THE ROMAN CATHOLIC

ARCHDIOCESE OF ATLANTA

OFFICE OF HUMAN RESOURCES

DECEMBER 2024						
SUN	MON	TUE	WED	THU	FRI	SAT
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24 Christmas Eve	25 Christmas Day	26	27	28
29	30	31 New Year's Eve				

2024 ANNUAL ENROLLMENT
CHANGES DUE DECEMBER 3, 2024

To Our Employees and Their Families:

The Archdiocese of Atlanta provides Group Health Benefits to all full-time employees of the Archdiocese of Atlanta working at least 1,500 hours per year.

The 2025 Annual Enrollment materials are available online on the Archdiocese of Atlanta website: https://archatl.com/offices/human-resources/insurance-information/
Please see the enclosed information sheet containing pertinent annual enrollment and website information.

The 2025 Lay Employee Benefits Quick Guide, Summary of Benefits and Coverage (SBC), The Group Health Care Plan Document and The Hartford Benefit Plan Booklet are available on the Archdiocese of Atlanta website.

The Lay Employee Benefits Quick Guide provides annual mandated notices and an overview of the benefits available to you and your family through the Archdiocese of Atlanta. The Summary of Benefits and Coverage (SBC), The Group Health Care Plan Document and The Hartford Benefit Plan Booklet documents provide essential information about the health coverage options, and the Long-Term Disability and Term Life Benefits offered by the Archdiocese of Atlanta.

Form 1095-C In compliance with the Affordable Care Act, the Archdiocese of Atlanta is required to provide form 1095-C to each employee who had coverage through The Archdiocese of Atlanta Group Health Care Plan at any time during 2024.

Tax form 1095-C will be mailed to you by the IRS mandated deadline.

2401 Lake Park Drive, S.E. • Smyrna, Georgia 30080-8862
404-920-7480 • Fax 404-920-7481 • **archatl.com**

Working Spouse Rule Effective January 1, 2025, the Roman Catholic Archdiocese of Atlanta (RCAA) Group Health Plan will implement **The Working Spouse Rule**. This provision states that if an employee's spouse is eligible for group health coverage under his/her employer sponsored plan, the spouse is not eligible under the RCAA's plan.

This will only impact members with a WORKING SPOUSE who is ELIGIBLE for his/her EMPLOYER'S health coverage. If currently covered, these spouses must be removed from coverage during 2025 Annual Enrollment. *You must complete a Meritain Enrollment/Change form and must complete the Declination of Enrollment on same form.*

Non-working spouses and working spouses **NOT** eligible for their employer's health coverage will **NOT** be impacted.

All members must complete, sign, and return the enclosed certification:
IMPORTANT NOTICE REGARDING SPOUSAL ELIGIBILITY FOR HEALTH INSURANCE.
Enclosed is a return-addressed envelope for your convenience.

Meritain Health continues as the Plan's claims processor. The Aetna Choice Plus POS II continues as our network of providers.

OptumRx continues as our Pharmacy Benefit Manager (PBM).

Health ID Card – Please continue to use your current Meritain Health ID card.

GROUP HEALTH PLAN RATES: Effective January 1, 2025 there will be a slight increase to the monthly premium amounts.

MONTHLY CONTRIBUTION	VALUE PLAN	PREMIER PLAN
Employee Only	$0	$127
Employee & Children	$482	$677
Employee & Spouse	$671	$841
Employee & Family	$693	$858

Please feel free to contact me at (404) 920-7485 or Rosa Montano-Parker at (404) 920-7486 should you have questions or need assistance.

God Bless,

Lily Gallagher
Director of Benefits
Archdiocese of Atlanta

Enclosures

2025 ANNUAL ENROLLMENT

Your 2025 Annual Enrollment materials are available online on the Archdiocese of Atlanta's website:

1. Go to www.archatl.com
2. Click on *Offices* at the top menu
3. Scroll down and select *Human Resources*
4. Click on *Benefits Information* on the right of the screen

You can also go directly to the documents with this link:
http://www.archatl.com/offices/human- resources/insurance-information/

PLEASE NOTE: **If you do not make any changes, you are automatically re-enrolled in your previous elections.**

Do not complete the Meritain form if there are no changes to your existing elections.

IF YOU CHANGE YOUR EXISTING COVERAGE OR MAKE NEW ELECTIONS:

- Complete and sign the Meritain Enrollment/Change Form, also available online.
- If adding spouse, child(ren) or family coverage, please include **proof of relationship documentation** to prevent enrollment from being delayed or denied.
- List each individual to be covered on the enrollment form, even if currently covered. The information on this form will replace all prior information.
- If you do make a change, you will receive a written confirmation of the payroll deduction amount to be effective the first payroll period of 2025.
- Return your completed/signed form to Rosa Montano-Parker no later than **Tuesday, December 3, 2024**.

