Health Plans are encouraged to use Well Connection if they feel they may have symptoms of the virus. Co-payments for use of Well Connection are waived. More information is available at catholicbenefits.org/PDF/health/telehealth.pdf. Blue Cross also offers the Blue Care Nurse Hotline (888-247-2583), which provides another method to seek clinical guidance for questions about the virus.

Section D: Co-Pays, Deductibles, and Co-Insurance

D1. How does the deductible work with the Blue Cross Plans? Is every service received from a physician or hospital subject to the deductible?

Enrolled employees are responsible for the first dollar of claims for certain non-preventive services received, up to the stated limit, at which point the Health Plan will begin paying claims. Even after the deductible is reached, co-pays are still due for services for which there is a co-pay (ex: sick visits, specialist visits, physical therapy, acupuncture or chiropractor visits, ER services). This is similar to a deductible with other insurance, such as auto or homeowner's insurance.

D2. What is the purpose of an annual "out-of-pocket maximum"?

The "out-of-pocket maximum" (OOPM) serves as a cap on all payments an employee or family member makes to pay for health care during a Plan Year. This includes deductibles, co-payments, and co-insurance. It does not include payroll deductions. Our Plan Year is July 1 to June 30 each year.

D3. Are there deductibles for prescriptions? Are there separate annual "out-of-pocket maximums" for medical services and prescriptions?

There are no deductibles for prescriptions under either the Enhanced or the Basic Plans. There are separate OOPMs for medical services and prescriptions for both the Enhanced and the Basic Plans.

D4. For families who are enrolled in the Health Plan, does each family member need to pay the full deductible each Plan Year?

The deductible can work in two ways: (1) two individuals in a family plan can each satisfy the full deductible for the year, which means that there are no deductibles for additional family members for the remainder of the Plan Year; or (2) more than two members in a family can pay towards a deductible, and although none has paid in her/his full deductible, as a family, the family deductible limit is reached, which means that NO family members have any further deductibles for the Plan Year.

D5. For families who are enrolled in the Health Plan, does each family member need to satisfy the OOPM each Plan Year before costs are capped for other family members?

Similar to the deductible question in D4, the OOPM can work in two ways: (1) two individuals in a family plan can each reach his/her individual OOPM for the year, which means that there are no out-of-pocket costs (e.g., co-payments, deductibles, co-insurance) for additional family members for the remainder of the Plan Year; or (2) more than two members in a family can pay towards the OOPM, and although none has met the individual OOPM, as a family, the family deductible limit is reached, which means that NO family members have any further out-of-pocket costs for the Plan Year.

D6. What is "co-insurance"? There are references to a range of numbers on this line in the Plan Summaries, from 60% to 90%.

Co-insurance is the amount of medical expenses an enrolled employee or family member will be responsible for after a deductible is satisfied. For example, an employee enrolled in the individual Enhanced Plan receiving an MRI that costs $900 will be responsible for the $500 deductible, and then 10% of the remaining balance ($900 - $500 = $400). The 10% co-insurance cost is $40. Note that the $500 individual deductible is only paid once per Plan Year.

D7. Could the deductible, co-insurance and OOPM amounts increase in future Plan Years?

Yes, these amounts could increase or decrease in future Plan Years. Any changes will be described in the applicable Summary of Benefits & Coverage, distributed each year with Open Enrollment materials.

Section E: Prescription Services

E1. Is there a separate ID card for prescription services?

Yes, you will receive a new CVS/Caremark ID card upon enrollment in either of the Enhanced or Basic Plans.

E2. Do I need to use a CVS pharmacy for my prescriptions?

No. You are not required to use a CVS pharmacy. You can use any pharmacy within the Caremark network, which includes many national chains and local pharmacies. You can determine which pharmacies are in the Caremark network by visiting www.caremark.com/wps/myportal/PHARMACY_LOCATOR_FAST

E3. Is mail order still an option under the Blue Cross Plans? Will I have to pay extra if I fill maintenance medications on a 30-day basis?

The Plans continue to encourage use of mail order or at a CVS retail pharmacy with a 90-day prescription for maintenance medications. Please review the information at

www.catholicbenefits.org/health/rx.htm for details on the financial benefits of filling maintenance prescriptions with 90-day fills through mail order or from a CVS retail pharmacy.

E4. Is the CVS Minute Clinic $5 co-pay still in place?

Yes. Please visit www.cvs.com/minuteclinic for more information about the services available at these convenience urgent care clinics.

E5. Which card do I use for my CVS Minute Clinic visit?

You should present your Blue Cross Member ID card for your visit at a CVS Minute Clinic. You can find a CVS Minute Clinic near you by visiting www.cvs.com/minuteclinic/clinic-locator.

Section F: Wellness

F1. Can I earn HRA dollars through a Wellness Program with Blue Cross? What are the annual maximum amounts?

The Blue Cross Plans provide access to a robust Wellness Program through the *ahealthyme* portal. General information about the Blue Cross Wellness Program is available after registering with www.ahealthyme.com/login. Employees and spouses will continue to be able to earn incentives for completing wellness activities, which will be deposited to a Health Reimbursement Account (HRA) with HealthEquity. The annual maximum amounts have increased to $1,000 per year per enrolled employee and spouse, until at least June 30, 2021.

