# YOUR BENEFITS ENGAGED

## 2022 ENROLLMENT GUIDE

ALBUQUERQUE PUBLIC SCHOOLS

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**Required Notices Including:**

- Medicare Notice of Creditable Coverage
- COBRA Coverage Reminder
- Health Insurance Marketplace Coverage Notice
- HIPAA Notice of Privacy Practices


**And all other compliance notices are included in Appendix A starting on page 48**

| | | | |
|---|---|---|---|
| **Medical** | **True Health New Mexico**<br>Group #GTAPS01 | Customer Service:<br>877-210-8339 | 2440 Louisiana Blvd NE, Suite 601<br>Albuquerque, NM 87110<br>https://www.truehealthnewmexico.com/aps.aspx |
| | **Cigna**<br>Group #3343551 | Customer Service:<br>800-853-2713 | 6565 Americas Pkwy #150<br>Albuquerque, NM 87110<br>www.myCigna.com |
| | **Presbyterian Health Plan**<br>Group # A0000037 | Member Services:<br>505-923-5600 or<br>888-275-7737 | PO Box 27489<br>Albuquerque, NM 87125-7489<br>www.phs.org/APS |
| | **Blue Cross and BlueShield of New Mexico**<br>Group #L04121 | Member Services:<br>888-371-1928 | PO Box 27630<br>Albuquerque, NM 87125-7630<br>www.bcbsnm.com |
| **Prescription Drugs** | **Express Scripts**<br>Group # APSNMRX | 866-563-9297 | P.O. Box 650322<br>Dallas, TX 75265-9446<br>www.express-scripts.com |
| **Dental** | **Delta Dental PPO New Mexico**<br>Group # 8542 | 505-855-7111<br>(Member #<br>is Employee's SSN) | One Sun Plaza – 100 Sun Ave NE Suite 400<br>Albuquerque, NM 87109<br>www.deltadentalnm.com |
| **Vision** | **Davis Vision**<br>Client Code: 2267 | 800-999-5431 | Vision Care Processing Unit<br>PO Box 1525<br>Latham, NY 12110<br>www.davisvision.com |
| **Flexible Spending Account Administrator** | **ASIFlex** | 800-659-3035<br>Fax: 877-879-9038 | P.O. Box 6044<br>Columbia, MO 65205-6044<br>www.asiflex.com |
| **Life and Long Term Disability Insurance** | **Standard Insurance Company** | 888-609-9763 | For claim forms, enrollment and information, contact the APS Employee Benefits Department or log on to https://www.standard.com/employee-benefits/aps |
| **Employee Assistance Program (EAP)** | **APS offers free, short-term counseling for APS employees and their families** | 505-884-9738 | 6400 Uptown Blvd NE, Suite 480-W<br>Albuquerque, NM 87110<br>http://www.aps.edu/student-family-and-community-supports/employee-assistance-programs |
| **Pension Plan Administrator** | **New Mexico Educational Retirement Board** | Albuquerque office:<br>505-888-1560<br><br>Santa Fe office:<br>505-827-8030 | 8500 Menaul Blvd NE, Suite B-450<br>Albuquerque, NM 87112<br><br>701 Camino de los Marquez<br>Santa Fe, NM 87502<br>www.nmerb.org |
| **Voluntary Retirement Savings Plans** | **403(b) Plan Administrator – TCG Administrators**<br>**457(b) Plan – Voya Financial** | 800-943-9179<br>505-989-4992 or<br>866-827-6639 | http://tcgservices.com/<br><br>www.newmexico457dc.com |
| **Credit Union** | **Nusenda** | 505-889-7755 | www.nusenda.org |
| **Administration** | **Employee Benefits Department Albuquerque Public Schools** | 505-889-4859<br>Fax: 505-889-4882 | 6400 Uptown Blvd NE, Suite 115-E<br>Albuquerque, NM 87110<br>Email: Employee.benefits@aps.edu<br>Website: http://www.aps.edu/human-resources/benefits/ |

December 2022

**To: Albuquerque Public Schools Employees**
**From: Valerie Atencio, Sr. Director, Employee Benefits Department**

Albuquerque Public Schools is pleased to offer employees and their families a comprehensive benefits package that is designed to meet the needs of the District's many employees and their families. The 2022 APS Employee Benefits Enrollment Guide is a valuable resource that includes a summary of our employee benefit plans, eligibility and enrollment guidelines, and federal government required notices. Please note that our benefits programs run on a calendar year basis, not on a school year basis.

For 2022, the APS benefit package includes: Medical with Prescription Drug Plan coverage, Dental, Vision, Pre-tax Insurance Premium Plan (PIPP), Flexible Spending Accounts, Long Term Disability Insurance, Basic and Additional Life Insurance, Employee Assistance Plan, and 403(b) and 457(b) Retirement Savings Plans. Over 16,000 APS employees and their dependents are covered by our benefit plans.

Our medical, prescription drug, dental and vision plans are self-insured; in other words, premium dollars go directly toward the payment of our claims. Our health plan partners provide administrative services only; the money to pay claims comes from the premium contributions from APS and employees. The District is responsible for the plan design and sets the premium contribution amounts to match expected costs – which continue to rise.

All of us can help contain costs by using in-network providers, choosing generic drugs (when possible) and practicing a healthy lifestyle for ourselves and our families; making healthy decisions, eating the right foods, exercising, and avoiding unhealthy habits such as smoking and other addictive behaviors. The cost of health care consumes a large portion of the District's budget. For 2022, the District will pay 60%, 70% or 80% of premiums on behalf of our employees, depending upon salary level. Employees pay only 20%, 30% or 40% of medical plan, dental plan and vision plan premiums.

Each plan is subject to a rigorous quality and financial evaluation and is purchased through a cooperative arrangement with three other public entities. This volume purchasing, using our combined strengths – close to 200,000 lives covered - enables APS to provide the highest quality plans that our state offers. Plan designs are also evaluated each year to help contain costs, since in some cases a small change to cost sharing may offset the need for a premium increase.

Remember that the success of our benefit plans depends on us, as employees, understanding our options and using them wisely. Please read all information carefully. Be fully informed to make the best benefit package selection for yourself and your family, and to make the most responsible use of your benefits package.

*For additional information, please contact the health plan administrators directly at their toll-free Customer Service Center number or access their website. See "Important Contact Information" in this Guide. You may also contact the APS Employee Benefits Department at 505-889-4859 for assistance, or access the Employee Benefits Website at: www.aps.edu (select "A-Z Directory", then select "Benefits").*

| | New Hire (Full-Time Employee) | New Hire (Part-Time Employee) | During Open Enrollment (for January 1st effective date) | Existing Employee (other than as a new hire) | Mid-Year Change due to Qualifying Life Event | Retired Employees | Termed Employees |
|---|---|---|---|---|---|---|---|
| **PIPP (Pre-Tax Insurance Premium Plan)** | ✓ | | ✓ | | ✓ | | |
| **Medical and Prescription Drug Plan** | ✓ | Hours will be measured as required by the ACA. If employee averages over 30 hours of service a week, they will be offered medical and prescription drug plan coverage | ✓ | | Within 60 days of Qualifying Life Event | Eligible for NMRHCA plan or may elect COBRA continuation coverage (COBRA must be elected within 60 days of loss of coverage) | If terminated with medical coverage, may elect COBRA continuation coverage within 60 days of loss of coverage |
| **Employee Wellness** | ✓ | **X** | X | X | **X** | | |
| **Dental Plan** | ✓ 2-year coverage rule applies | | ✓ 2-year coverage rule applies | | Within 60 days of Qualifying Life Event; 2-year coverage rule applies | Eligible for NMRHCA plan or may elect COBRA continuation coverage (COBRA must be elected within 60 days of loss of coverage) | If terminated with dental coverage may elect COBRA continuation coverage within 60 days of loss of coverage |
| **Vision Plan** | ✓ 2-year coverage rule applies | | ✓ 2-year coverage rule applies | | Within 60 days of Qualifying Life Event 2-year coverage rule applies | Eligible for NMRHCA plan or may elect COBRA continuation coverage (COBRA must be elected within 60 days of loss of coverage) | If terminated with vision coverage may elect COBRA continuation coverage within 60 days of loss of coverage |

| | New Hire (Full-Time Employee) | New Hire or existing Part-Time Employee | During Open Enrollment (for January 1st effective date) | Existing Employee (other than as a New Hire) | Mid-Year Change due to Qualifying Life Event | Retired Employees | Termed Employees |
|---|---|---|---|---|---|---|---|
| **Flexible Spending Account**<br><br>**(FSA)** | ✓<br>MUST re-enroll during Open Enrollment if FSA is desired | | ✓<br>MUST re-enroll every year if FSA is desired | | Contact Employee Benefits | May be eligible to continue FSA through the end of the Plan Year Contact Employee Benefits Department | May be eligible to continue FSA through the end of the Plan Year Contact Employee Benefits Department |
| **Life Insurance** | ✓<br>Guarantee Issue up to plan limits when enrolled as new hire | | ✓<br>A1 status employees may apply at any time during the year except between September 20th and October 31st. Subject to evidence of insurability (good health) | | ⇐ | May be eligible for Retiree Life Insurance. Otherwise, contact Life Insurance Carrier within 30 days of termination of employment | Contact Life Insurance Carrier within 30 days of termination of employment |
| **Long Term Disability**<br><br>**(LTD)** | ✓<br>Guarantee Issue up to plan limits when enrolled as new hire | | ✓<br>A1 status employees may apply at any time during the year except between September 20th and October 31st.Subject to evidence of insurability (good health) | | ⇐ | Not applicable | Not applicable |
| **Retirement Savings Plan**<br><br>**New Mexico Educational Retirement Board Plan** | Employees who work more than 25% of the time (.25 full time-equivalents) are mandated by the New Mexico Educational Retirement Act to participate in the retirement plan administered by the New Mexico Educational Retirement Board. Participation in the plan begins on the date of hire. | | | | | Determination of retirement benefits is part of the NMERB/APS retirement application process | Contact the New Mexico Educational Retirement Board with any questions |
| **Credit Union Membership** | Employees may join Nusenda Credit Union (formerly New Mexico Educators Federal Credit Union) at any time. Contact Nusenda at 505-889-7755 for details on how to open an account. | | | | Contact the credit union for eligibility | | |
| **Education Savings Plan** | Employees may set up an account at any time. Contact The Education Plan for more information or to open an account. | | | | | | |
| **Employee Assistance Program (EAP)** | No enrollment is required. All full-time and part-time employees are eligible for this benefit, which consists of free professional, confidential counseling for family, work, marital, stress or substance abuse support. | | | | Not applicable | Not applicable | |
| **Voluntary Retirement Savings Plans 403(b) Plan 457(b) Plan** | ✓ | ✓<br>All employees, regardless of classification (status), are eligible | ✓ | Employees may enroll at any time. Generally, Enrollment completed by the 20th of the month will be effective the 1st of the following month (summer & winter break payroll deadlines may impact this date) | Pre-tax and/or Roth contributions will stop once an employee is no longer receiving an APS paycheck. Money that has already been invested may be left in the plan or distributed to the employee (IRS regulations apply). Please contact your investment fund vendor or 403(b) or 457(b) plan administrator with questions. | | |

## INTRODUCTION

Through its benefits program, Albuquerque Public Schools (APS) helps you pay for health care services, build retirement savings, and assists in providing financial security for you and your family. The benefit programs encourage wellness, personal health assessments, and preventive health measures. The program offers you a range of optional benefits, including coverage for family members, letting you customize your coverage to meet your personal needs. You contribute toward the cost of the benefits you elect.

Your benefits enrollment is very important. Please review the following guidelines to assist you in understanding eligibility and in submitting the appropriate forms and documentation to enroll in the APS benefit plans. Timely submission of your forms and documents will ensure coverage for you and your family members. If you have any questions about your benefit plan options, please contact the APS Employee Benefits Department at (505) 889-4859 or employee.benefits@aps.edu.

## ELIGIBILITY FOR BENEFITS FROM APS

- **Employee Eligibility:** You, an APS employee, are eligible for benefits if you are classified as the following APS employee status codes:
    a. **A1:** meaning a full-time employee (30 or more hours of service/week) who is benefit eligible on a pre-tax or post-tax basis;
    b. **A3:** meaning a non-full-time employee who 1) was previously an A1 status employee for a minimum of twelve continuous months of service or one contract year, and 2) this service was immediately preceding their FTE Reduction to an A3 status employee, and 3) continues to maintain at least 45% or more of the full-time hours of the occupied position, and 4) understands and agrees that premium contribution rate is based on 1.0 full-time equivalency salary.
    c. **ACA status:** meaning the non-full-time employee's hours of service are assessed (in accordance with Affordable Care Act (ACA) and IRS regulations) to determine if and when the employee is eligible for an offer of medical plan coverage. ACA status includes employees in any of the following codes:
        1) **A4, A5, A6, and A8:** a part-time or variable hour employee who is medical plan benefit eligible in a stability period only if the employee achieves an average of 30 hours of service or more in the corresponding measurement period. If eligibility is achieved, the employee is offered medical/ prescription drug benefits only, benefits are offered to the employee and their eligible dependents and, benefits are payable on a post-tax basis.
        2) **Part-time Employee** means an employee for whom, based on facts and circumstances on their hire date, the employee is reasonably expected to average less than 30 hours of service per week during their Initial Measurement Period. **Variable Hour Employee** means an employee for whom, based on facts and circumstances on their hire date, it cannot be determined whether the employee is reasonably expected to average at least 30 hours of service/week during an Initial Measurement Period.
        3) ACA status employees are measured under the Look-Back Measurement Method to determine if the employee averages 30 or more hours of service/week in the corresponding stability period.
- **Non-Employee Eligibility (for members of the APS Board of Education)**
    a. **A7:** an elected member of the APS Board of Education is eligible to elect medical, dental or vision benefits for themselves and their eligible Dependents, on a post-tax basis, paying 100% of the premium. Board members are also eligible to elect Basic life insurance, paying 100% of the premium.

**Determining Full-time Status**

APS determines full-time employee status in compliance with IRS regulations under the Affordable Care Act. Full-time employee means an employee who averages **30 hours of service** or more using the Look-Back Measurement method.

APS reserves the right to use a **Look-Back Measurement Method** to determine if an employee reaches the level of a full-time employee, in accordance with IRS regulations under the Affordable Care Act.

- The Look-Back Measurement Method determines the status of a new employee or an ongoing employee as full-time or not for a future period (called a stability period) based on the average number of hours of service per week the employee attained in a prior period (called a measurement period).

- APS uses an 11-month **Initial Measurement Period** to determine hours of service for **new** variable hour or part-time employees. Based on the average hours of service attained in the Measurement period, APS will then be able to determine if the employee is to be treated as a medical plan eligible employee for the corresponding 12-month Initial Stability Period.
- APS uses a 12-month **Standard Measurement Period** (October 15 to October 14) to determine full-time status for the 12-month Standard Stability Period of January 1 to December 31.
- The specific duration of periods under the Look-Back Measurement Method (when used) are addressed in policies/procedures in the Employee Benefits Department. If an employee is determined to be a full-time employee who is eligible for benefits, APS will determine the effective date for coverage and notify the employee who is then eligible to elect medical/prescription drug coverage for the employee and any eligible dependents.

**Hour(s) of Service:** means, as determined by APS:

(1) each hour for which an employee is paid, or entitled to payment, for the performance of duties; and

(2) each hour for which an employee is paid, or entitled to payment on account of a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or leave of absence.

An hour of service does not include any hour of service performed as a bona fide volunteer, as part of a Federal Work-Study Program (or a substantially similar program of a State or political subdivision thereof) or (according to the final Shared Responsibility regulations) to the extent the compensation for services performed constitutes “income from sources without the United States.”