Annual Enrollment, Employee Benefits Department
Archdiocese of Atlanta
2401 Lake Park Dr. SE
Smyrna, GA 30080

If you would like to request a hard copy of any of these documents, please email your request to rmontano-parker@archatl.com or submit your request in writing to:

The Roman Catholic Archdiocese of Atlanta
Attn: Employee Benefit Office
2401 Lake Park Drive SE
Smyrna, Georgia 30080

THE ROMAN CATHOLIC
ARCHDIOCESE OF ATLANTA
OFFICE OF HUMAN RESOURCES

IMPORTANT NOTICE REGARDING SPOUSAL ELIGIBILITY FOR HEALTH INSURANCE

Effective January 1, 2025, the Roman Catholic Archdiocese of Atlanta (RCAA) Group Health Plan will implement **The Working Spouse Rule.** This provision states that if an employee's spouse is eligible for group health coverage under his/her employer sponsored plan, the spouse is not eligible under the RCAA's plan.

Please initial one of the following and sign below as indicated.

______ I do not have a spouse.

______ My spouse is enrolled in the RCAA Group Health Plan and is not employed.

______ My spouse is enrolled in the RCAA Group Health Plan and is self-employed or is an independent contractor.

______ My spouse is employed and does not have group health coverage available through his/her employer.

______ My spouse is employed and does have health coverage available through his/her employer. I understand that my spouse is no longer eligible for the RCAA Group Health Plan and must be disenrolled in the RCAA Group Health Plan.

(Employee must complete the Declination of Enrollment on the Meritain Enrollment/Change form.)

______ I have **not** elected to enroll my spouse in the RCAA Group Health Plan.

(Employee must complete the Declination of Enrollment on the Meritain Enrollment/Change form.)

If your spouse loses or obtains group health coverage through his/her employer, you have 31 days to notify Employee Benefits of such change, in writing and with supporting documentation.

I certify that the information provided on this form is a true and correct representation.

I understand that if my spouse's group health coverage status changes, it is my responsibility to notify Employee Benefits in writing within 31 days of such change.

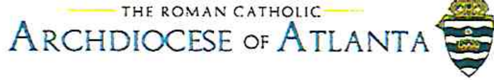
I understand that false and deliberate misrepresentation on this or future forms shall be considered grounds for disciplinary action, including dismissal; may result in termination of this dependent's health coverage; and may result in requiring reimbursement of all claims paid by RCAA Group Health Plan.

Employee's printed name ____

Employee's signature ______________________________ Date ________________

EMPLOYEE ENROLLMENT/CHANGE FORM

Meritain Health® an aetna company



THE ROMAN CATHOLIC ARCHDIOCESE OF ATLANTA

APPLICATION BEING MADE FOR: HEALTH PLAN

(Check One):

- ○ EMPLOYEE COVERAGE
- ○ EMPLOYEE + SPOUSE COVERAGE
- ○ EMPLOYEE + CHILD(REN) COVERAGE
- ○ EMPLOYEE + FAMILY COVERAGE

Plan Option Selection:

- ○ Value Plan
- ○ Premier Plan

For completion by employer:

Application being made for:

- ○ New employee coverage
- ○ Special enrollee (attach proof)
- ○ Late enrollee/open enrollment

EMPLOYEE NAME - LAST, FIRST, MIDDLE INITIAL	DATE OF BIRTH (type)	SEX MALE ○ FEMALE ○	SOCIAL SECURITY NO.
HOME ADDRESS	CITY	STATE	ZIP CODE	AREA CODE PHONE NUMBER
SPOUSE ADDRESS (if different)	CITY	STATE	ZIP CODE	AREA CODE PHONE NUMBER
MARITAL STATUS ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed Date:	DIVISION (Select One) ☐ 01 - PRIESTS ☐ 02 - LAY ☐ 03 – SEMINARIANS ☐ 04 - RELIGIOUS			
EMPLOYER: Roman Catholic Archdiocese of Atlanta	LOCATION NAME	EMAIL ADDRESS (optional)		

If you are adding a dependent, you may need to provide additional documentation to prove their eligibility.

PRINT NAMES OF DEPENDENTS APPLYING FOR COVERAGE: (LAST, FIRST) (LIST THE NAME OF EVERY DEPENDENT THAT WILL BE COVERED)	SOCIAL SECURITY NUMBER	LEGAL RELATIONSHIP: SPOUSE, CHILD, STEP-CHILD, ETC	GENDER: (M / F)	DATE OF BIRTH MO DAY YR

I hereby authorize any health plan, provider of health care services or their Business Associates who have any records, knowledge, or Protected Health Information of me or any family member for whom coverage is requested, to share the information with Corporate Benefit Services of America, Inc., and its Business Associates who provide services for the health plan described herein, for the purposes of determining eligibility for enrollment or underwriting for me and for my family members for the health plan. A photographic copy of this authorization shall be as valid as the original.

I hereby request the amount(s) and Benefits for which I am or may become eligible and hereby authorize my employer to deduct the required contributions, if any, from my earnings.

