WHAT IS CONTINUATION COVERAGE?
The Catholic Diocese of Richmond provides for the continuation of the group health plan for terminated employees, employees whose hours of employment have been reduced below 30 hours and are no longer eligible for insurance, and dependents of a deceased or divorced employee for a limited period of time.

Continuation coverage provides the same health and dental benefits coverage that is offered to active employees and their dependents. Each subscriber that elects continuation coverage will have the same rights under the Plan as active employees and their dependents.

HOW LONG WILL CONTINUATION COVERAGE LAST?
The continuation period will commence on the 1st day of the month following the effective date of termination, reduction in hours, or death. The length of the continuation period will be equivalent to the number of months the employee was eligible for health/dental insurance up to a maximum of 18 months. (For example, if you were eligible for coverage for more than 18 months prior to the need for continuation, you are eligible for 18 months of continuation coverage. If you were eligible for coverage for only 7 months prior to needing continuation, you would be eligible for 7 months of continuation coverage.) The continuation coverage will end on the last day of the month of eligibility. If continuation occurs during a period of long-term disability, coverage may continue for up to twenty-nine months or Medicare eligibility, whichever occurs first.

WHAT IS THE COST TO CONTINUE MY COVERAGE?
The cost of continued coverage is 102% of the total premium cost. The affected employee, dependent, or surviving dependents are responsible for the full cost of the continued health care coverage to include a 2% administration fee. Monthly rates are subject to change January 1 of each year at plan renewal. The current monthly rates are listed below:

<table>
<thead>
<tr>
<th></th>
<th>Anthem Blue Cross &amp; Blue Shield</th>
<th>HealthKeepers POS 25/30 Medical Only (no deductible)</th>
<th>HealthKeepers Medical Only ($1000 deductible)</th>
<th>HealthKeepers High Deductible Medical Plan</th>
<th>Anthem Dental Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subscriber Only</td>
<td>$784.46</td>
<td>$731.00</td>
<td>$661.15</td>
<td></td>
<td>$37.94</td>
</tr>
<tr>
<td>Subscriber + Child/ren</td>
<td>$1,083.40</td>
<td>$1,009.20</td>
<td>$914.28</td>
<td></td>
<td>$56.22</td>
</tr>
<tr>
<td>Subscriber + Spouse</td>
<td>$1,277.61</td>
<td>$1,190.30</td>
<td>$1,078.37</td>
<td></td>
<td>$63.65</td>
</tr>
<tr>
<td>Subscriber + Family</td>
<td>$2,328.27</td>
<td>$2,170.06</td>
<td>$1,964.94</td>
<td></td>
<td>$111.70</td>
</tr>
</tbody>
</table>
HOW DO I ELECT CONTINUATION COVERAGE?
The employer should notify the affected employee and/or dependent by providing the Notice of Continuation of Group Health Insurance Coverage upon termination or eligibility for continuation of coverage. The employee and/or dependent should review the notice and return the Election Form (located on pages 3 & 4) to the diocesan Office of Human Resources by the 15th of the month preceding the month of coverage.

Insurance coverage is limited to the plan in which the employee and/or dependent participated immediately prior to the effective date of employment termination, reduction in hours, or death.

HOW DO I PAY FOR MY CONTINUATION COVERAGE?
The affected employee, dependent, or surviving dependents will submit payment of the monthly premium with the initial request for continuation by the 15th of the month preceding the month of coverage. Payment must be made by personal check or money order. Non-payment of the monthly premium by the 30th of the month of coverage will result in cancellation of coverage. Once the continuation of coverage is cancelled, the employee and/or dependent will be ineligible to re-enroll into the plan.

HOW DO I REQUEST TO CANCEL MY CONTINUATION COVERAGE?
Except where benefits expire in accordance with the continuation period maximum as provided in this document, the affected employee or dependent should provide a written request to the diocesan Office of Human Resources for cancellation of plan benefits by the 5th of the month preceding the effective date of cancellation.