**Additional Eligibility Provisions**

- **Full-time A1 status employees who elect to move to part-time A3 status** will continue their benefit eligibility (with the exception of long-term disability insurance) as long as the following conditions are met:

  a. The employee has completed twelve continuous months of service or one contract year of employment with APS as an A1 employee, and this service was immediately preceding their FTE reduction to an A3 status employee; and

  b. Part-time employment for purposes of benefit continuation is .45 FTE or greater (employee continues to maintain at least 45% or more of the full-time hours of the occupied position); and

  c. The employee’s premium contribution rate is based on his/her 1.0 full-time equivalency salary. For employees enrolled for benefits when they move to A3 status, premium rates will remain the same and will not drop to a lower amount when the status changes to part-time.

In addition, an A3 employee who experiences a qualifying event is eligible to make the same elections and changes that an A1 status employee with the same qualifying event could make. A3 status employees are eligible to elect and/or change coverage during Open Enrollment, subject to the same provisions as an A1 status employee. In keeping with provisions in the long-term disability (LTD) insurance policy, A3 status employees are not eligible for LTD insurance.

- **Part-time status employees who move to full-time (A1) status**
  a. A4, A5, A6 and A8 employees who move to an A1 status are eligible to enroll for benefits under the Initial Enrollment provisions (refer to page 12 of this booklet)
  b. A3 status employees who return to A1 status may continue all benefits in place as an A3 employee and may enroll for Long-Term Disability Insurance without Evidence of Insurability, as long as that is done within 60 days of the effective date of the change to A1 status. The employee must wait until the next Open Enrollment Period if they wish to enroll for medical, dental and/or vision plan coverage. The employee is eligible to apply for Additional Life Insurance (subject to Evidence of Insurability), just as any other A1 employee.
- **Leave of Absence/Break in Service**: In accordance with ACA and IRS regulations when using the Look-Back Measurement Method, for rehired employees with a break in service, or employees returning from an approved leave of absence, the employee will be credited with zero hours of service during the period of non-employment or unpaid leave of absence.

- During an approved leave of absence (maximum of 24 months), the employee may continue the benefits he or she was enrolled for prior to the leave. For the first year of approved leave, benefit contributions will be deducted from the employee's paychecks (if applicable), or the employee may pay their contributions on a monthly basis. If an employee is approved for a second year of leave, the employee must pay, on a monthly basis, 100% of the premium amount to maintain his or her benefit coverage. (Note: Long-term disability insurance cannot be continued during a second year of approved leave.) If the employee elects to drop coverage while on approved leave, he or she may reinstate medical, dental and/or vision coverage provided that, 1) the employee is benefit eligible at that time, 2) he/she requests a new Enrollment Form from the Employee Benefits Department and, 3) submits the completed form via the Winocular system within 60 days of the return to work date. Coverage will be effective the first day of the month following the date the Employee Benefits Departments receives the completed Enrollment Form.
  - If the employee elects to drop long-term disability insurance while on an approved leave, or was not enrolled for long-term disability insurance prior to the approved leave, the employee may enroll or re-enroll for long-term disability insurance without Evidence of Insurability, provided that, 1) the employee returns as an A1 status (full-time, benefit eligible) employee, and 2) the period of approved leave was not more than 24 months, and 3) the total period of approved medical leave was not more than 12 months, and 3) the employee requests and submits an Enrollment Form via the Winocular system within 60 days of the return to work date. Coverage will be effective the first day of the month following the date the Enrollment Form is received by the Employee Benefits Department.
  - If the employee elects to drop additional life insurance, spouse and dependent life insurance while on an approved leave, the employee may elect to re-enroll in the same amount of life insurance coverage (self, spouse and dependent) that was in place on the day prior to the approved leave, without Evidence of Insurability, provided that, 1) the employee returns as an A1 status (full-time, benefit eligible) employee, and 2) the period of approved leave was not more than 24 months, and 3) the total period of approved medical leave was not more than 12 months, and 3) the employee requests and submits an Enrollment Form via the Winocular system within 60 days of the return to work date. Coverage will be effective the first day of the month following the date the Enrollment Form is received by the Employee Benefits Department. If an A1 status employee was not enrolled for additional life insurance prior to the approved leave, the employee may apply for life insurance coverage subject to Evidence of Insurability. (Contact the Employee Benefits Department or refer to the Benefits webpage for the steps to take to apply for additional life insurance coverage.)

  a. If the period of absence with no hour of service is at least 26 consecutive weeks, then employee may be treated as a New* employee upon return to employment.
  b. If the period of absence with no hour of service is less than 26 consecutive weeks, but more than 4 consecutive weeks, then employee must be considered a Continuing** employee upon return to employment. See also the Rule of Parity.
  c. The Rule Of Parity says if the period of absence with no hours of service is between 4 and 26 weeks, and the break is longer than the employee's period of employment before the break, the employee may be treated as a New* employee.
  d. *When treated as a "New" employee, APS is permitted to restart the Initial Measurement Period or apply the plan's benefits waiting period.
  e. **For a Continuing employee, if the employee is to be treated as a full-time employee (and eligible for coverage because the employee is in a Look-Back Stability period), the employee may reinstate medical plan coverage as of the first day of the month following the resumption of service.

- **Dependent Eligibility: If you, an employee, are eligible for APS benefits you may elect coverage for any of the** following eligible dependents (proof of dependent status will be required):

  a. Your legal spouse
  b. Your Domestic Partner (must complete notarized Affidavit of Domestic Partnership and supply required supporting documentation)
  c. Your unmarried or married children to the age of 26, including:

1) natural child(ren), legally adopted child(ren) or stepchild(ren) of the employee or Domestic Partner;
2) foster child(ren) for whom you have a Placement Order, as long as the foster home is appropriately licensed;
3) child(ren) for whom you have legal guardianship;
4) child named as an "alternate recipient" under a Qualified Medical Child Support Order (QMCSO);
5) Disabled Adult Child: A dependent who is a disabled adult child may stay eligible for APS benefits beyond the normal age limit if that Dependent child meets the eligibility requirements explained here. (The Plan will require initial and periodic proof of disability.) You will have 60 days from the date of the request for proof of disability to provide this proof before the child is determined to be ineligible. To be eligible as a disabled adult child, the individual must meet all of the following eligibility requirements:
   a) is an unmarried Dependent Child (as defined above) of a covered employee or Domestic Partner;
   b) is age 26 or older;
   c) was covered under this Plan on the day before their 26th birthday;
   d) is permanently and totally disabled (for example the disability has lasted 12 months, is expected to last 12 months, or is expected to result in death);
   e) has a disability that causes the individual to be incapable of self-sustaining employment (substantial gainful employment) as a result of that Disability,
   f) the dependent chiefly relies on the employee or spouse or Domestic Partner for support and maintenance;
   g) the Disability existed prior to attainment of the age that causes a non-disabled dependent child's coverage to end under this Plan (meaning prior to the child's 26th birthday); and
   h) the child is eligible for tax-free health coverage as a "qualifying child" or "qualifying relative" under the applicable requirements of Internal Revenue Code Section 152(c) or 152(d), respectively, OR will be claimed as a dependent on the employee's/participant's federal income tax return for each plan year for which coverage is provided.
      i. A child whose coverage has terminated under this Plan due to reaching the age limit, and then becomes disabled, is not eligible to re-enroll as a disabled adult dependent child under the APS benefit plan.
      ii. With the exception of a Dependent Child who is permanently and totally disabled prior to age 26, or a child whose coverage ends on the last day of the month following the date of death of the employee, coverage for a child will terminate at the end of the month in which the child attains age 26.

The following individuals are not eligible under the APS Plan: a spouse of a Child (e.g. the employee's son-in-law or daughter-in-law), a spouse under a common law marriage or civil union, a divorced spouse, or the employee's parents, parents-in-law, or grandparents. Extended family members are not eligible under any circumstances.

No individual may be covered under the APS Plan both as an Employee and as a Dependent, nor may any Child be covered as the Dependent of more than one Employee.

- **Applicable to the 403(b) and 457(b) Plans ONLY**: All employees, whether full-time, part-time, or on an hourly status, are eligible to participate in either of the voluntary retirement savings plans (403(b) and 457(b) Plans).

## PROOF OF DEPENDENT STATUS

Specific documentation to substantiate Dependent status will be required by the APS Plan, and may include (see the list below) a birth certificate, hospital proof of birth, marriage certificate, proof of the dependent's age, the dependent's social security number, and other documents deemed necessary by the Plan. Documents must be uploaded using the Winocular system at the time an Enrollment/Change Form is submitted via that system.

- **Marriage:** the certified Marriage Certificate. (It is recommended that you review your life insurance and New Mexico Educational Retirement Board (pension plan) beneficiary designation for any needed changes or updates.)
- **Birth:** the certified birth certificate showing biological child of employee. Provide Birth Certificate or Hospital Proof of Birth within 60 days of date of birth. If a Hospital Proof of Birth is supplied because the Birth Certificate is not yet available, the Birth Certificate must be submitted as soon as you receive it. The baby's SSN must be provided as soon as you receive it.
- **Stepchild:** the certified birth certificate and marriage certificate.
- **Adoption or placement for adoption**: court order document signed by the judge showing that employee has adopted or intends to adopt the child, and the certified birth certificate.
- **Foster Child:** a foster child living in your household as a result of placement by a state licensed placement agency, as long as the foster home is appropriately licensed, is considered an eligible dependent. Supporting documentation required to enroll the child is proof of placement, a copy of foster home license, the child's birth certificate and proof of any state-provided health coverage.
- **Legal Guardianship:** the court-appointed legal guardianship documents and certified birth certificate.
- **Disabled Dependent Child:** Documentation for a disabled dependent child must be submitted to the Claims Administrator (medical plan carrier), not to the APS Employee Benefits Department (with the exception of Cigna members). Proof of disability is required within 60 days of the date of request and/or within 60 days of the child's 26th birthday in order to ensure that coverage can continue for that child beyond the last day of the month in which the child reaches age 26. Documentation required: Current written statement from the child's Physician indicating the child's diagnoses that are the basis for the Physician's assessment that the child is currently mentally or physically disabled and that disability existed before the child's attainment of age 26, and that the child is incapable of self-sustaining employment as a result of that disability; and the child chiefly relies on you and/or your Spouse for support and maintenance. The APS Employee Benefits Department and/or the Claims Administrator may require that you show proof of initial and ongoing disability and that the child meets the Plan's definition of Dependent Child including proof that the child is claimed as a dependent for federal income tax purposes.
- **Qualified Medical Child Support Order (QMCSO):** Valid QMCSO document signed by a judge or a National Medical Support Notice.
- **Domestic Partner**: Signed affidavit by the employee and domestic partner that they meet the requirements of this Plan's domestic partner eligibility, an original notarized Affidavit of Domestic Partnership and three (3) forms of evidence of financial responsibility is required to enroll a domestic partner.
- **Loss of Coverage:** Loss of Coverage letter from prior employer or prior insurance provider is required to enroll yourself or your eligible family members if you are enrolling mid-year due to an involuntary loss of other coverage. (If you are enrolling a spouse, domestic partner or child(ren), documentation to prove dependent status is required along with the Loss of Coverage letter.)
- **Required documentation must be submitted via Winocular with your Enrollment/Change Form(s)**

## ASSISTANCE OBTAINING REQUIRED DOCUMENTATION

If you do not have the required documents and need records for a birth in New Mexico or a marriage in Bernalillo County, see below for help ordering a document:

| | |
|---|---|
| **NM Certified Birth Certificate** | Mid-Town Public Health Office / Vital Records<br>2400 Wellesley NE Albuquerque, NM 87107<br>(505) 841-4185<br>Monday – Friday from 8:30 a.m. to 3:00 p.m.<br>Closed on holidays |
| **Certified Marriage Certificate** | Bernalillo County Clerk's Office<br>Alvarado Square<br>415 Silver SW, 1st Floor<br>Albuquerque, NM 87102<br>(505) 468-1243 |
| **Social Security Card** | Social Security Office<br>www.ssa.gov<br>(800) 772-1213 |

## *ENROLLMENT PROCEDURES*

**There are three opportunities to enroll for coverage under the APS Plan:** Initial Enrollment, Special Enrollment and Switch/Open Enrollment. Completion and electronic submission of the correct documents is crucial to your enrollment in the plans offered. APS requires dependent documentation to safeguard against fraudulent enrollment.

**Procedure to enroll:** Generally, an individual must submit enrollment documents to the APS Employee Benefits Department through the Winocular Workflow process to indicate their desire to enroll in the Plan. Note that the Switch/Open Enrollment procedure may differ from this process and if so, the procedure on how to enroll at this time will be announced by the APS Employee Benefits Department at the beginning of the Switch/Open Enrollment period. (Announcements regarding Switch/Open Enrollment and other announcements about the Plan are made in the *Perspective* electronic newsletter.)

The steps to enroll include all of the following:

a) submit a completed Enrollment/Change Form (form will be assigned to you through the Winocular Workflow system. Contact the APS Employee Benefits Department if you do not receive the Enrollment Form through Winocular). Enrollment materials must be submitted within 60 days of the date of Initial eligibility for coverage, a Special Enrollment event or by the end of the period designated for Switch/Open Enrollment. To enroll an eligible dependent, you must provide the Dependent's social security number (SSN) or tax payer identification number (TIN), at the time you enroll (or as soon as you receive a newborn's SSN) and
b) upload proof of Dependent status or other required supporting documentation through Winocular, and
c) electronically sign the Enrollment/Change Form authorizing APS to deduct from your earnings the required contributions to pay for coverage, and submit the form and required supporting documentation through Winocular, and
d) perform steps a through c above in a timely manner according to the timeframes noted under the Initial, Special, or Switch/Open Enrollment provisions of this Plan.

Proper enrollment is required for coverage under this Plan. If enrollment has been requested within the required time limit but proper enrollment including completion of an enrollment form has not been completed and submitted via Winocular to the APS Employee Benefits Department, coverage will not be provided.

**A person who has not properly enrolled by completing the Plan's enrollment procedures (noted above) in a timely manner, has no right to any coverage for Plan benefits or services under this Plan.**

Employee's Social Security Number (SSN) and the SSN for all enrolled members (spouse/domestic partner and/or children) are required under federal law. SSNs are required under the Mandatory Insurer Reporting Law (Section 111 of Public Law 110-173) for purposes of coordination of benefits to the Centers for Medicare and Medicaid Services (CMS). Section 6055 and Section 6056 of the Internal Revenue Code require Albuquerque Public Schools to file an annual report with the Internal Revenue Service that includes tax identification numbers (SSN) for our employees and for their dependents who are covered on our medical plan.

**If you want your baby to have medical, dental and/or vision plan coverage effective on his/her date of birth, do not wait until you receive the Birth Certificate or Social Security Card. As soon as possible after the baby is born, contact the Employee Benefits Department and request that an Enrollment Form be assigned to you in Winocular Workflow. Complete the Enrollment Form and submit it along with the Hospital Proof of Birth letter to enroll your newborn. Both documents must be received by the Employee Benefits Department within 60-days of the date of birth for coverage to begin on the baby's date of birth. (Submit a copy of the Birth Certificate and the Social Security number to the Employee Benefits Department as soon as you receive those documents.)**

**REMINDER: DEPENDENT SOCIAL SECURITY NUMBERS NEEDED**

To comply with federal Medicare coordination of benefit regulations and certain IRS reporting rules, you must promptly furnish to the APS Employee Benefits Department the Social Security Number (SSN) of your Eligible Dependents for whom you have elected, or are electing, Plan coverage, and information on whether you or any of such dependents are currently enrolled in Medicare or have disenrolled from Medicare. This information will be requested when you first enroll for Plan coverage but may also be requested at a later date.

If a dependent does not yet have a social security number, you can go to this website to complete a form to request a SSN: http://www.socialsecurity.gov/online/ss-5.pdf. Applying for a social security number is FREE.

