Continuation of Health Care and Dental Coverage Notice
Effective July 1, 2020

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 (*e.g.,* per the RCAB Severance Policy), 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 www.bostoncatholicbenefits.org/health/health.htm for information on the Health Plans or www.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 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 COC for the RCAB Health and/or Dental Plans:

- Complete the enclosed election form and Direct Debit Authorization Form and return it to the Benefits Office (contact information is listed below), **postmarked no more than 60 days after your active employee coverage termination date**.
- 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.
- Payments will be debited per the Direct Debit Authorization Form on the 1st 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

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	$ 717.06
□ Blue Cross **Enhanced** Individual + One Health Plan	$ 1,612.83
□ Blue Cross **Enhanced** Family Health Plan	$ 2,007.07
□ Blue Cross **Basic** Individual Health Plan	$ 641.87
□ Blue Cross **Basic** Individual + One Health Plan	$ 1,443.70
□ Blue Cross **Basic** Family Health Plan	$ 1,796.60
□ Individual Dental	$ 48.32
□ Family Dental	$ 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.

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

Relationship	**Name**
____________________	______________________________________
____________________	______________________________________
____________________	______________________________________

_______________________________________ ________________

Participant Signature Date

In order to activate your coverage, mail 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 1st business day of the month following receipt.

Archdiocese of Boston Lay Benefits Office
66 Brooks Drive, Braintree, MA 02184
Phone Number: 617-746-5642 Fax: 617-779-4567 benefits@rcab.org

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. Each participant should also confirm with his/her bank that the account is set up for debit EFT/ACH transactions. All premiums will be pulled on the 1st 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

RCAB
999 Hope St. 123
Somewhere, MA
Date ____
Pay to the order of ________________$
_________________________________dollars

Central Bank
Memo________________

012106664 02111199977 123

Routing or ABA Number

Checking/Savings Account Number

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