

# TOWN OF SOUTHBOROUGH

17 COMMON STREET  
SOUTHBOROUGH, MA 01772

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Dear Employee (and/or eligible dependent(s)),

**YOU (and YOUR ELIGIBLE DEPENDENT(S)) SHOULD READ THIS INFORMATION, REGARDLESS OF YOUR CURRENT EMPLOYMENT STATUS WITH THE TOWN OF SOUTHBOROUGH.**

**This notice has been updated to include the language from the IRS FINAL COBRA REGULATIONS effective on January 1, 2000 AND Notification required by the Women's Health and Cancer Rights Act of 1998.**

This notice summarizes your rights and your obligations under COBRA, and should be reviewed, retained with other benefit documents, and referred to in the event any action is required on your part.

## COBRA Continuation Coverage:

If you or your eligible dependent(s) should lose coverage under your group health plan due to a "Qualifying Event" listed below; COBRA guarantees an opportunity to elect temporary continuation of health care coverage at group rates. It is important that the Treasurer's Office has your current address. Notification of a "Qualifying Event", should one occur, will be sent to your last known address at the time of the event. We provide you with the following summary of information concerning COBRA and the procedures, which should be followed if or when a "Qualifying Event" occurs.

**If you are an employee of the *Town of Southborough***, covered by one of our group health plans, you have the right to choose continuation coverage for yourself, and/or covered dependent(s), if you, and/or your covered dependent(s) lose group health coverage under the plan because of a reduction in your hours or termination of employment (for reasons other than gross misconduct).

**If you are a covered spouse** of an employee of the *Town of Southborough*, you have the right to continuation of coverage for yourself and/or your covered dependent child(ren), if you or your covered dependent child(ren) lose group coverage for any of the following reasons:

1. Death of the employee
2. Reduction in hours of the employee's employment or termination of employment (except due to gross misconduct)
3. Divorce or legal separation from your spouse
4. Your spouse becomes entitled to Medicare

**If you are a covered dependent child(ren)** of an employee of the *Town of Southborough*, you have the right to continuation coverage if group health coverage is lost for any of the following reasons:

1. Death of the employee
2. Reduction in hours of the employee's employment or termination of employment (except due to gross misconduct)
3. Parent's divorce or legal separation
4. Employee becomes entitled to Medicare
5. You cease to be a "dependent child" under the terms of the plan (example: child reaching his/her age limitation, or any other change in status which effects eligibility for coverage)

**The covered employee or eligible dependent(s)** has the responsibility to directly inform the *Town of Southborough*, of a divorce or legal separation, or a child losing dependent status under the group health plan(s) limitations. Written notice is required within 60 days of the date of the event or the date that you would lose coverage due to a "Qualifying Event". If notice is not made within 60 days, rights to continue coverage will terminate. In situations where a covered employee discontinues coverage of a spouse in anticipation of a divorce or legal separation, the *Town of Southborough*, when receipt of timely notification, is required to make COBRA continuation coverage available effective from the date of the divorce or legal separation (but not prior to that date). The written notice should include:

Date(mo/day/yr): \_\_\_\_\_

Dependent's Name: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Dependent's mailing address: \_\_\_\_\_

\_\_\_\_\_

Dependent's telephone: \_\_\_\_\_

Gender: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Relationship to employee: \_\_\_\_\_

Employee's Name: \_\_\_\_\_

Employee's Social Security Number: \_\_\_\_\_

Reason for loss of coverage: \_\_\_\_\_

Date of loss of coverage: \_\_\_\_\_

Once the *Town of Southborough*, has been notified that one of these events has happened, we have the responsibility of notifying the Plan Administrator of the event. When the Plan Administrator is notified that one of these events has happened, the Plan Administrator will, in turn, notify you that you have the right to choose continuation coverage. Under the law, you have at least 60 days from the date you would lose coverage because of one of the events described above, or date of your election notice is sent to you, whichever is later, to inform the Plan Administrator that you want continuation coverage.

If you do not choose continuation coverage, your group health insurance coverage will end in accordance with the provisions outlined in your plan(s).

If you choose COBRA continuation coverage, the *Town of Southborough*, is required to give you coverage which, as of the time coverage is being provided, is identical to that coverage

provided under the plan to similarly situated nonCOBRA beneficiaries or family members. Under the law, Qualified Beneficiary(ies) losing coverage has 60 days from either the date of loss of coverage or from the date of the notice to elect COBRA continuation, whichever is later. You have 45 days from the date of the initial election to make your first premium payment and any other premium payments that are due for periods of coverage that end before 45 days from the date of that election.