Failure to provide the SSN or failure to complete the CMS model form (if requested by the Claims Administrator) means that claims for eligible individuals may not be considered a payable claim for the affected individuals until the SSN or CMS model form is received. The CMS model form is available at http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Group-Health-Plans/Downloads/New-Downloads/RevisedHICNSSNForm081809.pdf)

## *DECLINING (WAIVING OR OPTING OUT OF) COVERAGE*

**Medical/dental and/or vision coverage**

The opportunity to decline coverage in the medical/dental and/or vision plans is only available at one of the Plan's normal enrollment times: Initial, Special, or Switch/Open Enrollment. Benefit eligible employees may pass up the opportunity to enroll in (may waive/decline/opt out of) medical, dental, and vision coverage under this Plan. To do so, submit via Winocular to the APS Employee Benefits Department the completed Enrollment/Change Form indicating that you are waiving/declining the offer of medical, dental and/or vision coverage. Failure to submit a completed Enrollment/Change Form (and any required supporting documentation) in a timely manner will also result in declining (waiving) the offer of medical, dental and/or vision coverage. Remember that a Dependent may not be enrolled for coverage unless the employee is also enrolled.

If, at a later date, an employee wants the medical, dental and/or vision coverage that was declined, you may enroll only under the Special Enrollment provisions (when applicable) or the annual Switch/Open Enrollment provisions. Enrollment forms may be obtained through the Winocular system by contacting the APS Employee Benefits Department.

**Life Insurance and/or Long-Term Disability Insurance**

If an A1 status (full-time, benefit eligible) employee declines to enroll for additional life insurance, spouse life insurance, and/or long-term disability insurance (LTD) during his/her Initial Enrollment period, he/she may apply for that coverage at a later date, subject to Evidence of Insurability (a medical history statement is required) provided he/she is still an A1 status employee. (Refer to the Late Entrant Rule information on page 18 of this guide.) There is no guarantee that the employee or spouse will be approved for coverage by the life and long-term disability insurance company. If an employee enrolls for additional life insurance for him/herself, but declines to enroll for dependent life insurance for his/her children, the employee may elect dependent child life insurance any year during Switch/Open Enrollment (provided the additional life insurance coverage is still in place), with coverage effective January 1st of the following year. (Refer to the information on page 19 if you are an A3 status (part-time, benefit eligible) employee).

There is **no additional compensation paid** to you if you waive/decline any benefit coverage.

## *INITIAL ENROLLMENT*

A new benefit-eligible employee has 60 days from the date of benefit eligibility in which to enroll for benefit plan coverage offered by the District.

Coverage will be effective the 1st day of the month following the date your completed Enrollment Form is received via the Winocular system by the APS Employee Benefits Department, provided the Enrollment Form and any required supported documentation is received within 60 days of your Initial Eligibility for benefits.

**If you do not enroll yourself, or if you do not enroll any of your eligible dependents in the medical, dental and/or vision plans during the Initial Enrollment period**, you will not be able to enroll yourself (if benefit eligible) and/or them until the next Switch/Open Enrollment period, unless you or your dependents qualify for Special Enrollment. If you do not enroll for additional life insurance or long-term disability insurance during the Initial Enrollment period, you may apply for that coverage at a later date, subject to Evidence of Insurability. There is no guarantee that you will be approved for that coverage.

## *SPECIAL ENROLLMENT*

There are **three HIPAA Special enrollment opportunities for A1 and A3 status employees to enroll in the Plan's benefits mid-year**: a) upon gaining (acquiring) a new dependent, b) loss of other coverage, and c) on account of Medicaid or a State Children's Health Insurance Program (CHIP). These opportunities are explained below and on the next two pages:

**A. Newly Acquired Spouse and/or Dependent Child(ren)** (as these terms are defined under this Plan)

- **If you are enrolled for coverage** under this Plan and acquire a Spouse by marriage, or acquire any Dependent Child(ren) by birth, adoption or placement for adoption, or marriage, you may request enrollment for your new Spouse and/or any eligible Dependent Child(ren) no later than 60 days after the date of marriage, birth, adoption or placement for adoption. (Note: A child is "Placed for Adoption" with you on the date you first become legally obligated to provide full or partial support of the child whom you plan to adopt.)
- **Spouse Life Insurance coverage** amounts over $30,000 require Evidence of Insurability.

**To request Special Enrollment or if you have questions about Special Enrollment, contact the APS Employee Benefits Department.**

### THE FOLLOWING PROVISIONS APPLY TO MEDICAL, DENTAL AND/OR VISION COVERAGE

- **If you are eligible for coverage but not enrolled for coverage** under this Plan and acquire a Spouse by marriage, or acquire any Dependent Child(ren) by birth, adoption or placement for adoption, or marriage, you may request enrollment for yourself, you may also request enrollment for your new Spouse and/or any eligible Dependent Child(ren) no later than 60 days after the date of marriage, birth, adoption or placement for adoption. If you, the employee, are eligible but not already enrolled for coverage, you must request enrollment for yourself in order to enroll a new Dependent.
- **If you are eligible for coverage but did not enroll your Spouse for coverage** within 60 days of the date on which he or she became eligible for coverage under this Plan, and if you subsequently acquire a Dependent Child(ren) by birth, adoption or placement for adoption or marriage, you may request enrollment for your Spouse and/or your new Dependent Child(ren) and/or any eligible Dependent Child(ren) no later than 60 days after the date of your new Dependent Child(ren)'s birth, adoption or placement for adoption. If you, the employee, are eligible but not already enrolled for coverage, you must request enrollment for yourself in order to enroll a new Dependent.

  To request Special Enrollment or if you have questions about Special Enrollment, contact the APS Employee Benefits Department.

**B. Loss of Other Coverage**

If you did not request enrollment under this Plan for yourself, your Spouse, your Domestic Partner, the Domestic Partner's children, and/or any Dependent Child(ren) within **60 days** after the date on which coverage under the Plan was previously offered because you or they had health care coverage under another group health plan or health insurance policy (including COBRA Continuation Coverage, certain types of individual health insurance, Medicare, or other public program) **and** you, your Spouse, your Domestic Partner, the Domestic Partner's children and/or any Dependent Child(ren) **lose coverage** under that other group health plan or health insurance policy; and you are eligible for coverage under this Plan, you may request enrollment in the medical, dental and/or vision plan for yourself and/or your Spouse, your Domestic Partner, the Domestic Partner's children and/or any eligible Dependent Child(ren) within **60 days** after the termination of their coverage under that other group health plan or health insurance policy **if** that other coverage terminated because of:

- loss of eligibility for that coverage including loss resulting from legal separation, divorce, death, voluntary or involuntary termination of employment or reduction in hours (but does not include loss due to failure of employee to pay premiums on a timely basis or, termination of the other coverage for cause, such as making a fraudulent claim or intentional misrepresentation of a material fact); or
- termination of employer contributions toward that other coverage (an employer's reduction but not cessation of contributions does not trigger a special enrollment right); or
- the health insurance that was provided under COBRA Continuation Coverage, and such COBRA coverage was **"exhausted"** (explained below); or
- moving out of an HMO service area if HMO coverage terminated for that reason and, for group coverage, no other option is available under the other plan; or
- the other plan ceasing to offer coverage to a group of similarly situated individuals; or
- the loss of dependent status under the other plan's terms if the dependent meets the APS eligibility requirements; or
- the termination of a benefit package option under the other plan, unless a substitute plan of coverage is offered; or
- loss of eligibility due to reaching the lifetime benefit maximum <u>on all benefits</u> under the other plan. For Special Enrollment that arises from reaching a lifetime benefit maximum on all benefits, an individual will be allowed to request Special Enrollment in this Plan within 60 days after a claim is denied due to the operation of a lifetime limit on all benefits.
- A HIPAA Special Enrollment loss of coverage event that allows an employee to enroll on the APS medical plan mid-year (or enroll his/her dependents on the medical plan mid-year), gives the employee the opportunity to elect to enroll for medical plan, dental plan and/or vision plan coverage. (This is true even if only medical plan coverage was lost.)
- If only dental or vision plan coverage was lost, that gives the employee the opportunity to enroll for only the type of coverage (dental and/or vision plan) that was lost, or enroll his/her dependents for only the type of coverage that was lost. See also the

Enrollment Procedures for more information. Proof of loss of other coverage is required by this Plan.

COBRA Continuation Coverage is **"exhausted"** if it ceases for any reason other than either the failure of the individual to pay the applicable COBRA premium on a timely basis, or for cause (such as making a fraudulent claim or an intentional misrepresentation of material fact in connection with that COBRA Continuation Coverage). Exhaustion of COBRA Continuation Coverage can also occur if the coverage ceases:

- due to the failure of the employer or other responsible entity to remit premiums on a timely basis;
- when the employer or other responsible entity terminates the health care plan and there is no other COBRA Continuation Coverage available to the individual;
- when the individual no longer resides, lives, or works in a service area of an HMO or similar program (whether or not by the choice of the individual) and there is no other COBRA Continuation Coverage available to the individual; or
- because the 18-month, 29-month or 36-month (as applicable) period of COBRA Continuation Coverage has expired.

**C. Special Enrollment due to Medicaid or a State Children's Health Insurance Program (CHIP):**

A benefit-eligible employee and their eligible dependents **may also enroll in this Plan** if that employee (or their eligible dependents):

- have coverage through **Medicaid or a State Children's Health Insurance Program (CHIP)** and you (the employee) or your dependents **lose eligibility for that coverage**. However, you must submit an Enrollment/Change Form via Winocular to enroll in the APS Plan within **60 days** after the Medicaid or CHIP coverage ends. Coverage will be effective the first day of the month following receipt via Winocular by the APS Employee Benefits Department of the completed Enrollment/Change Form and supporting documentation; or
- become **eligible for a premium assistance program through Medicaid or CHIP**. However, you must submit an Enrollment Change/Form via Winocular within **60 days** after you (or your dependents) are determined to be eligible for such premium assistance.

### *START OF COVERAGE FOLLOWING SPECIAL ENROLLMENT:*

**Coverage of an individual enrolling because of loss of other coverage or because of marriage:** If the individual requests Special Enrollment **within 60 days** of the date of the event that created the Special Enrollment opportunity, including for a newborn and newly adopted child or on account of Medicaid or a State Children's Health Insurance Program (CHIP), (discussed below) coverage will become effective on the first day of the month following the date the Plan receives the completed Enrollment/Change Form and any required supporting documentation via Winocular requesting Special Enrollment. The enrollment form and supporting documentation must be received within 60 days of the event.

- **Coverage of a newborn or newly adopted newborn Dependent Child** who is properly enrolled within 60 days after birth will become effective as of the date of the child's birth.
- **Coverage of a newly adopted Dependent Child or Dependent Child Placed for Adoption** who is properly enrolled more than 60 days after birth, but within 60 days after the child is adopted or placed for adoption, will become effective as of the date of the child's adoption or placement for adoption, whichever occurs first.

Individuals enrolling during Special Enrollment have the same opportunity to select plan benefit options at the same contributions (costs) and based on the same enrollment requirements as are available to similarly situated employees at Initial Enrollment.

**Very Important Information - Failure to Enroll During Special Enrollment:** If you fail to submit via Winocular an Enrollment/Change Form (and any required supporting documentation) to request medical, dental and/or vision plan enrollment for yourself and/or any of your Eligible Dependents within 60 days after the date on which you and/or they first become eligible for Special Enrollment, you will not be able to enroll yourself or them until the next Switch/Open Enrollment period.

**Switch/Open Enrollment Period**: Switch/Open Enrollment is the period during the fall of each year designated by APS during which eligible employees (A1, A3 and ACA status) and COBRA qualified beneficiaries may make the elections specified below. Enrollment/Change Forms will be assigned to employees via the Winocular Workflow system. Information will be communicated via the *Perspective* electronic newsletter and via social media and may be obtained from the APS Employee Benefits Department. Individuals enrolling during Switch/Open Enrollment should follow the procedures explained at the time of Switch/Open Enrollment.

**Elections Available during Switch/Open Enrollment:** During the Switch/Open Enrollment period, you may elect, for yourself and your Eligible Dependents who are eligible for coverage, (subject to General Coverage Guidelines below) to

- **enroll** in one of the medical, dental, and/or vision coverages offered by the Plan, or enroll in one of the Flexible Spending Account plans, or
- **add or drop** Eligible Dependents to the medical, dental, or vision coverage (2-year lock-in rule applies to dental and vision coverage), or
- **change** medical, and/or dental plan options (2-year lock-in rule applies to dental coverage), or
- **enroll, apply, change or dis-enroll** in other benefit elections that you are eligible for, such as Flexible Spending Accounts.
- **A-1 status (full-time benefit eligible) employees** who already have additional life insurance coverage on themselves may enroll for dependent child life insurance during Switch/Open Enrollment.

- **Restrictions on Elections during Switch/Open Enrollment:** No Dependent may be covered unless you are covered.
- You and all your covered Eligible Dependents must be enrolled for the same medical, dental, and vision coverages. All relevant parts of the Enrollment/Change Form must be completed, and the form must be submitted via Winocular before the end of the Switch/Open Enrollment period to the APS Employee Benefits Department along with proof of Dependent status. See also the Enrollment Procedures section for more information.

### START OF OR CHANGES TO COVERAGE FOLLOWING SWITCH/OPEN ENROLLMENT:

- If you or your Spouse, Domestic Partner, or Dependent Child(ren) are **enrolled for the first time during a Switch/Open Enrollment period**, that person's coverage will begin on the first day of the new Plan Year (January 1st) following the Switch/Open Enrollment period.
- If you or your Spouse, Domestic Partner, or Dependent Children are **changing or discontinuing coverage during Switch/Open Enrollment**, such changes will become effective on the first day of the new Plan Year (January 1st) following the Switch/Open Enrollment period.

## FAILURE TO MAKE A NEW ELECTION DURING SWITCH/OPEN ENROLLMENT:

- If you have been enrolled for coverage and you **fail to make a new election during the Switch/Open Enrollment period**, you will be considered to have made an election to retain the same medical, dental vision, additional life insurance and long-term disability coverage you and any previously enrolled Eligible Dependents had during the preceding Plan Year. If there are changes to the medical, dental, vision, additional life insurance and/or long-term disability plan designs and/or premium contributions for the new plan year, you will be considered to have elected the changes to the plan design and/or premium contributions for the new plan year.

  Note, that for employees **to participate in the Plan's Flexible Spending Account for the next Plan Year** (Health Care FSA or Dependent Care FSA) the employee **must complete a new Flex Plan electronic enrollment**, even if you were enrolled in the Flex plan the previous year.

**Caution:** Switch/Open Enrollment procedures can differ from the process outlined in this document and if so, the procedure on how to enroll at Switch/Open Enrollment time will be announced by the APS Employee Benefits Department prior to the beginning of the Switch/Open Enrollment period. (Announcements regarding Switch/Open Enrollment are made in the *Perspective* electronic newsletter and via social media.) Being dropped from coverage at Switch/Open Enrollment time is not a COBRA qualifying event to permit the election of temporary COBRA continuation coverage.

### Very Important Information

**Failure to Enroll During Switch/Open Enrollment:** If you fail to enroll yourself and/or any of your Eligible Dependents for medical, dental and/or vision plan coverage within the Switch/Open Enrollment period (unless you or your Eligible Dependents qualify for Special Enrollment), you will not be able to enroll yourself and/or them until the next Switch/Open Enrollment period (assuming you are benefit-eligible), unless you have a Special Enrollment or other mid-year change event. If you fail to enroll for the Flexible Spending Accounts during the Switch/Open Enrollment period, you will not be able to enroll until the next Switch/Open Enrollment period.

## NEWBORN DEPENDENT CHILDREN (SPECIAL RULE FOR COVERAGE)

Your newborn Dependent Child(ren) **will be covered from the date of birth, only if** you request enrollment for that newborn Dependent Child within 60 days after the child's date of birth and follow the enrollment procedure of this Plan by submitting a completed Enrollment/Change Form via Winocular (contact the APS Employee Benefits Department to have the form assigned to you in Winocular), provide proof of Dependent status in the form of a Hospital Proof of Birth Letter or Birth Certificate, and electronically sign and submit the Enrollment/Change Form authorizing APS to deduct from your earnings the required contributions to pay for that Dependent Child's coverage. Remember that you may not enroll a newborn Dependent Child for coverage unless you, the employee, are also enrolled for coverage. See also the Special Enrollment provisions and the Enrollment Procedures. If a Hospital Proof of Birth Letter was used to enroll a newborn, submit the birth certificate and SSN as soon as you receive the documents.

