Continuation of Health Care and Dental Coverage Notice

You are receiving this Notice because your coverage under the Plan 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 the RCAB Health Plan, 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 chose to elect Continuation of Coverage, you should use the enclosed Election Form.

The medical 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 (*e.g.*, per the RCAB Severance Policy), even if paid for by your former employer, the maximum period for your Continuation of Coverage will be reduced. Please note that staff members age 65 and over (*i.e.*, those who are Medicare eligible) are not eligible to elect continuation of medical coverage. For those who age 64 and electing Continuation of Coverage, this coverage will terminate the last day of the month prior to the participant's 65th birthday.

Coverage for eligible participants begins the first of the month following the coverage termination date. The Participant is responsible for payment of the unsubsidized monthly premium, plus an applicable administrative fee of up to 2% of the monthly premium. Enclosed is the Summary of Benefits and Coverage (SBC) for the RCAB Health 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 www.HealthCare.gov or call 1-800-318-2596 for additional information. For Massachusetts residents, you can also visit www.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 (www.medicare.gov or www.socialsecurity.gov)

If you wish to elect Continuation of Coverage through the RCAB Health and/or Dental Plan:

- The election form and payment must be returned to the Benefits Office **within 60 days of your coverage termination date**.
- If you are currently enrolled in the family plan, you have the option of enrolling in the individual plan for purposes of continuation.
- Payments are due no later than the 25th of the month for the following month's coverage. Payments not made in a timely manner will result in the cancellation of coverage.
- Please make checks payable to: RCAB Health Benefit Trust. On the memo line of the check, please indicate the month the payment is being submitted for along with the full name of the participant who has elected COC.
- If you wish to cancel your medical and/or dental coverage prior to exhausting the maximum continuation benefit period, please notify the Benefits Office in writing, specifying the month you would like to terminate your coverage. Coverage will end at 11:59 pm on the last day of the month indicated in the cancellation notice.

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

If you wish to decline Continuation of Coverage through the RCAB Health Plan, please return the Election Form with this selection indicated.

Benefits Administration Office
Mailing Address: RCAB Benefits Office, 66 Brooks Drive, Braintree, MA 02184
Phone Number: 617-746-5642 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

Name _____Phone#_____

E-mail Address_____

Home Address _____

Date of Birth_____ SSN_____

Please check one of the following:

_____ DECLINE COVERAGE - IRREVOCABLE ELECTION: By selecting this option and signing below, I acknowledge my understanding that the decision to decline continuation of the Archdiocese of Boston Health and Dental Plan coverage is final and the decision cannot be reversed.

_____ ELECT COVERAGE: By selecting this option and signing below, I acknowledge that I understand this notice 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*
❑	Individual Medical	$ 759.17
❑	Family Medical	$1,953.31
❑	Individual Dental	$ 46.69
❑	Family Dental	$ 106.90

Dependents to be Enrolled (please use additional paper or reverse if needed):

SSN	**Name**	**DOB**
_____	_____	_____
_____	_____	_____
_____	_____	_____

*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.

_____ _____

Participant Signature Date