F2. How do I pay for out-of-pocket medical costs with HRA dollars?

HealthEquity manages the HRA account in which you accumulate HRA dollars. When you participate in wellness activities, you earn HRA points. Each point can be used as one dollar in your HRA account. HealthEquity mails a credit card to you once you begin earning HRA dollars. The card works like a debit card and can be used for payment of out-of-pocket medical costs. More information about HRA accounts with HealthEquity can be found at www.catholicbenefits.org/health/wellness.htm.

F3. What happens to my unused HRA dollars at the end of the Plan Year? Can I still use them in the following Plan Year?

Yes, enrolled employees and spouses who have earned HRA dollars may use them for co-pays for medical services and prescriptions for themselves and any enrolled family members, as long as those members remain enrolled in one of the RCAB Health Plans. For out-of-network services, HRA dollars can be used towards the deductible and co-insurance.

F4. Can I use my HRA dollars to pay for dental, vision, and other expenses?

Yes, employees and spouses who have earned HRA dollars can use them for co-pays for medical services and prescriptions, qualified out-of-pocket dental and vision expenses, certain over-the-counter medical expenses, and menstrual care products. Additional information about what additional expenses are "qualified" is available at www.catholicbenefits.org/health/wellness.htm under the HealthEquity Health Reimbursement Accounts (HRA) section.

F5. Is the Wellness Rewards Program (reimbursements for wellness expenses such as gym memberships, fitness tracker purchases, etc., funds deposited into HRA accounts) still available?

Yes, the Wellness Rewards Program will continue to be available. For more information on the Wellness Rewards program, visit www.catholicbenefits.org/health/wellness.htm and scroll down to Wellness Rewards.

F6. Is a Worksite Wellness Nurse still available for on-site visits?

No, at this time we do not have a Worksite Wellness Nurse on staff who can visit locations and meet with employees. We hope to offer this resource sometime in the future.

F7. I don't understand the difference between Health Coaching and Care Management. Are both options available to me?

Employees and spouses enrolled in the RCAB Health Plans can only participate in one of these wellness activities. Health Coaching involves working with a Blue Cross Blue Shield certified Wellness Coach who can provide one-on-one support to help meet a personal health goal. These goals may be related to nutrition, weight, smoke cessation, or stress management. Care Management is only offered to those with chronic or complex health conditions. A nurse coach will reach out to those who are eligible for Care Management.

F8. I noticed that if I serve as a Wellness Champion, I could earn up to 150 HRA points. Does serving as a Wellness Champion require significant time and effort?

Wellness Champions help promote the RCAB wellness programs and serve as a resource for their worksites regarding wellness and the RCAB Health Plans. They are expected to participate in monthly calls (once a month for approximately a half hour) and engage in activities designed to increase participation in the wellness programs. Based on feedback from current Wellness Champions, the time commitment is reasonable.

Section G: Miscellaneous

G1. Will there be any change to the exclusion of services that are considered in conflict with Catholic teachings?

No. All current exclusions of services that conflict with Catholic teachings will continue to be excluded under the Blue Cross Plans. For information about these services, please review the Summary of Benefits & Coverage currently in effect at www.catholicbenefits.org/health/healthplan_info.htm.

G2. I have a very specific question about a provider or a health condition for which I am seeking treatment. How can I contact someone at Blue Cross to obtain an answer?

Blue Cross Member Services will be available by phone to answer questions about specific providers, treatment plans, coverage, and benefits at (800) 832-3871.

G3. How can I learn more about making a decision that is right for me?

Before annual Open Enrollment, you are encouraged to review all material posted online at www.catholicbenefits.org/newplans and to contact the Benefits Office at (617) 746-5640 or benefits@rcab.org. You should also attend any webinars or meetings offered to you. The information posted online will be updated periodically every May.

G4. I am turning 65 and currently enrolled in one of the RCAB Health Plans. I am not sure if I should enroll in Medicare. If I enroll in Medicare Parts A and B, do I lose my coverage with the Archdiocese of Boston? Are there any advantages associated with enrolling in Medicare?

No, you don't lose your coverage in the RCAB Health Plan unless you submit a life event in MyEnroll and elect to disenroll from the Plan. The Health Plan Trustees elected to implement a program that allows Medicare to become the primary payer of medical expenses for eligible employees and spouses who are employed at locations with fewer than 20 employees. If you work at such a location, you may be eligible to participate in this program.

Because Medicare Part B pays for common expenses in full or with a lower out-of-pocket cost than the RCAB Health Plan, enrollment in Medicare Part B would allow you to avoid or reduce payment of these out-of-pocket expenses. You would also be entitled to the following ***enhanced*** benefits:

- Free urgent care visits to CVS MinuteClinics
- $100 annual reimbursement for eyeglasses or contact lenses
- $5 co-pays for generic prescriptions on the Enhanced Blue Cross Plan ($10.00 for 90-day supply if purchased through mail order)

In addition, if you or your spouse enrolls in Medicare Parts A and B and participates in the Medicare Primary Payer program, the overall premium charged to your employer will be reduced by 10%, which will in most cases result in cost savings of more than 10%. For questions about the Medicare Primary Payer program, contact the Benefits Office at benefits@rcab.org. You may also learn more about the program by visiting www.catholicbenefits.org/health/medicare.htm.