## ADOPTED DEPENDENT CHILDREN (SPECIAL RULE FOR COVERAGE)

Your adopted Dependent Child will be covered from the date that child is adopted or "Placed for Adoption" with you, whichever is earlier, provided you follow the enrollment procedure of this Plan by submitting a completed Enrollment/Change Form via Winocular, provide proof of Dependent status, and electronically signing the Enrollment/Change Form authorizing APS to deduct from your earnings the required contributions to pay for that Dependent Child's coverage. A child is "Placed for Adoption" with you on the date you first become legally obligated to provide full or partial support of the child whom you plan to adopt.

- **A Newborn Child whom is placed for Adoption** with you within 60 days after the child was born will be covered from the date the child was placed for adoption if you comply with the Plan's requirements for enrolling for coverage for a Newborn Dependent Child, described above.
- **A Dependent Child adopted more than 60 days after the child's date of birth** will be covered from the date that child is adopted or "Placed for Adoption" with you, whichever is earlier, if you comply with the Plan's requirements for enrolling for coverage for an Adopted Dependent Child, described above, within 60 days of the child's adoption or placement for adoption.

If the adopted Dependent child is not properly enrolled in a timely manner, you must wait to enroll them at the next Switch/Open Enrollment period or Special Enrollment period, if applicable. However, if a child is placed for Adoption with you, and if the adoption does not become final, coverage of that child will terminate as of the date you no longer have a legal obligation to support that child. Remember that you may not enroll an adopted Child or a Child Placed for Adoption for coverage unless you, the employee, are also enrolled for coverage.

If you are eligible for coverage but not enrolled and acquire a new Dependent Child by adoption or placement for adoption, you may request enrollment in the medical, dental and/or vision plans for yourself and/or any other Eligible Dependents along with the newly adopted Dependent Child within 60 days of the adoption, placement for adoption, or birth, as applicable. See also the Special Enrollment provisions and section on Enrollment Procedures.

## GENERAL COVERAGE GUIDELINES

Employer Paid Basic Life & Accidental Death & Dismemberment (AD&D) Coverage

- If you work the required minimum number of hours per week and are classified as A1 or A3 status, you are automatically covered for basic life and AD&D insurance in the amount of $10,000. This coverage is provided by the District at no cost to you. You need to complete a beneficiary designation form via the Winocular system and submit it to the APS Employee Benefits Department even if you do not enroll for any other benefits.

Additional Voluntary Life & Accidental Death & Dismemberment (AD&D) and Long-Term Disability Insurance

- If you work the required minimum number of hours per week and are classified as A1 status, you may enroll for additional voluntary life and AD&D insurance and/or long-term disability insurance within 60 days of your date of hire. You may also enroll for additional voluntary life insurance for your spouse or domestic partner and/or your children (subject to plan rules). If you are an A1 or A3 status employee and are already enrolled in additional life insurance, you may add additional voluntary life insurance for a new spouse and/or a new child within 60 days of the date of your marriage or the birth or adoption of the child (subject to plan rules). If you do not enroll for these coverages as a new employee (or within 60 days of a qualifying event), are an A1 status employee, and want to apply at a later date, you will be subject to the Late Entrant Rule shown below. In all cases, enrollment is completed through the Winocular Workflow system.

Late Entrant Rule for Voluntary Life and Accidental Death & Dismemberment (AD&D) Insurance and Long-Term Disability Insurance

- If you work the required minimum number of hours per week and are classified as A1 (full-time benefit eligible) status, you may apply for Additional Life and AD&D Insurance. If you work the required minimum number of hours per week and are classified as A1 status, you may also apply for Long-Term Disability insurance. You may apply for these coverages at any time during the year except between September 20th and October 31st, subject to approval by the insurance company, based on Evidence of Insurability (medical underwriting). There is no guarantee you will be approved. The insurance company will notify both you and the APS Employee Benefits Department if you are approved or denied. If your coverage is approved by the

insurance company your coverage and required payroll deductions will start the first of the month following receipt of that notification by the Employee Benefits Department provided you have also submitted an Enrollment Form via the Winocular Workflow system.

- If you work the required minimum number of hours per week and are classified as A1 status, and have additional voluntary life insurance on yourself, you may apply for additional voluntary spouse life insurance. You may apply for spouse coverage at any time during the year except between September 20th and October 31st, subject to approval by the life insurance company based on Evidence of Insurability (medical underwriting). There is no guarantee that your spouse will be approved. If your spouse's coverage is approved, the life insurance company will notify both you and the APS Employee Benefits Department. That coverage and required payroll deductions from your paycheck will start the first of the month following receipt of that notification by the Employee Benefits Department provided you have also submitted an Enrollment Form via the Winocular Workflow system.
- If you work the required minimum number of hours per week and are classified as A1 status, and have additional voluntary life insurance on yourself, you may enroll for additional voluntary dependent life insurance for your children (through age 25) during Switch/Open Enrollment, following the procedures announced by the Employee Benefits Department. That coverage and required payroll deductions from your paycheck will start the following January 1st.
- If you are an A3 (part-time, benefit eligible) status employee, you may continue the additional life insurance (self, spouse and dependent) that you had in place on the day prior to your change to A3 status. While an A3 status employee, you are not eligible to increase the amount of your additional life insurance (self, spouse and dependent). You may add spouse or child life insurance (subject to plan rules) only within 60 days of acquiring a new spouse or a new child, provided you request and submit an Enrollment Form via the Winocular system within that 60 days. You may decrease or drop your additional life insurance (self, spouse and dependent) coverage at any time; however, you will not be eligible to re-enroll in that coverage while you remain an A3 status employee. If you drop your additional life insurance (self, spouse and dependent) while you are on an approved leave of absence, you will not be eligible to re-enroll for that coverage when you return from leave.
  - In keeping with the provisions in the long-term disability (LTD) insurance policy, A3 status employees are not eligible for LTD insurance.

Two-Year Lock-in Rule for Dental Plan Election

- The District requires that, once enrolled in dental plan coverage, you may not drop or switch dental plan options until you and each of your covered dependents have been enrolled in the dental plan for two years.

Two-Year Lock-in Rule for Vision Plan Election

- The District requires that, once enrolled in vision plan coverage, you may not drop the vision plan until you and each of your covered dependents have been enrolled in the vision plan for two years.

## CHANGING YOUR COVERAGE DURING THE YEAR (MID-YEAR CHANGE OF STATUS/ELECTION CHANGE)

**Note: Many of these provisions DO NOT apply to additional Life Insurance and Long-Term Disability Insurance.**

**Government regulations generally require that your Plan coverages remain in effect throughout the Plan Year** (from January 1 through December 31), but you may be able to make some changes during the year (mid-year) if the APS Employee Benefits Department determines that you have a permissible **change** in your status (as permitted by the IRS) and that change affects your benefit eligibility.

Note that this Plan covers Domestic Partners. Mid-year, if a Domestic Partner experiences a HIPAA Special Enrollment Loss of Other Coverage event, you may enroll your Domestic Partner in the Plan within 60 days of that event. Coverage will be provided on a **post-tax** basis. In the new plan year, the Domestic Partner can have his or her benefits applied pre-tax only if the Domestic Partner met the definition of a qualifying relative in the prior calendar year (IRS Code Section 152 (d) (1) and (d) (2) (H) without regard to the gross income limit – meaning the Domestic Partner is a “qualifying relative” of the employee).

If your Domestic Partner has not experienced a HIPAA Special Enrollment Loss of Other Coverage event, you may only enroll your Domestic Partner when you are initially eligible for coverage or during Switch/Open Enrollment.

Generally, proof of the change of status event will be required. The following changes are the only ones permitted under the Plan:

1. **Change in employee’s legal marital status**, including gaining a Spouse through marriage, or losing a Spouse through divorce, legal separation (where permissible by law), annulment or death.
2. **Change in number of employee’s Dependents**, including gaining a child through birth, adoption, or placement for adoption, or losing a child such as through death.
3. **Change in your, your Spouse’s or Dependent Child’s employment status or work schedule IF it impairs (or creates) your, your Spouse’s or your Dependent Children’s eligibility for benefits**, including the start or termination of employment, an increase or decrease in hours of employment (including a switch in part-time and full-time employment), a strike or lock-out, the start of or return from an unpaid leave of absence that is either required by law (such as FMLA and military leave or, other leave permitted by your employer), or a change of work-site.
4. **Change in Dependent status that satisfies or ceases to satisfy the Plan’s eligibility requirements**, including changes due to attainment of age, or a change affecting a requirement described under the definition of Dependent in this document.
5. **Change of residence or worksite that allows or impairs** your, your Spouse’s or Dependent Child’s eligibility for benefits.
6. **Change required under the terms of a Qualified Medical Child Support Order (QMCSO),** including a change necessary to add the child as a covered Dependent as specified in the order, or to cancel coverage for the child if the order requires your former Spouse to provide that coverage.
7. **Change consistent with your right to Special Enrollment.**
8. **Change consistent with entitlement to (or loss of eligibility for) Medicare or Medicaid** affecting you, your Spouse or Dependent Child (except for coverage solely under the program for distribution of pediatric vaccines), including prospective cancellation of coverage of the person entitled to Medicare/Medicaid following such entitlement or prospective reinstatement or election of coverage following loss of eligibility for Medicare/Medicaid.
9. **Automatic Change in the Cost of Coverage**. If the cost of a qualified benefit plan increases or decreases during the Plan year and under the terms of the Plan employees are required to make a corresponding change in their payments, the Plan may, on a reasonable and consistent basis, automatically make a prospective increase or decrease in the affected employees’ elective contribution for the Plan.
10. **Significant Change in the Cost of Coverage**. If the cost charged to an employee for a benefit package significantly increases or significantly decreases during the Plan year, the Plan may permit the employee to make a corresponding change in election under the Plan. In such a case the employee may start coverage in the Plan option with the decreased cost; or, revoke coverage in the Plan option with an increased cost and elect, on a prospective basis, coverage under another plan option providing similar coverage, if one is available, or drop the coverage if no other such plan option is available.

11. **Significant curtailment without loss of coverage**. If the employee or employee's Spouse or Dependent child has a significant curtailment of coverage under a plan during the Plan year that is not a loss of coverage, the Plan may permit the employee who has been participating in the Plan to revoke his/her election for that coverage and elect to receive, on a prospective basis, coverage under another benefit package option providing similar coverage, or to drop coverage if no similar benefit package option is available. Coverage is significantly curtailed only if there is an overall reduction in coverage provided to participants under the Plan so as to constitute reduced coverage to participants generally.
12. **Addition or elimination of a benefit package option providing similar coverage**. If during a Plan Year, the Plan adds a new benefit package option or other coverage option (or eliminates an existing benefit package option or other coverage option) the Participant may elect the newly-added option (or elect another option if an option has been eliminated) prospectively and make corresponding election changes with respect to other benefit package options providing similar coverage.
13. **Addition or significant improvement of any Plan option under the employer's Health Care Programs or the Spouse's employer's health care plans or programs**. In such a case, a Participant may revoke coverage in the current plan and either elect, on a prospective basis, coverage under a new or improved plan option.
14. **Change in coverage under another employer's plan or program** that permits Participants to make an election change that would be permitted by these mid-year changes, or that permits Participants to make an election for a period of coverage that is different from the Plan Year of this Plan (e.g. Spouse's employer coverage has different open enrollment/Plan year). In such a case, a Participant may elect, on a prospective basis, the same change in coverage under this Plan that was available under the other plan.
15. **Exchange Coverage.** An employee who is eligible to enroll in Marketplace coverage (during a Marketplace special enrollment or open enrollment period) may prospectively drop the District's group health plan coverage midyear, but only if the change corresponds to the employee's intended enrollment (and the intended enrollment of any related individuals whose coverage is being dropped) in Marketplace coverage that is effective no later than the day after the last day of the original coverage. This means that the District's group health plan coverage is not to be terminated until Marketplace coverage takes effect.

**These rules apply to making changes to your benefit coverage(s) during the year:**

1. Any change you make to your benefits must be determined by the APS Employee Benefits Department to <u>be necessary, appropriate to and consistent with the change in status</u>; *(For example, if mid-year, the employee and Spouse deliver a newborn child they can add that child to this Plan but it would be inconsistent with a birth event to drop the Spouse from coverage at this time);* **and**
2. You must notify this Plan electronically (by completing and submitting an Enrollment/Change Form via Winocular) within **60 days** of the change in status, otherwise, the request will not be considered to be made on account of your change of status and you will have to wait until the next Switch/Open Enrollment period to make your changes in coverage; **and**
3. If you have a permissible change in status, you are only allowed to make changes to your coverage that are consistent with the change of status event. <u>Generally, only coverage for the individual who has lost eligibility as a result of a change of status (or who has gained eligibility elsewhere and actually enrolled for that coverage) can be dropped mid-year</u> from this Plan. Proof of the change of status event will be required; **and**
4. If you will be adding an eligible individual to the Plan, **coverage changes associated with a mid-year change of status opportunity for benefits-eligible persons <u>must be prospective</u>** and are therefore effective the first day of the month following the date you submit a completed Enrollment/Change Form via Winocular to the APS Employee Benefits Department, except for:
   - Newborns, who are effective on the date of birth and
   - Children adopted or placed for adoption, who are effective on the date of adoption or placement for adoption.

If you will be removing an individual from the Plan mid-year, coverage will terminate in accordance with the "When Coverage Ends" provisions.