I certify that the information I have set forth in this application is true and correct to the best of my knowledge. No information has been knowingly withheld or omitted concerning me or my dependents. I understand that providing false information in this application is a crime and may result in the denial of claims or cancellation of coverage. In addition I may be subject to civil and/or criminal penalties.

X____ ____________________

Sign your name, DO NOT PRINT OR TYPE Date

Providing the above authorization makes it possible to determine your eligibility for enrollment in this health plan. As described in the Notice of Privacy Practices, you may revoke this authorization at any time as provided by applicable law and except to the extent that this authorization has been relied upon.

FOR EMPLOYER USE ONLY/EMPLOYEE BENEFITS OFFICE:

DIVISION # ______________ LOCATION # ______________ DATE OF FULL TIME EMPLOYMENT ________________

EFFECTIVE DATE OF CHANGE / COVERAGE ________________ ORIGINAL PART TIME HIRE DATE ________________

WHAT IS THE MINIMUM NUMBER OF HOURS WORKED PER WEEK? ________________

Comments: ____

FOR MERITAIN HEALTH USE ONLY:

- ☐ Timely
- ☐ Late
- ☐ Special
- ☐ New

Prior Plan Credits

Wait Start

Cert Start ________________

Cert End

Group Number 10974

Effective Date

Account Rep

LF _____ MD _____ DI _____ DN _____ DL _____ OTH _____ VS _____ 24 _____ SAL _____ LTD _____ PPO _____

DEPT _____ LIFE2 _____ CV SUFFIX _____ COMMENTS: ________________ RETURN TO REP: ________________

OTHER COVERAGE INFORMATION

This information you provide about other coverage will be used to coordinate benefits with any other group health plan you may have. Please provide the month, day and year for effective dates of coverage.

1. Will your dependents continue to be covered under another health insurance or dental plan while covered by this plan?
   Medical ☐ Yes ☐ No   Dental ☐ Yes ☐ No
   If yes, please answer the following:
   a. Name of policy holder__________ Date of birth __________
   b. If this coverage is through your spouse's employer, please list the employer's name: __________
   c. If this is not through an employer, please list the source of other coverage: __________
      Name of medical insurance company__________ Telephone number __________
      Name of dental insurance company__________ Telephone number __________
   d. Who will continue to be covered: ☐ Spouse ☐ Children
      List names of covered persons:__________
   e. Effective date of medical policy__________ Type of plan: ☐ Group ☐ Individual ☐ COBRA ☐ Other
   f. Term date of medical policy __________
   g. Effective date of dental policy__________ Type of plan: ☐ Group ☐ Individual ☐ COBRA ☐ Other
   h. Term date of dental policy __________

MEDICARE INFORMATION

1. Do your dependents currently have Medicare coverage? ☐ Yes ☐ No
   (If yes, please answer the following:)

a. If you or your spouse are retired, please supply the retirement date(s) __________
b. Name of person covered by Medicare__________ Medicare claim Number__________
c. Medicare eligibility is due to: ☐ Overage 65 ☐ End-stage renal disease ☐ Total Disability
d. Part A effective date__________ Part B effective date __________

OTHER COVERAGE

1. Is there other coverage for your children due to a court decree? ☐ Yes ☐ No
   If yes, name of parent(s) with legal custody of children: __________
   Address of parent(s) with legal custody: __________

   Is there a court order making the non-custodial parent responsible for the child(ren)'s medical/dental expenses? ☐ Yes ☐ No
   If yes, please supply a copy of the legal documentation for this decision.
   Failure to provide this information will result in denial of claims submitted for you or your family members.

DECLINATION OF ENROLLMENT IMPORTANT! If you are waiving your dependents' right to coverage under this plan, you must declare the reason for declination in writing below. Failure to declare your reasons for waiving coverage may limit your opportunity to join the plan later.

If you are declining enrollment for your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll your dependents in this plan, provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll your dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

I have been given the opportunity to participate in the benefit plan, but after due consideration, I have elected not to participate in each of the categories checked below:

Effective Date of Declination __________ ☐ SPOUSE ☐ CHILD(REN)

List names of dependents to be declined: __________

REASON FOR REFUSAL OF MEDICAL COVERAGE:

☐ Have coverage under another plan. Name of Other Plan __________
   Indicate who is currently covered under other plan(s): ☐ Spouse ☐ Children

☐ Other. Give Explanation __________

I understand that failure to specify that I am declining coverage because my spouse and/or children have other coverage may waive my special enrollment rights as described above. I further understand that by not applying for the coverage above, I will not be entitled to those benefits. I further understand that by applying for coverage at a future date, I may be asked to provide health status information. Penalties such as deferred effective dates may be imposed. I hereby certify that I am declining coverage for the dependents indicated above because such dependents are currently covered under the plan(s) named above, and that this information is true and correct to the best of my knowledge. I understand that if I have provided false information regarding the coverage of my dependents under other plan(s) that I may be subject to adverse employment action, including but not limited to termination.

X__________

Sign your name, DO NOT PRINT OR TYPE   Date