If COBRA continuation coverage is elected, the law requires that you be afforded the opportunity to maintain continuation coverage for three years unless you lost group health coverage due to a termination of employment or a reduction in hours. In that case, the required continuation coverage period is 18 months. This 18 months may be extended to 36 months if other events (such as death, divorce, legal separation, or Medicare entitlement) occur during that 18 month period.

**Disability Extension:** Under current laws, if an individual is entitled to COBRA continuation coverage because of a termination of employment or reduction in hours of employment, that plan is generally required to make COBRA continuation coverage available to the individual for 18 months. However, if the individual entitled to the COBRA continuation coverage is disabled (as determined under the Social Security Act) and satisfies the application notice requirements, the plan must provide COBRA continuation coverage for 29 months, rather than 18 months. The current law also states, the individual must be disabled at the time of termination of employment or reduction in hours of employment. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) make changes to current law to provide that, beginning January 1997, the disability extension will also apply if the individual becomes disabled at any time during the first 60 days of COBRA continuation coverage. HIPAA also makes it clear that, if the individual entitled to the disability extension has non disabled family members who are entitled to COBRA continuation coverage, those non disabled family members are also entitled to the 29 month disability extension.

The Qualified Beneficiary must notify the *Town of Southborough*, Plan Administrator within 30 days of any final determination that the individual is no longer disabled. In no event will continuation last beyond 3 years from the date of the event that originally made a qualifying beneficiary eligible to elect coverage.

A "Qualifying Beneficiary" are individuals entitled to COBRA continuation coverage. Individuals who may be qualified beneficiaries are the spouse, and dependent child(ren) of a covered employee and, in certain circumstances, the covered employee. Under current law, in order to be a qualified beneficiary, an individual must generally be covered under a group health plan on the day before the event that causes a loss of coverage (such as termination of employment, or a divorce from, or death of, the covered employee). HIPAA changes this requirement so that a child born to the covered employee, or who is placed for adoption with the covered employee, during the period of COBRA continuation coverage, is also a qualified beneficiary.

The law also provides that the COBRA continuation coverage may end sooner for any of the following reasons:

1. If the *Town of Southborough*, no longer provided group health coverage for any of its employees
2. If the premium for your COBRA continuation coverage is not paid in a timely manner
3. If you become covered by another group plan, unless the plan contains any exclusions or limitations with respect to any preexisting conditions you or your covered dependent(s) may have
4. If you first become, after the date of the election, entitled to Medicare
5. If you extend coverage for up to 29 months due to your disability and there has been a final determination that you are no longer disabled

You do not have to show that you are insurable to choose continuation coverage. However, under law, you may have to pay all or part of the premium for your continuation coverage. There is a grace period of at least 30 days for payment of the regularly scheduled premium. **(The law also says that at the end of the 18 month or 36 month COBRA continuation coverage period, you must be allowed to enroll in an individual coverage plan provided under the *Town of Southborough*).**

This law applies to the *Town of Southborough's*, group health plan. If you have any questions, please contact the Treasurer's Office, Monday, Wednesday, Thursday 8am – 5pm, Tuesday 8am – 7pm & Friday 8am-noon (508) 485-0710. Also, if you have changed marital status, or you or your eligible dependent(s) have a change in address, please notify the Treasurer's Office.

## NOTICE

### Women's Health and Cancer Rights Act Notice

**Special Rights Following Mastectomy.** A group health plan generally must, under federal law, make certain benefits available to participants who have undergone a mastectomy. In particular, a plan must offer mastectomy patients benefits for:

- \*Reconstruction of the breast on which the mastectomy has been preformed;
- \*Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- \*Prostheses; and
- \*Treatment of physical complications of the mastectomy.

Our Plan complies with these requirements. Benefits for these items generally are comparable to those provided under our Plan for similar types of medical services and supplies. Of course, the extent to which any of these items is appropriate following mastectomy is a matter to be determined by consultation between the attending physician and the patient. Our Plan neither imposes penalties (for example, reducing or limiting reimbursement) nor provides incentives to induce attending providers to provide care inconsistent with these requirements. Please contact the Plan Administrator for specific questions regarding your particular health plans policy.