**A Brief Summary of Common Change of Status Events and the Mid-Year Enrollment Changes Allowed Under the Medical Plan**

Mid-year changes are only those permitted in accordance with Section 125 of the Internal Revenue Code. Generally, proof of the permitted election change event will be required. This chart is only a summary of some of the permitted medical plan changes and is not all inclusive. This chart should NOT be referenced for a Health FSA or Dependent Care Assistance Plan (DCAP).

| If you experience the following Event... | You may make the following change(s) within 60 days of the Event. | YOU MAY NOT make these types of changes... |
|---|---|---|
| ***REMINDER:*** *Failure to notify the Plan within 60 days of the date of a divorce or the date a child loses eligibility will cause the individuals losing coverage to forfeit the right to elect COBRA continuation coverage.* | | |
| ***Family Events*** | | |
| Marriage | • Enroll yourself, if applicable<br>• Enroll your new Spouse and other eligible dependents<br>• Drop health coverage (to enroll in your Spouse's plan)<br>• Change health plans, when options are available | • Drop health coverage and not enroll in Spouse's plan. |
| Divorce | • Remove your Spouse from your health coverage<br>• Enroll yourself (and your children) if you or they were previously enrolled in your Spouse's plan | • Change health plans<br>• Drop health coverage for yourself or any other covered individual |
| Gain a child due to birth or adoption | • Enroll yourself, if applicable<br>• Enroll the eligible child and any other eligible dependents<br>• Change health plans, when options are available | • Drop health coverage for yourself or any other covered individuals |
| Child requires coverage due to a QMCSO | • Add child named on QMCSO to your health coverage (enroll yourself, if applicable and not already enrolled)<br>• Change health plans, when options are available, to accommodate the child named on the QMCSO | • Make any other changes, except as required by the QMCSO |
| Loss of a Dependent's eligibility (*e.g.,* child reaches the maximum age for coverage) | • Remove the Dependent from your health coverage<br>• Dependent will be offered COBRA | • Change health plans<br>• Drop health coverage for yourself or any other covered individuals |
| Death of a dependent (Spouse or child) | • Remove the dependent from your health coverage<br>• Change health plans, when options are available | • Drop health coverage for yourself or any other covered individuals |
| Covered person has become entitled to (or lost entitlement to) Medicaid or Medicare | • Drop coverage for the person who became entitled to Medicare or Medicaid.<br>• Add the person who lost Medicare/Medicaid entitlement. | • Drop health coverage for yourself or any other covered individuals |
| • ***Employment Status Events*** | | |
| Spouse becomes eligible for health benefits in another group health plan | • Remove your Spouse from your health coverage, with proof of Spouse's other new plan coverage<br>• Remove your children from your health coverage, with proof of children's other new plan coverage<br>• Drop coverage for yourself only with proof that Spouse added you to the Spouse's new group health plan | • Change health plans<br>• Add any eligible dependents to your health coverage |
| Spouse loses employment or otherwise becomes ineligible for health benefits in another plan | • Enroll your Spouse and, if applicable, eligible children in your health plan<br>• Enroll yourself in a health plan if previously not enrolled because you were covered under your Spouse's plan<br>• Change health plans, when options are available | • Drop health coverage for yourself or any other covered dependents |
| You lose employment or otherwise become ineligible for health benefits | • Enroll in your Spouse's plan, if available<br>• Elect temporary COBRA coverage for the Qualified Beneficiaries (you and your covered Dependents) | |

***Proof of a status change may be required to make a corresponding change in coverage/enrollment.***

## REMINDERS RELATED TO CERTAIN QUALIFYING LIFE EVENTS

- **Change of Name, Address or Phone Number** – Follow the APS Human Resources Department procedures to update your name, address and/or phone number within 30-days of the change. This will ensure that your benefit information is updated as well.
- **Divorce – You may not leave a divorced spouse on your benefit plans. A divorced spouse is no longer eligible for benefits.** Complete and submit via Winocular an Enrollment/Change Form **as soon as possible but not later than the end of the month in which the divorce is final**. Provide a copy of your Final Divorce Decree via upload to Winocular. Review your life insurance and New Mexico Educational Retirement Board (pension plan) beneficiary designation for any needed changes. Timely notification, including your former spouse's new address (if applicable), is required so APS can inform your former spouse of eligibility for COBRA continuation coverage. **It is fraudulent to continue coverage for your former spouse on the APS active medical and/or other benefit plans.**
- **Death –** Complete and submit via Winocular the Enrollment/Change Form as quickly as possible, but not later than 60 days after the death of a spouse/domestic partner or child. Provide a copy of the Death Certificate via upload to Winocular. Review your life insurance and New Mexico Educational Retirement Board (pension plan) beneficiary designation for any needed changes.
- **Employment Status Change –** Change from an A4, A5, A6 or A8 status to A1 (full-time, benefit eligible) status **is** a Qualifying Life Event: May enroll in all benefits offered to A1 employees. Complete and submit via Winocular an Enrollment Form and provide any required document via upload to Winocular within 60 days of becoming an A1 employee. Also be certain to complete a Basic Life Insurance beneficiary form (complete a beneficiary form even if you do not plan to enroll for any other benefits). If you are not assigned the Enrollment Forms through Winocular, contact the Employee Benefits Department to request that those forms be assigned to you.

  Change from an A3 status to A1 (full-time, benefit eligible) status is **not** a Qualifying Life Event: May enroll for Long-Term Disability Insurance without Evidence of Insurability, as long as that is done within 60 days of the effective date of the change to A1 status. The employee may continue all other benefits that were in place as an A3 employee, however, must wait until the next Open Enrollment Period to enroll for medical, dental and/or vision plan coverage if that coverage was not in place as an A3 employee. The employee is eligible to apply for Additional Life Insurance (subject to Evidence of Insurability), just as any other A1 employee.
- **Full-Time Short-term Employees –** May enroll in all benefits when first hired. Complete and submit via Winocular an Enrollment/Change Form and provide any required documentation via upload to Winocular within 60 days of date of hire. If coverage is not elected or coverage is dropped, the employee will not be able to enroll in medical, dental and/or vision coverage until the next Switch/Open Enrollment period. If employee's contract is renewed after the first day of school, APS will determine when the employee is again eligible to elect benefits.
- **Loss of Other Coverage** – If the employee is benefits-eligible when the loss of other coverage occurs, then complete and submit via Winocular an Enrollment/Change Form to enroll in APS benefits for you and your eligible family members. This must be done within 60 days of the loss of coverage and the Loss of Coverage Letter from the previous employer or insurance provider must be provided to the APS Employee Benefits Department via upload to Winocular. The effective date of coverage for you and/or your family members will be the first day of the month following the date you submit the Enrollment/Change Form and required documentation. If you fail to meet these deadlines, you will not be able to enroll until the next Switch/Open Enrollment period.
- **Child turns age 26** – The APS Employee Benefits Department will terminate eligibility and cancel medical, dental and/or vision coverage as of the last day of the calendar month in which your child turns age 26. The APS Employee Benefits Department will send a COBRA Election Notice to your child within 14 days of cancellation of coverage. Dependent life insurance coverage ends the day before your child's 26th birthday. Life insurance cannot be continued under COBRA. If the child who is age 26 is considered to be a disabled adult child, the parents must provide proof of disability within 60 days of the child's 26th birthday in order to ensure that medical, dental and/or vision plan coverage can continue for that child beyond the last

day of the month in which the child reaches age 26. (Proof of disability documentation for a disabled dependent child must be submitted to the Claims Administrator (medical plan carrier), not to the APS Employee Benefits Department, unless you are enrolled on the Cigna medical plan option. If you are enrolled on the Cigna plan, contact the APS Employee Benefits Department for the procedure to continue coverage for a disabled dependent.)

- **Leave of Absence** – During an approved leave of absence (such as for FMLA, Military leave or a District-approved leave), you may elect to continue your benefits coverage, provided that you pay your portion of the total required monthly premium. (Details will be included in the letter you receive from the APS Leaves Department.) If you are an A1 status employee and you cancel your benefits while you are on approved leave, refer to page 8 and page 26 of this guide for information about reinstating those benefits when you return from approved leave.

  While on approved leave, you are responsible for notifying the Employee Benefits Department of any Special Enrollment event (the birth of a baby, marriage, divorce, etc.) and completing an Enrollment/Change Form within 60 days of the event.

- **Resignation, Retirement, or Termination** – Contact the APS Employee Benefits Department to find out when your benefit coverage ends. COBRA continuation coverage may be available.

- **New Coverage Available for you, your spouse or child(ren) resulting from change in Employment Status or eligibility for Medicaid or Medicare** – You may cancel APS coverage for yourself, spouse and/or children within 60 days from the effective date of the new coverage for yourself, your spouse and/or child(ren). You must provide APS with a Proof of New Coverage Letter on letterhead from the new insurance provider or the employer's Human Resources/Employee Benefits Department. This letter must specify who will be covered; type of coverage and the date coverage goes into effect. APS benefits for yourself and/or your family members will terminate at the end of the month in which you submit your Proof of New Coverage Letter and completed Enrollment/Change Form via the Winocular Workflow system to the APS Employee Benefits Department. Please note that handwritten notices or enrollment forms will NOT be accepted as proof of other coverage. Insurance identification cards may be accepted as proof of other coverage if they show the name(s) of the covered individual(s), and both the type of coverage (medical, dental and/or vision) and the effective date of coverage are readily apparent on the ID card.

### WHEN COVERAGE ENDS

**Employee coverage ends on the earliest** of the last day of the month in which:

- For 256 or 248-day contracts, and any other contract ended PRIOR to the last scheduled work date of the contract – coverage ends at the ends of the month in which your employment ends (last work-calendar date of employment), provided all required premiums are paid, or
- For all other contracts COMPLETED through the last scheduled work date of the contract – coverage ends at the end of the month in which you receive your final paycheck, provided all required premiums are paid, or
- you enter the Armed Forces (the military) on full-time active duty; or
- you are no longer eligible to participate in the Plan (for example, you are no longer classified as a benefit eligible employee); or
- you cease to make any contributions required for your coverage; or
- you drop coverage at Switch/Open Enrollment or due to a Special Enrollment mid-year change event; or
- the date the Plan is discontinued; or
- the date of your death.

**Dependent or Domestic Partner coverage ends on the earliest** of the last day of the month in which:

- the Employee's coverage ends (refer to Life Insurance Certificate for the date additional voluntary life insurance ends for a covered dependent of a deceased employee); or
- your covered Spouse, Dependent Child(ren) or Domestic Partner no longer meet the definition of Spouse or Dependent Child(ren) or Domestic Partner as defined in this document; or
- you cease to make any contributions required for coverage of your Spouse or Dependent Child(ren) or Domestic Partner; or
- the date the Spouse, Dependent Child(ren) or Domestic Partner enters the Armed Forces on full-time active duty; or
- the date Dependent coverage is discontinued under the Plan; or
- the date of the Dependent's or Domestic Partner's death; or
- the date the Plan is discontinued.

## OPTIONS WHEN COVERAGE ENDS UNDER THIS PLAN

**When coverage under this Plan terminates you may have** the option to:

a. buy temporary continuation of this group health plan coverage by electing COBRA; or

b. convert your group insurance coverage to an individual insurance policy (when permitted by the insurance company); or

c. you can look into your options to buy an individual insurance policy for health care coverage from the **Health Insurance Marketplace**.

Also, in the Marketplace you could be eligible for a tax credit that lowers your monthly premiums for Marketplace-purchased coverage. Being eligible for COBRA does not limit your eligibility for Marketplace coverage or for a tax credit. For more information about the Health Insurance Marketplace, visit www.healthcare.gov.

Also, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), if you request enrollment in that other plan within 30 days of losing coverage under this Plan.

## WHEN THE PLAN CAN END YOUR COVERAGE FOR CAUSE (RESCISSION)

In accordance with the requirements in the Affordable Care Act, the Plan will not retroactively cancel coverage (a rescission) except when premiums and contributions are not timely paid in full, or in cases when an individual performs an act, practice or omission that constitutes fraud, or makes an intentional misrepresentation of material fact that is prohibited by the terms of the Plan, as discussed below:

A. The Plan Administrator or its designee may end your coverage and/or the coverage of any of your covered Dependents for cause 60 days after it gives you written notice of its finding that you or your covered Dependent:

1. **engages in an act, practice or omission that constitutes fraud, insurance fraud, or an intentional misrepresentation of a fact** in any enrollment, claim or other form in order to obtain coverage, services or benefits under the Plan. Keeping an ineligible dependent enrolled under the Plan (for example, an ex-spouse, over-age or ineligible dependent child, etc.) is considered fraud; or

2. **allowed anyone else to use the identification card** that entitles you or your covered Dependent to coverage, services or benefits under the Plan; or

3. **altered any prescription** furnished by a Physician or other Health Care Practitioner.

If your coverage is terminated for any of the above reasons, it may be terminated retroactively (a rescission) to the date that you or your covered Dependent performed or permitted the acts described above.

For example, you must immediately notify the APS Employee Benefits Department, by completing and submitting via Winocular an Enrollment/Change Form, of any change in eligibility status for any Dependent enrolled for coverage under the Plan, such as divorce or other event resulting in a loss of eligibility. A failure to notify the Plan of such a change in status will be deemed an act of omission constituting fraud or an intentional misrepresentation of a fact by the Participant and ineligible Dependent.

B. The Claims Administrator may end your coverage and/or the coverage of any of your covered Dependents for cause 30 days after it gives you written notice of its finding that you or your covered Dependent(s) engaged in **conduct that was abusive, obstructive, or otherwise detrimental to a Physician or Health Care Practitioner**. If your coverage is terminated for this reason, it will be terminated on a going forward (prospective) basis.

C. The APS Employee Benefits Department may end your coverage and/or the coverage of any of your covered Dependents for cause 15 days after it gives you written notice of its finding that you have failed to pay your premium payment. In this instance, your coverage may be terminated retroactively to the date of the delinquent premium payment. In addition, your coverage may be suspended during the 15-day notice period.

**Insurance Fraud**
**(Federal and State Insurance Laws Apply)**
Anyone who knowingly or willfully makes any false or fraudulent statement or representations shall risk forfeiting all employee and family member rights to coverage or benefits. APS will take the appropriate disciplinary action against the offending employee.

### LEAVE OF ABSENCE (SPECIAL CIRCUMSTANCES)

To find out about leave, including FMLA (Family Medical Leave Act) and military leave, visit the "Extended Leaves" or "Sick Leave Bank" pages on the APS website. You may also contact the APS Leaves Department. Contact information is found on the APS website (www.aps.edu).

While you are on FMLA leave, leave for military service (Uniformed Services Employment and Reemployment Rights Act leave - USERRA) or other approved APS leave, you can keep benefit coverage for yourself and your Dependents or Domestic Partner or child of a Domestic Partner in effect during that leave by paying your contributions for coverage during that period.

- Since you may not be paid while you are on leave, you may pay your contributions to the APS Employee Benefits Department on a monthly basis.
- During your first year of approved leave, you must pay your contribution amount (the same amount that would have been withheld from your paycheck) on a monthly basis.
- If you are approved for a second year of leave, you must pay 100% of the premium contribution amount on a monthly basis.
- Whether or not you keep your benefit coverage while you are on approved leave, if you return to work promptly at the end of that approved leave, and are benefit eligible at the time, the medical, dental and/or vision plan you were enrolled for prior to your leave may be reinstated without any additional limits or restrictions imposed on account of your approved leave. (This is also true for any of your Dependents, Domestic Partner, or child of a Domestic Partner who were covered by the Plan at the time you took your approved leave.) You may re-enroll for the medical, dental and/or vision plan coverage you had at the time you went out on approved leave. You are not eligible to add medical, dental and/or vision plan coverage that you did not have at that time, nor are you eligible to add Dependents who were not covered at the time you went out on approved leave. To re-enroll in these plans, contact the Employee Benefits Department to request that the Enrollment Form be assigned to you through the Winocular Workflow system, and complete and submit those forms through Winocular. You have 60 days from the date you return from an approved leave to submit the Enrollment Form, with coverage effective the first day of the month following the date the Employee Benefits Department receives your completed enrollment.
- If you elect to drop long-term disability insurance while on approved leave or were not enrolled for long-term disability insurance prior to the approved leave, you may enroll for long-term disability insurance <u>without</u> Evidence of Insurability, provided that 1) you are an A1 status employee 2) the period of approved leave was not more than 24 months, <u>and</u> 3) the total period of approved <u>medical</u> leave was not more than 12 months, <u>and</u> 4) the enrollment is submitted via the Winocular system within 60 days of the return-to-work date. Coverage will be effective the first day of the month following the date the Employee Benefits Department receives your completed enrollment.
- If you elect to drop additional life insurance, spouse and dependent life insurance while on approved leave, you may elect to re-enroll in the <u>same amount</u> of life insurance coverage (self, spouse and dependent) that was in place on the day prior to the approved leave, <u>without</u> Evidence of Insurability, provided that 1) you are an A1 status employee 2) the period of leave was not more than 24 months, <u>and</u> 3) the total period of approved <u>medical</u> leave was not more than 12 months, <u>and</u> 4) the enrollment is submitted via the Winocular system within 60 days of the return to work date. Coverage will be effective the first day of the month following the date the Employee Benefits Department receives your completed enrollment.
- If you were not enrolled for additional life insurance prior to an approved leave and you are an A1 employee, you may <u>apply</u> for life insurance coverage <u>subject</u> to Evidence of Insurability. Contact the Employee Benefits Department or refer to the Benefits webpage for the steps to take to apply for additional life insurance coverage.
- Of course, any changes in the Plan's terms, rules or practices that went into effect while you were away on that approved leave will apply to you and your Dependents or Domestic Partner or child of a Domestic Partner in the same way they apply to all

other employees and their Dependents and Domestic Partner or child of a Domestic Partner.

- To find out more about your entitlement to family or medical leave, or military leave as required by federal and/or state law, and the terms on which you may be entitled to it, contact the APS Leaves Department. Contact information is available on the APS website. (From www.aps.edu, select the A – Z Directory from the menu bar, then select the letter E, and then Extended Leaves. Scroll down to the bottom of the page and select Department Staff Listing in the Contact Us box).