FOR MORE INFORMATION
If you have any questions concerning the information in this notice, your rights to coverage, or if you want a copy of your summary plan description, you should contact:

Catholic Diocese of Richmond
Office of Human Resources
7800 Carousel Lane
Richmond, Virginia 23294-4201
Phone 804-622-5233

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES
In order to protect you and your dependent’s rights, you should keep the Office of Human Resources informed of any changes in your address and the addresses of dependents. You should also keep a copy of any communication that you forward to the Office of Human Resources, for your records.
# Catholic Diocese of Richmond

*Notice of Continuation of Group Health Insurance Coverage*  
**Election Form**

## 1. Employee Information

<table>
<thead>
<tr>
<th>Employee Name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Employing Location/Number:</td>
<td></td>
</tr>
<tr>
<td>Social Security Number:</td>
<td></td>
</tr>
</tbody>
</table>

## 2. Continuation Election

Do you wish to continue coverage?  
**Yes**  **No**  (If no, please skip to section 6.)

If yes, please describe reason for continuation:  

Have you filed a disability claim with The Hartford?  
**Yes**  **No**

## 3. Type of Coverage (Please select the coverage(s) you are continuing.)

### Coverage Option:

- [ ] Healthkeepers POS (No Deductible)  
- [ ] Healthkeepers Medical ($1,000 Deductible)

- [ ] Healthkeepers High Deductible Plan  
- [ ] Anthem Dental ONLY

### Medical Level of Coverage:

- [ ] Subscriber Only  
- [ ] Subscriber and Spouse  
- [ ] Subscriber and Child/ren  
- [ ] Subscriber and Family  
- [ ] Waive

### Dental Level of Coverage

- [ ] Subscriber Only  
- [ ] Subscriber and Spouse  
- [ ] Subscriber and Child/ren  
- [ ] Subscriber and Family  
- [ ] Waive

Cost for selected health coverage:  

Cost for selected dental coverage:  

TOTAL COST FOR CONTINUATION:  

(Current rates are listed on Page 1)

## 4. Employee/Subscriber Information

<table>
<thead>
<tr>
<th>Name:</th>
<th>Social Security #:</th>
<th>Date of Birth:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td>Email:</td>
<td></td>
</tr>
<tr>
<td>Phone:</td>
<td>Relationship to Employee:</td>
<td></td>
</tr>
</tbody>
</table>

## 5. Family Information (If electing Employee/Subscriber Only Coverage, skip to Section 6)

### Health Coverage

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship to Employee/Subscriber</th>
<th>Date of Birth</th>
<th>Social Security Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Catholic Diocese of Richmond  
Notice of Continuation of Group Health Insurance Coverage  
Election Form

<table>
<thead>
<tr>
<th>Dental Coverage</th>
<th>Relationship to Employee/Subscriber</th>
<th>Date of Birth</th>
<th>Social Security Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6. SUBSCRIBER SIGNATURE

If you are continuing health and/or dental coverage, you must submit the first month’s premium(s) with this form. Additional enrollment forms may be required, but we’ll contact you if this is necessary. Please be advised that rates are subject to change January 1 of each year at plan renewal. (Current rates are listed on Page 1)

If you are waiving Continuation Coverage, you understand that you can no longer participate in the diocesan health care plans.

You will be billed for subsequent payments monthly. Your payments are due by the 15th of each month. Your check/money order should be made payable to: CDR Health Insurance Plan. Mail your payment and Election Form to: Office of Human Resources, ATTN: Benefits at 7800 Carousel Lane, Richmond, VA 23294.

We may, at any time, request verification of spouse and/or dependent status.

☐ I DO elect to continue Health/Dental Insurance Coverage, continuation coverage effective _________________

☐ I have enclosed my first payment in the amount of $______________

☐ I DO NOT elect to continue the Health/Dental Insurance Coverage, cancellation effective ________________

<table>
<thead>
<tr>
<th>Subscriber Signature</th>
<th>Date</th>
</tr>
</thead>
</table>