### *IMPORTANT NOTICE*

You or your Dependents (or Domestic Partner) must promptly furnish to the APS Employee Benefits Department information regarding marriage, divorce or legal separation, change in Domestic Partner status, death of any covered family member, birth or change in status of a Dependent Child, Medicare enrollment or disenrollment, an individual no longer meeting the eligibility provisions of the Plan, or the existence of other coverage. Proof of legal documentation will be required for certain changes.

You must promptly furnish to the APS Human Resources (HR) Department information regarding a change of name, address, or phone number. Notify the Plan (or the HR Department, as applicable) preferably within 31 days, but no later than 60 days, after any of the above noted events.

**Failure to give the APS Employee Benefits Department or HR Department a timely notice of the above noted events may:**

a. cause you, your Spouse and/or Dependent Child(ren) to lose the right to obtain COBRA Continuation Coverage,
b. cause the coverage of a Dependent Child to end when it otherwise might continue because of a disability,
c. cause claims to not be considered for payment until eligibility issues have been resolved,
d. result in your liability to repay the Plan if any benefits are paid to or on behalf of an ineligible person.

**APS Employee Benefits Department**
**6400 Uptown Blvd. NE, Suite 115-E**
**Albuquerque, NM 87110**
**Phone: (505) 889-4859 - Fax: (505) 889-4882**

**"Wellness is the complete state of physical, mental and social well-being, and not merely the absence of disease or infirmity."**
-World Health Organization (WHO)

Our physical and mental health are intricately connected. Stress, anxiety, depression and other common behavioral health struggles result in weight gain, high blood pressure, diabetes, cancers and other preventable chronic illnesses. Recognizing that link and taking simple, daily actions to enhance our social, emotional and physical wellbeing is essential to long-term wellness.

APS Employee Wellness encourages an environment that promotes a culture of total well-being for all employees. We provide resources and programs to improve physical and mental health and safety, as well as reduce the risk of preventable chronic diseases. This not only boosts our immune system, but also enhances our complete wellness state so that we are not merely surviving but thriving.

The APS Employee Wellness Program includes a year-round employee wellness incentive campaign. Participants can engage in this flexible program anytime of the year through a wide range of wellness options. Some activities include exercise, nutrition, wellness challenges, cooking classes, preventive screens, doctor visits, mindfulness and stress reduction programs, volunteering, even buckling your seatbelt and wearing sunscreen! The concept is simple: Do wellness, log points, and earn rewards.

Employee Wellness hosts an annual wellness fair. This includes on-site preventive screens like mammograms and annual vaccinations. A multitude of community organizations provide fitness, nutrition and well-being education and activities.

Visit [http://www.aps.edu/staff/employee-wellness](http://www.aps.edu/staff/employee-wellness) for more information and the monthly newsletter.

**Refer to pages 52 - 54 of Appendix A: Required Notices**

**The notices include important wellness program information.**

Click icon to connect on social media *APS Employee Wellness*

## *FLEXIBLE SPENDING ACCOUNTS (FSA)*

Flexible Spending Accounts (FSAs) allow you to set aside money from your paycheck before taxes are taken out. Electing to enroll in a health care FSA means you can then use these pre-tax dollars to pay for eligible health, dental, vision and hearing expenses throughout the year. A dependent care FSA allows you to do the same thing to pay for child or elder care expenses.

An FSA means you save money on expenses you are already paying for, like copayments for doctor's visits or prescription drugs, or paying for daycare for your child. Money deposited into your FSA will not count as taxable income, so you will have immediate tax savings.

- There are two types of FSAs—Health Care and Dependent Care. **Remember that if you want the FSA, you must re-enroll in the FSA each year during Switch/Open Enrollment.** Your election from one year does not continue into the following calendar year.

### *HEALTH CARE FSA*

The Health Care FSA (HCFSA) allows you to use pre-tax dollars to pay for out-of-pocket medical, dental, vision and hearing expenses for you, your spouse and any of your dependents (even if they are on a different insurance plan and even if you are not enrolled in the APS medical plan). There are hundreds of eligible expenses, including copayments, deductibles, and prescription drugs. Check the Eligible Expense list at www.asiflex.com for more information. Enrolling in a HCFSA helps you offset the rising cost of health care. You can set aside up to $2,750 per year in the HCFSA and use these dollars for eligible expenses you incur throughout the year. **Your HCFSA also helps your household budget because your full annual election is available to you on the first day of your plan year!**

**How much should I set aside?**

Estimating your annual election amount can be the most difficult part of the process, but don't let that discourage you from enrolling for an FSA. Start by making a list of predictable or recurring expenses that you know you will have, such as copayments for doctor's visits or maintenance medications, contact lens supplies or the annual deductible if you anticipate a surgery or another medical procedure. Next, think about any other anticipated expenses you expect to incur next year, such as eyeglasses or major dental work including orthodontia. ASIFlex's Eligible Expense list is a great reference for hundreds of eligible expenses. Visit the website – www.asiflex.com – and use the ASIFlex expense estimator and the tax savings calculator to actually see your savings.

**Participation in the flexible spending accounts is optional, and you should be sure you understand how the plans work before you enroll.** Once you enroll, your election will stay in place for the balance of the calendar year (or the full calendar year if you enroll during Switch/Open Enrollment).

### *DEPENDENT CARE FSA*

The Dependent Care FSA (DCFSA) is generally used for work-related child care expenses, but you can also use DCFSA money to pay for work-related expenses for older tax dependents that are incapable of self-care. Eligible expenses include daycare, summer day camps (overnight camps are NOT eligible), babysitting, before and after school care, nursery school and pre-kindergarten expenses that are primarily for the protection and well-being of the dependent.

You can set aside up to $5,000 per household, per calendar year ($2,500 if married and filing separate income tax returns).

Take some time to estimate the expenses that your family will incur for the remainder of the calendar year, or if you will be enrolling during Switch/Open Enrollment, estimate your expenses for 2023.

- Don't let the use it or lose rule scare you away from an FSA. Only estimate predictable expenses but note that you also have a grace period to use your funds. **If you haven't spent everything by the end of the calendar year, you actually have until March 15th into the next plan year to spend your FSA balance.**
- You have 60 days from your hire date to decide whether to participate and how much to elect for the balance of the calendar year. Please note that your election is not effective until the first of the following month after submitting your FSA Enrollment Form via the Winocular Workflow process. **During Switch/Open Enrollment, you must enroll during the announced timeframe and are electing your FSA amount for the new plan year beginning on January 1, 2023.** (You must re-enroll for **each** calendar year.)

- Submit your completed FSA Enrollment Form to the Employee Benefits Department via the Winocular system. **During Switch/Open Enrollment, you will make your FSA election online**, following the instructions provided by the APS Employee Benefits Department.

**How do I get reimbursed**?

- If you enroll for the health care FSA, **you will receive a debit card that you may use for payment of many eligible health care expenses**. All Health Care FSA enrollees will receive two debit cards. **Please note that the use of the debit card is NOT paperless; you must submit supporting documentation** to substantiate certain expenses when you use the card. Failure to do so will result in your debit card being disabled.
- File a claim using the ASIFlex mobile app available for Android and iPhone users or File a claim online
- Fax or mail a claim form and documentation

**When is my money available to me?**

- **For the health care FSA, your money is available on your effective date.** That's right, if you elect to have $2,000 for the remainder of the plan year (or the new plan year) and you schedule an appointment for services two weeks after your effective date, you can submit a claim for reimbursement of the full $2,000.

- **However, the rules are not the same for Dependent Care.** Before you can be reimbursed for a daycare expense, the funds must be in your account. As long as the services have been rendered, you can file a claim for the full amount paid to the daycare provider. If you do not have the full amount available in your account at that time, the remaining amount or up to your deduction amount will be reimbursed automatically when the next deduction occurs from your paycheck.

***HAVE QUESTIONS?***
ASIFlex Customer Service Hours:
Monday -Friday 7:00 am - 7:00 pm CT
Saturday 9:00 am - 1:00 pm CT

**800-659-3035**;
www.asiflex.com;
asi@asiflex.com.

APS benefit-eligible employees may elect from four different medical plan options; two EPO (Exclusive Provider Organization) plans which are administered by Presbyterian Health Plan and True Health New Mexico, and two PPO (Preferred Provider Organization) plans which are administered by Cigna and Blue Cross and Blue Shield of New Mexico. The EPO plans offer lower out-of-pocket costs with slightly higher premium contributions, and all medical care must be obtained from contracted, in-network providers (except in the case of an emergency). The PPO plans offer the flexibility to see any licensed provider (in-network or out-of-network), and slightly lower premium contributions. (Premium contributions are the amount that is withheld from your paycheck to pay the employee portion of the premium.) The chart below includes an overview of the four medical plan options. Refer to the APS Benefits Department website at https://www.aps.edu/human-resources/benefits for additional information about each of the plans.

Before you enroll for one of the medical plan options, be sure that you understand how that plan works. If you have a particular doctor that you want to be able to see, it is important that you elect a plan with which that provider is contracted. If you have questions, please contact the Employee Benefits Department at employee.benefits@aps.edu or call (505) 889-4859.

NOTE: All of the medical plan options include limitations and exclusions, and rules that you must follow when obtaining medical services. Please refer to the plan documents (or benefit booklet) for each medical plan option (available on the APS Employee Benefits website), or call the plan administrator (THNM, PHP, Cigna or BCBSNM) if you have questions and to check your benefits prior to receiving services.

**Documents Govern: Every effort has been made to accurately reflect the APS medical, prescription drug, dental and vision plan benefits. However, it must be understood that, in case of error, this document does not modify or change the actual benefits to which you may be entitled. These are fully described in the certificates, master contracts and other legal documents which govern the administration of the Plans.**

**True Health New Mexico has notified APS that they are exiting the New Mexico health insurance market after 12/31/2022. Due to this coming change, APS will no longer accept new enrollments into the True Health plan effective 5/1/2022. Employees and dependents who are already enrolled on the True Health plan will continue on that plan through 12/31/2022 (or through the date they are no longer eligible for APS coverage, if that date precedes 12/31/2022).**

| Service | THNM EPO (in-network benefits only) | Cigna Open Access Plan | | Blue Cross Blue Shield of New Mexico PPO | | Presbyterian EPO (in-network benefits only) |
|---|---|---|---|---|---|---|
| | | *In-Network* | *Out-of-Network* | *In-Network* | *Out-of-Network* | |
| **Deductible** | $500/Employee<br>$1,000/Employee+1<br>$1,250/Family | $1,000/Employee<br>$2,000/Employee+1<br>$2,500/Family | $5,000/Employee<br>$10,000/Employee +1<br>$15,000/Family | $1,000/Employee<br>$2,000/Employee+1<br>$2,500/Family | $5,000/Employee<br>$10,000/Employee+1<br>$15,000/Family | $500/Employee<br>$1,000/Employee+1<br>$1,250/Family |
| **Coinsurance** | 20% | 20% | 50% | 20% | 50% | 20% |
| **Copayments** | $20/Primary Care<br>$50/Specialist | $30/Primary Care<br>$60/Specialist | Deductible/ Coinsurance | $30/Primary Care<br>$60/Specialist | Deductible/ Coinsurance | $20/Primary Care<br>$50/Specialist |
| **Preventive Services** | Plans pays 100% | Plans pays 100% | Deductible/ Coinsurance | Plans pays 100% | Deductible/ Coinsurance | Plans pays 100% |
| **Out-of-Pocket Maximum** | 4,000/Employee<br>$8,000/Employee+1<br>$12,000/Family | $5,000 /Employee<br>$10,000/Employee+1<br>$12,500/Family | $8,500/Employee<br>$14,875/Employee +1<br>$21,250 Family | $5,000 /Employee<br>$10,000/Employee+1<br>$12,500/Family | $8,500/Employee<br>$14,875 Employee+1<br>$21,250 Family | 4,000/Employee<br>$8,000/Employee+1<br>$12,000/Family |
| **Inpatient Hospitalization/ Inpatient or Outpatient Surgery** | Deductible/ Coinsurance | Deductible/ Coinsurance | Deductible/ Coinsurance | Deductible/ Coinsurance | Deductible/ Coinsurance | Deductible/ Coinsurance |
| **Emergency Room** | $350 copay (in-network or out-of-network) | $450 copay | | $450 copay | | $350 copay (in-network or out-of-network) |
| **Follow Up Care after an emergency room visit is subject to place of service copay or deductible & coinsurance** | | | | | | |

| Service | THNM EPO (in-network benefits only) | Cigna Open Access Plan | | Blue Cross Blue Shield of New Mexico PPO | | Presbyterian EPO (in-network benefits only) |
|---|---|---|---|---|---|---|
| | | *In-Network* | *Out-of-Network* | *In-Network* | *Out-of-Network* | |
| **Urgent Care** Follow-up Care | $50 Subject to place of service copay or deductible & coinsurance (no coverage out-of-network) | $75 Subject to place of service copay or deductible & coinsurance | $75 Subject to place of service copay or deductible & coinsurance | $75 Subject to place of service copay or deductible & coinsurance | $75 Subject to place of service copay or deductible & coinsurance | $50 Subject to place of service copay or deductible & coinsurance (no coverage out-of-network) |
| **Ambulance/ Emergency Air Transport** | Deductible/ Coinsurance | Deductible/ Coinsurance | In-Network Deductible/ Coinsurance | Deductible/ Coinsurance | In-Network Deductible/ Coinsurance | Deductible/ Coinsurance |
| **Lab/X-ray/ Other Basic Diagnostic Testing** | $20 copay/day | $30 copay/day | Deductible/ Coinsurance | $30 copay/day | Deductible/ Coinsurance | $20 copay/day |
| **MRI, CT Scans, PET Scans** **(Note that cost to patient is based on place of service)** | $120 copay per day **(if performed at a free-standing imaging center)** **OR** Deductible/ Coinsurance **(if performed at a hospital)** | $175 copay/ day | Deductible/ Coinsurance | $120 copay per day **(if performed at a free-standing imaging center) OR** Deductible/ Coinsurance **(if performed at a hospital)** | Deductible/ Coinsurance | $120 copay per day **(if performed at a free-standing imaging center)** **OR** Deductible/ Coinsurance **(if performed at a hospital)** |
| **Transplants** | Deductible/ Coinsurance | Deductible/ Coinsurance | Deductible/ Coinsurance | Deductible/ Coinsurance | Deductible/ Coinsurance | Deductible/ Coinsurance |
| **Maternity Services** | | | | | | |
| Pre/Post Natal Care & Routine Nursery Care | $50 copay Initial visit only, then plan pays 100% | $60 copay Initial visit only, then plan pays 100% | Deductible/ Coinsurance | $60 copay initial visit only, then plan pays 100% | Deductible/ Coinsurance | $50 copay Initial visit only, then plan pays 100% |
| Hospital Admission & OB Delivery | Deductible (mother) & Coinsurance | Deductible (mother) & Coinsurance | Deductible (mother) & Coinsurance | Deductible (mother) & Coinsurance | Deductible (mother) & Coinsurance | Deductible (mother) & Coinsurance |
| Extended stay charges for covered newborn | Deductible (baby) & Coinsurance | Deductible (baby) & Coinsurance | Deductible (baby)/ Coinsurance | Deductible (baby) & Coinsurance | Deductible (baby)/ Coinsurance | Deductible (baby) & Coinsurance |
| **Durable Medical Equipment** | 20% coinsurance, deductible does not apply | 20% coinsurance, deductible does not apply | Deductible/ Coinsurance | 20% coinsurance, deductible does not apply | Deductible/ Coinsurance | 20% coinsurance, deductible does not apply |
| **Physical, Occupational & Speech Therapy** Combined in- & out-of-network max 60 days/ condition/ calendar year | $20/visit to $320 annual maximum | $30/visit to $480 annual maximum | Deductible/ Coinsurance | $30/visit to $480 annual maximum | Deductible/ Coinsurance | $20/visit to $320 annual maximum |

| Service | THNM EPO (in-network benefits only) | Cigna Open Access Plan | | Blue Cross and Blue Shield of New Mexico PPO | | Presbyterian EPO (in-network benefits only) |
|---|---|---|---|---|---|---|
| | | *In-Network* | *Out-of-Network* | *In-Network* | *Out-of-Network* | |
| **Radiation, Dialysis, Chemotherapy** | Deductible/ Coinsurance | Deductible/ Coinsurance | Deductible/ Coinsurance | Deductible/ Coinsurance | Deductible/ Coinsurance | Deductible/ Coinsurance |
| **- Hospice, - Bereavement counseling, - Respite Care** | Deductible/ Coinsurance | Deductible/ Coinsurance Respire Care Not Covered | Deductible/ Coinsurance Respire Care Not Covered | Deductible/ Coinsurance | Deductible/ Coinsurance | Deductible/ Coinsurance |
| **Behavioral/Mental Health/Chemical Dependency** | | | | | | |
| Outpatient services | Plan pays 100% | Plan pays 100% | Deductible/ Coinsurance | Plan pays 100% | Deductible/ Coinsurance | Plan pays 100% |
| Inpatient Services - Partial Hospitalization - Residential Treatment (in or out-of-network – 60 days max/calendar year) | Plan pays 100% | Plan pays 100% | Deductible/ Coinsurance | Plan pays 100% | Deductible/ Coinsurance | Plan pays 100% |
| **Hearing Aids (children under age 21)** | Plan pays 100% of covered charges (including fitting & dispensing services) max of $2,200 every 36 months/ hearing impaired ear | Plan pays 100% of covered charges (including fitting & dispensing services) up to a maximum of $4,400, then plan pays 80% | Deductible/ Coinsurance | Plan pays 100% of covered charges (including fitting & dispensing services) max of $2,200 every 36 months/ hearing impaired ear | Deductible/ Coinsurance | Plan pays 100% of covered charges (including fitting & dispensing services) max of $2,200 every 36 months/ hearing impaired ear |
| **Dental/Facial Accident, TMJ/CMJ Services (for limited medical conditions only – Prior Authorization required)** | Deductible/ Coinsurance | Deductible/ Coinsurance | Deductible/ Coinsurance | Deductible/ Coinsurance | Deductible/ Coinsurance | Deductible/ Coinsurance |
| **Follow Up Care after Dental/Facial Accident visit is subject to place of service copay or deductible & coinsurance. (Some services may not be covered under the medical plan, however may be covered under any applicable dental plan coverage.)** | | | | | | |

| Service | THNM EPO (in-network benefits only) | Cigna Open Access Plus | | Blue Cross and Blue Shield of New Mexico PPO | | Presbyterian EPO (in-network benefits only) |
|---|---|---|---|---|---|---|
| | | *In-Network* | *Out-of-Network* | *In-Network* | *Out-of-Network* | |
| **Diabetes Coverage** | | | | | | |
| - Office visit & Diabetes education | $10 per visit to $260 annual maximum | $10 per visit to $260 annual maximum | Deductible/ Coinsurance | $10 per visit to $260 annual maximum | Deductible/ Coinsurance | $10 per visit to $260 annual maximum |
| - Diabetic supplies, Equipment and appliances *Rx – *See Prescription Drug* | Plan pays 100% | Plan pays 100% | Deductible/ Coinsurance | Plan pays 100% | Deductible/ Coinsurance | Plan pays 100% |
| **Allergy Testing & Treatment** | $50 | $60 | Deductible/ Coinsurance | $60 | Deductible/ Coinsurance | $50 |
| - Allergy Injections - Allergy Extract preparation | $10 | $10 | Deductible/ Coinsurance | $10 | Deductible/ Coinsurance | $10 |
| **Acupuncture, Chiropractic, Massage Therapy & Rolfing** Combined in- & out-of-network max 25 visits/ calendar year | $20 | $30 (20 visit annual limit per type of service, rolfing is not covered) | Deductible/ Coinsurance (20 visit annual limit per type of service, rolfing is not covered) | $30 | Deductible/ Coinsurance | $20 |
| **Infertility related services (testing services to identify medical diagnosis)** | Subject to place of service copay | Subject to place of service copay | Not Covered | Subject to place of service copay | Deductible/ Coinsurance | Subject to place of service copay |

**NOTE: All of the medical plan options include limitations and exclusions, and rules that you must follow when obtaining medical services. Please refer to the plan documents (or benefit booklet) for each medical plan option (available on the APS Employee Benefits website), or call the plan administrator (THNM, PHP, Cigna or BCBSNM) if you have questions, and to check your benefits prior to receiving services.**

**When you enroll in one of the Albuquerque Public Schools medical plans, you are also covered under the prescription medication program administered for APS by Express Scripts.** The program allows you to fill prescriptions at participating retail pharmacies, Express Scripts home delivery pharmacy and Accredo specialty pharmacy.

To learn more about your benefits, log in to Express-Scripts.com and select “Benefits Overview” from the “Benefits” menu or call Member Services at 866-563-9297. Member Services representatives are available 24 hours a day, 7 days a week (except Thanksgiving and Christmas) to assist with questions about your benefits or orders.

| | **Retail Participating Pharmacy** up to 34 consecutive days supply | | | **Home Delivery or Smart90 Walgreens** up to 90 consecutive days supply |
|---|---|---|---|---|
| | **Coinsurance** | **Minimum** | **Maximum** | |
| **Generic medication** | 20% | $10 | $25 | $25 |
| **Preferred brand formulary medication** | 30% | $35 | $65 | $70 |
| **Non-preferred brand medication** | 40% | $70 | $140 | $150 |
| **Insulin and diabetic supplies** | $0 copayment | | | |

If you need a long-term (maintenance) medication, you are allowed two fills at an in-network retail pharmacy **before you must move your prescription to either Express Scripts home delivery pharmacy or use a Walgreens retail pharmacy for a 90-day supply**. (To locate a Walgreens pharmacy that participates in filling a 90-day supply, log in to Express-Scripts.com and select “Find a Pharmacy” from the menu under “Prescriptions”.) Express Scripts home delivery pharmacy will deliver a 90-day supply right to you, and standard shipping is free. Your doctor can send your prescription electronically or via fax to 800-837-0959.

If you fill a prescription for a brand-name medication when a generic is available, you will pay **the applicable copayment/ coinsurance, PLUS the difference in cost** between the brand and the generic. The difference in cost will apply toward the out-of-pocket maximum.

| **Specialty Medications administered by Accredo Specialty Pharmacy** | |
|---|---|
| **Specialty medications must be filled at an Express Scripts home delivery pharmacy**. Refer to the complete prescription drug plan Summary of Benefits (on the APS Benefits Department website) for more information. | |
| **Generic specialty medication** | $70 |
| **Preferred brand specialty medication** | $100 |
| **Non-preferred brand specialty medication** | $150 |
| | APS utilizes a specialty pharmacy copay assistance program through SaveOnSP. A select group of specialty medications in several therapy classes are part of this program. Refer to the Express Scripts Summary of Benefits (on the APS Benefits Department website) for more information. |

**Out-Of-Pocket:** Once you’ve reached your annual out-of-pocket maximum of $2,850 employee only/$3,700 employee + 1 or employee + family coverage, your plan pays 100% of prescription medication expenses for the remainder of the benefit year. (The out-of-pocket maximum applies to total retail, home delivery and specialty medications. There is no separate out-of-pocket maximum for specialty medications.)

NOTE: The prescription drug plan includes limitations and exclusions, and rules that you must follow when obtaining prescription drugs. Please refer to the complete prescription drug plan Summary of Benefits (available on the APS Benefits Department website), or call Express Scripts if you have questions and to check your benefits prior to filling a prescription.

## MEDICAL PLAN OPTIONS

Albuquerque Public Schools offers four medical plan options from which to choose:

- Exclusive Provider Organization (EPO) plan administered by True Health New Mexico (THNM)
- Exclusive Provider Organization (EPO) plan administered by Presbyterian Health Plan (PHP).
- Preferred Provider Organization (PPO) plan administered by Blue Cross and Blue Shield of New Mexico (BCBSNM)
- Preferred Provider Organization (PPO) plan administered by Cigna. (Also referred to as an OAP (Open Access Plus plan.)

**NOTE: All of the medical plan options include limitations and exclusions, and rules that you must follow when obtaining medical services. Please refer to the plan documents (or benefit booklet) for each medical plan option (available on the APS Employee Benefits website), or call the plan administrator (THNM, PHP, Cigna or BCBSNM) if you have questions and to check your benefits prior to receiving services.**

## TRUE HEALTH NEW MEXICO (THNM) EPO MEDICAL PLAN

**True Health New Mexico has notified APS that they are exiting the New Mexico health insurance market after 12/31/2022. Due to this coming change, APS will no longer accept new enrollments into the True Health plan effective 5/1/2022. Employees and dependents who are already enrolled on the True Health plan will continue on that plan through 12/31/2022 (or through the date they are no longer eligible for APS coverage, if that date precedes 12/31/2022).**

## WHY TRUE HEALTH NEW MEXICO?

True Health New Mexico is the state's only non-profit health plan. Their mission to improve the health of all New Mexicans drives everything they do. From building a statewide network of providers to focusing on keeping you well rather than waiting until you become sick, True Health New Mexico strives to be a different kind of health plan.

**Highlights.** In the Albuquerque area, THNM's EPO Medical Plan offers you access to the Lovelace Hospital System and UNM Hospital. THNM is also contracted with multispecialty and specialty groups such as Optum Medical Group, Lovelace Medical Group, New Mexico Heart Institute, New Mexico Cancer Center, Southwest Medical Associates, and UNM Medical Group. This plan does not require a referral to see an in-network specialist and, like all four of the medical plan options, there is no charge for preventive care services. Medical emergencies are covered under this plan, even if you see an out-of-network provider due to the emergency. Participants have access to a variety of medical management services – from a 24-hour nurse advice line to disease management programs, to a "tobacco quit" line. All of this assistance is confidential and available at no additional cost for participants. More information can be found at https://www.truehealthnewmexico.com/aps.aspx.

**How the plan works.** EPO plans require participants to see in-network – or exclusive – providers that have contracted with the plan. Therefore, in order for your medical services to be covered, you must see an in-network provider. When you see an in-network provider, the plan pays its allotted amount for the covered benefits and you pay for your share in the form of copayments, deductibles, and coinsurance. **The only out-of-network coverage on the EPO plan is for urgent and emergency care: the initial treatment will be covered when receiving this care from an out-of-network provider; however, all follow-up visits must be through in-network providers.**

Remember that it is less expensive for participants to use non-hospital facilities for certain types of care, like having x-rays or getting blood work. For example, it costs less to have your x-rays done at X-Ray Associates of New Mexico or to have blood work done at TriCore or Quest, rather than having them done at a hospital. Be sure to check with your provider before your visit to make sure they are part of THNM's network. In addition, some services such as hospitalization and surgery require Prior Authorization, so be sure to have your in-network provider request and receive that authorization.

**For more information**. APS members who participate in the EPO plan have a dedicated, toll-free customer service phone number. Call **877-210-8339** with any questions or for more information regarding the plan. In addition, participants can visit the APS-specific website, https://www.truehealthnewmexico.com/aps.aspx, for information about what the plan provides. You can access the Summary of Benefits, check to see if a provider is part of the contracted network, and access the secure member portal from this site. Select "My Account Login" (top of page) to view the status of your claims, see your benefit information or print an ID card. You can access THNM's provider search tool on this same website by selecting "Find a Doctor" from the top menu.

## PRESBYTERIAN HEALTH PLAN (PHP)

### WHY PRESBYTERIAN HEALTH PLAN?

Presbyterian Healthcare Services exists to improve the health of the patients, members and communities they serve. For 113 years, Presbyterian has been caring for New Mexicans, and also has a long tradition of serving Albuquerque Public Schools employees and their families. With Presbyterian Health Plan, you have full access to Presbyterian's integrated health system of doctors and hospitals in New Mexico. Presbyterian serves one in three New Mexicans with healthcare services or health plan coverage.

To locate contracted doctors and medical facilities, visit www.phs.org/aps, select Doctors & Services from the menu bar, and then Find a Doctor under "I want to . . .". (If you scroll to the bottom of the page and select "Find a provider in your network" (under the heading "Looking for a Presbyterian Health Plan In-Network Provider?), you will find a link (midway down the page) that allows you to select by Specific Employer Group --- select Albuquerque Public Schools from that list.)

**Highlights**. Participants in the EPO medical plan administered by Presbyterian Health Plan (PHP) have access to Presbyterian's integrated health system of over 800 doctors and 8 hospitals in New Mexico. As part of the medical plan, participants can access the online self-service program, myPRES, available 24/7 to look up benefit information, view claims status and request ID cards, among other services. myPRES also includes connections to the 24/7 nurse line and to member advocates who can assist with locating a contracted provider. More information can be found at **www.phs.org/APS**.

**How the plan works**. EPO plans require participants to see in-network – or exclusive – providers that have contracted with the plan. Therefore, in order for your medical services to be covered, you must see an in-network provider. When you see an in-network provider, the plan pays its allotted amount for the covered benefits and you pay for your share in the form of copayments, deductibles, and coinsurance. **The only out-of-network coverage on the EPO plan is for urgent and emergency care: the initial treatment will be covered when receiving this care from an out-of-network provider; however, all follow-up visits must be through in-network providers.**

**For more information**. APS members who elect PHP can find more information on Presbyterian's dedicated website, **www.phs.org/aps**. You may also contact customer service representatives by calling **505-923-5600** or **888-275-7737**, or by emailing **info@phs.org**.

**Video Visits.** Participants can receive care for non-emergency medical conditions through PHP's Video Visit feature. Go to **www.phs.org/videovisits** for more information.

## CIGNA MEDICAL HEALTH PLAN

### WHY CIGNA?

Cigna is ranked #13 on the 2020 Fortune 500 list with over 190 million customer and patient relationships around the world and a global network of 1.5 million affiliations with health care providers, clinics and facilities. Cigna's strategy is to be champions for affordable, predictable and simple health care. Every day, around the world, we work to deliver on our mission to improve the health, well-being and peace of mind of those we serve.

Cigna continues to develop services and solutions that create shared, aligned successes and deliver the highest value to our customers. Our approach to healthcare is to focus on whole person health for all aspects of well-being with 5,000 advocates available for our members 24/7/365 as well as around-the clock free Veteran support. Good health and well-being are the cornerstones of our purpose and the driving force of our passions.

**Cigna Open Access Plus.** Your Cigna Open Access Plus (OAP) Plan provides you with choice and convenience. It offers direct access to our broad seamless national OAP provider network, including Presbyterian Hospital, Presbyterian Medical Group, UNM Hospital and UNM Medical Group, and the option to make personalized health care choices. You have the option to choose a Primary Care Physician (PCP) to serve as your personal physician and help coordinate health needs. The selection of a PCP is encouraged but is not a requirement. Referrals are not required; however, certain services and procedures do require providers to obtain precertification/pre-authorization.

**Plan Highlights**

**Virtual Care through MDLive**. It's hard to find time to take care of yourself, especially when you are not

feeling well. That's why health plans through Cigna include access to medical and behavioral/mental health virtual care. As a Cigna member you can:
-Access care from just about anywhere via video or phone.
-Get minor medical virtual care 24/7/365 – even on weekends and holidays.
-Schedule a behavioral/mental health virtual care appointment online in minutes.
-Access board-certified doctors and pediatricians as well as licensed counselors and psychiatrists.

**Our whole-person approach**. Studies show that behavioral problems, such as depression, can contribute to heart disease. Many physical conditions can worsen with stress, substance use and other behavioral health issues. Our Cigna Total Behavioral Health program can help. If you or a loved one has been diagnosed with a behavioral health condition, Cigna is here for you. Our comprehensive program provides help with life events, dedicated support, lifestyle coaching, and online tools. We help you take control of your health − mind and body. As a Cigna member you have access to several Virtual Behavioral Health Providers for personalized care right from your smartphone, whenever you need it.

**Lifestyle Management.** Whether your goal is to lose weight, quit tobacco or lower your stress levels, you have the power to make it happen. Cigna Lifestyle Management Programs can help by providing personalized coaching support–all at no additional cost to you. Each program is easy to use and available where and when you need it. And, you can use each program online or over the phone – or both.

To learn more about Cigna, please visit https://www.cigna.com/ or call 1 (800) 997-1654. Current Cigna Members can go to https://my.cigna.com or call 1-800-244-6224 to find providers and care and to view your coverage details.

## BLUE CROSS BLUE SHIELD OF NEW MEXICO (BCBSNM)

### WHY BLUE CROSS AND BLUE SHIELD OF NEW MEXICO?

The PPO medical plan administered by Blue Cross and Blue Shield of New Mexico gives you the most choice in nationwide providers, along with the security of a health plan that is recognized across the country and around the world. If you travel often or have dependents who live out of state, it is good to know that 97 percent of hospitals and 92 percent of physicians in the United States are contracted with BCBS plans.

**Highlights.** In the Albuquerque area, Blue Cross and Blue Shield of New Mexico is contracted with Lovelace Hospital and Lovelace Medical Group, Optum Medical Group, UNM Hospital and UNM Medical Group, as well as many other providers. Statewide their network includes 25,000 provider locations. In addition, participants have access to providers across the country and around the world through the BlueCard program. Participants can go to www.bcbs.com or call **800-810-BLUE**(**800-810-2583)** for more information about the BlueCard program or for help finding a nationwide or worldwide provider. On the BCBSNM PPO plan, you have the flexibility to see any licensed provider by using your out-of-network benefits, although you should be aware that your out-of-pocket costs will be higher when you utilize out-of-network providers. BCBSNM participants can call a dedicated number, **888-898-0070**, to access covered behavioral health services, including 24-hour referral assistance and depression and anxiety support.

**Telehealth services:** Technology has evolved, and so has the way you see your doctor. Now APS Blue Cross and Blue Shield members can see a doctor 24 hours a day, 7 days a week using your phone, tablet or computer. There is no copayment on the APS plan for virtual visits with a **MDLIVE** doctor, so you can save time and money when you use virtual visits! For non-emergency medical issues, such as allergies, sinus infections, pinkeye, or depression, participants can speak with a board-certified doctor who can submit prescriptions electronically, if needed, to your local pharmacy. Go to www.MDLIVE.com/bcbsnm to register, schedule an appointment or download the mobile app. (You'll need your BCBSNM member ID number to register.)

**How the plan works**. The BCBSNM plan for 2022 is a Preferred Provider Organization (PPO) plan, giving you the flexibility to see any licensed provider, and the option to keep your out-of-pocket costs down by seeing a contracted BCBS provider.

**To find a BCBS contracted provider**

- Go to https://www.bcbsnm.com/aps/
- Select "Doctors and Hospitals" from the menu bar
- Select the "Do a quick search now" link (in the last sentence of the first paragraph)

- Use the search box or scroll down and use the links for common searches.

**For more information**. BCBSNM members can call **888-371-1928** or visit **https://www.bcbsnm.com/aps/**
**Well onTarget**. Participants can access their member portal, **Well onTarget**, which offers personalized resources and tools, online courses to reach health goals, an online health assessment and much more, by visiting http://www.wellontarget.com/

**Primary Care Physician? It Makes Sense!**

It is said that people who have a trusting, ongoing relationship with one medical professional over time are more likely to be satisfied with their health care than people who don't. And this seems to apply at any age. If you or any of your family members have not picked a primary care physician (PCP) yet, maybe you should. It will make things easier for each of you to have one doctor who knows you and your medical history. Among other things, a PCP can:

- Provide preventive care and teach healthy lifestyle choices;
- Identify and treat common medical conditions;
- Assess the urgency of your medical problems;
- Help you get the right care at the right place;
- Direct you to the appropriate network labs or x-ray facilities for needed testing; and
- Make referrals to network medical specialists when necessary.

**To find a PCP for you and your family:**

- **APS Presbyterian Health Plan** members can call **844-PRES-DOC** (**844-773-7362**) **or visit www.phs.org/aps, click on Tools & Resources, then click on Health Plan Members Tools & Resources to locate the online provider directory.**

- APS Blue Cross and Blue Shield of New Mexico members can use the Provider Finder at https://www.bcbsnm.com/aps/, or call the Lovelace Care Concierge at 505-727-2727 or 505-727-5252 or contact Optum Medical Group Patient Service Center at 505-262-7400 or use the website **http://www.abqhp.com/FindADoctor**

- True Health New Mexico members can call 855-7MY-NMHC (855-769-6642) or use the online provider search tool at the website below. You may also call the Lovelace Care Concierge at 505-727-2727 or 505-727-5252 or contact Optum Medical Group Patient Service Center at 505-262-7400, or visit https://truehealthnewmexico.com/find_a_doctor.aspx

- Cigna members can call (800) 244-6224 or use the online provider search tool at https://hcpdirectory.cigna.com/web/public/consumer/directory or log-in to myCigna.com. To locate a PCP in the Albuquerque area, Cigna members may call 844-773-7362.

## PRESCRIPTION DRUG BENEFITS

APS members who select any of the four medical plan options will automatically receive outpatient prescription drug coverage through Express Scripts. This program provides prescription coverage at participating retail pharmacies in addition to home delivery and specialty pharmacy services.
There are different levels of outpatient prescription drug coverage under this program: Generic, Preferred Brand Formulary, Non-Preferred Brand, and Specialty medications.

The amount you pay depends on what level your medication falls in. For example, for a generic medication, you'll only pay $10 to $25 if receiving the medication at a participating retail pharmacy. A preferred brand formulary medication costs you $35 to $65 and non-preferred brand medications can cost up to $140 – if purchased at a participating pharmacy. When your doctor prescribes a new medication for you or a family member, be a smart consumer and ask if the medication is a generic drug. If it isn't, ask if a generic drug might work for your condition.

To save money on the medications you need, you can use the home delivery service, which allows members to receive up to a 90-day supply of long-term (maintenance) medications shipped to your home. You may also fill your maintenance medications at Walgreens through the Walgreens Smart90 program. Long-term medications can be filled up to two times at a retail pharmacy before the prescription **must be moved** to Express Scripts' home delivery program or to the Walgreens Smart90 program.

Specialty Medications – medications used to treat complex conditions such as cancer, hepatitis C or multiple sclerosis – must be filled through Accredo. **You will pay the entire cost if you use any pharmacy other than Accredo pharmacy services.** Exceptions may apply for medications requiring an immediate fill. Accredo, an Express Scripts specialty pharmacy, is composed of therapy-specific teams that provide an enhanced level of individual service to patients with special therapy needs. Counseling, scheduled delivery, and safety checks are just a few of the services that Accredo provides.

To promote safe and effective medication therapy, and to better manage costs, the APS prescription drug plan has certain requirements and features:

- Some medications require coverage review (Prior Authorization)
- Some medications have quantity restrictions
- The plan uses a formulary (list of medications) which encourages you to use generics
- The plan requires that you first try one or more medications to treat a particular condition before it covers another (usually more expensive) medication. This is called Step Therapy.
- Certain vaccines are covered at a $0 copayment when administered by a certified retail pharmacist.

SaveOnSP Program: APS has partnered with SaveOnSP to provide a specialty pharmacy copay assistance program. A select group of specialty medications in several therapy classes are part of the SaveOnSP program. Employees and their family members who are taking one of the specialty drugs that are part of the program will be contacted by SaveOnSP to explain the program and assist with enrollment into the program.

For more information about your coverage go to www.express-scripts.com. Members can also find a participating pharmacy, order home delivery refills, compare costs and access other useful resources online.
To speak with an Express Scripts customer service representative, call **866-563-9297**.

The Albuquerque Public Schools Dental Plan is administered by Delta Dental of New Mexico, which has over 2,300 dental provider locations across the state. There are two plans available to APS members: the **Basic Plan** and the **Comprehensive Plan**. For 2022, the APS plans feature the enhanced Delta Dental PPO network of dentists. This allows our dental plan participants greater access to in-network providers. You will have the lowest out-of-pocket costs if you see a Delta Dental PPO contracted dentist, however you also have the flexibility to see Delta Dental Premier contracted dentists or non-participating providers. Refer to the 2022 Summaries of Benefits (available on the APS Benefits Department website) for details showing how the dental plan provider networks impact the amount you pay for covered services.

To find a participating dentist, visit **www.deltadentalnm.com** and click the "Find a Provider" link, then click "Providers in PPO New Mexico."

**NOTE: Both dental plan options include limitations and exclusions, and rules that you must follow when obtaining dental services. Please refer to the Summary of Benefits for your dental plan option (available on the APS Benefits Department website) for a more detailed explanation of coverage, or call Delta Dental Plan of New Mexico if you have questions and to check your benefits prior to receiving services.**

The **Basic Plan** provides coverage for diagnostic and preventive services (exams, cleanings, sealants, etc.) and basic services (fillings, crown repair, root canal, simple extractions, periodontal maintenance, etc.) only. The **Comprehensive Plan** provides coverage for these services in addition to coverage for major services (bridges, dentures, crowns, surgical extractions, etc.) and orthodontic services. On both plans, the deductible does not apply to diagnostic and preventive services. Each plan has an annual benefit maximum: the Basic Plan's annual benefit maximum is $1,000, and the Comprehensive Plan's annual benefit maximum is $1,500.

The following chart outlines the cost to you (i.e., what you pay) when you receive certain services under both dental plan options.

| | Delta Dental PPO Dentist | | Delta Dental Premier Dentist | | Non-Participating Dentist | |
|---|---|---|---|---|---|---|
| **Covered Services:** | **Basic Plan** | **Comprehensive Plan** | **Basic Plan** | **Comprehensive Plan** | **Basic Plan** | **Comprehensive Plan** |
| **Benefit Maximum** | **Annual benefit maximum per covered individual: Basic Plan - $1,000 / Comprehensive Plan - $1,500 (or Comprehensive Plan - $1,000 for non-participating dentists)** | | | | | |
| | **What You Will Pay:** | | | | | |
| Diagnostic and Preventive Services | No Charge | | No Charge | No Charge | 75% | No Charge |
| Deductible | Both plans have a $100 deductible for each covered individual with a maximum family deductible of $300/year. | | | | | |
| Basic Services | 30% after deductible | | 30% after deductible | 30% after deductible | 75% after deductible | 45% after deductible |
| Major Services | Not covered | 50% after deductible | Not covered | 50% after deductible | Not covered | 65% after deductible |
| Orthodontic Services (subject to separate lifetime max.) | Not covered | 50% | Not covered | 50% | Not covered | 50% |

A more detailed description of what is covered under each of the service categories can be found on the Delta Dental Summaries of Benefits on the APS Benefits Department website, by visiting **www.deltadentalnm.com,** or by calling Delta Dental at **505-855-7111**.

**For more information**. For assistance with dental benefit and/or claims questions, go to **www.deltadentalnm.com** or call Delta Dental's customer service line, Monday-Friday, 8:00 am to 4:30 pm, at **505-855-7111** or toll-free at **877-395-9420**.

Albuquerque Public Schools participants have access to vision benefits through Davis Vision, Inc. Davis Vision has a national network of vision providers across all 50 states.

**Highlights of the vision plan include**:

- A mail-order service for contact lenses, which will ship your lenses directly to your home.
- Designer and name brand frames from the Davis Vision's Collection that are covered in full as well as many popular contact lens brands.
- Discounts on laser vision correction.
- One-year breakage warranty for eyewear, included at no additional cost to you.

**NOTE: The vision plan includes limitations and exclusions, and rules that you must follow when obtaining vision services. Please refer to the complete vision plan Summary of Benefits (available on the APS Benefits Department website) for a more detailed explanation of coverage, or call Davis Vision if you have questions and to check your benefits prior to receiving services.**

The Davis Vision Premier Vision Plan* covers the following **in-network services:**

| **Eye exams every 12 months** | **Covered in full after a $15 copay** |
|---|---|
| **Eyeglasses**<br>• **Lenses every 12 months**<br>• **Frames every 24 months** | Clear plastic lenses in any single vision, bifocal, trifocal or lenticular prescription covered in full after $20 copay<br>Covered in full if from Davis Vision's Collection; otherwise, $110 toward any frame from provider plus 20% off any balance |
| **Contact lens evaluation and fitting every 12 months** | Fitting fee may apply (cost varies by provider) |
| **Contact lenses every 12 months (in lieu of eyeglasses)** | Covered in full if Davis Vision's Collection contacts; otherwise, $110 retail allowance toward provider supplied contact lenses, plus 15% off balance<br>Visually required contacts covered in full with prior approval |

You may choose to see an out-of-network provider, but your costs will be higher. When visiting an out-of-network provider, you'll pay the provider up front and then submit a claim to Davis Vision for reimbursement.

**For more information**. To learn more about what is covered under this plan, see the Davis Vision Summary of Benefits on the APS Benefits Department website. For assistance with other questions, go to **www.davisvision.com** or call **800-999-5431**. To find a participating provider, go to **www.davisvision.com**, scroll down and click the "Find an eye care professional" link in the "Need an eye care professional" box. (The APS client code is **2267**.)

**Documents Govern: Every effort has been made to accurately reflect the APS medical, prescription drug, dental and vision plan benefits. However, it must be understood that, in case of error, this document does not modify or change the actual benefits to which you may be entitled. These are fully described in the certificates, master contracts and other legal documents which govern the administration of the Plans.**

The Employee Assistance Program (EAP) is a no-cost counseling program available to all APS employees and their family members. EAP supports and assists employees with personal and /or work-related problems that may impact their job performance and their emotional well-being. It is voluntary, confidential and free. The program is short term and typically is limited to six sessions. The EAP addresses issues such as stress, depression, substance abuse, medical issues, divorce, eldercare, violence, trauma, relationship problems or distress on the job. Employees use the EAP to manage issues in their personal or professional lives to solve problems and enhance wellness.

### *HOW IT WORKS:*

The employee calls the EAP office at 505-884-9738 to schedule an appointment. Call backs are within 1-2 days, and sessions are scheduled within the week. Sessions are facilitated by licensed mental health professionals (LPCC) and are confidential. The office is located in the APS Alice & Bruce King Educational Complex (formerly City Center) at 6400 Uptown, Suite 480W. The program is open from 8:00 a.m. until 6:00 p.m. Monday through Thursday, and 8:00 a.m. to 5:00 p.m. on Fridays.

Crisis intervention services are provided as needed, as are mediation and conflict resolution for employees. The EAP staff provides assessment, triage, brief treatment, referrals and follow up with employees. The EAP staff assesses the client, determines appropriate treatment and refers to community resources as appropriate. The EAP also provides workshops and training regarding health and wellness issues as needed to various departments to improve communication and promote an environment of trust and support. EAP staff can travel to school sites if requested.

**Our goal is staff well-being!**

## LIFE INSURANCE, ACCIDENTAL DEATH & DISMEMBERMENT (AD&D), LONG TERM DISABILITY (LTD) INSURANCE

APS offers a variety of life insurance benefit options and a long term disability (LTD) plan to help you and your family achieve financial security. The advantages to you and your loved ones include:

- **Choice** – You decide how much coverage you need from the range of amounts or plans available;
- **Savings** – Typically group insurance rates are lower than the rates of individual insurance plans, generally providing you with coverage at a lower cost;
- **Convenience** – With premiums deducted directly from your paycheck, you don't have to worry about mailing monthly payments; and
- **Peace of Mind** – You can take comfort and satisfaction in knowing that you have done something positive for your family's future.
- **Guarantee Issue** up to plan limits when enrolled during Initial Eligibility period.

## YOUR INSURANCE BENEFITS OPTIONS

| Coverage Type | Coverage Amount | Who Pays the Premium? |
|---|---|---|
| **Basic Life and AD&D** | | |
| **Employee** | $10,000 | APS pays 100% |
| **Basic Dependent Life** | | |
| **Spouse**<br>**Child(ren)** | $5,000<br>$5,000 | Employee pays 100% |
| **Additional Life and AD&D*** | | |
| **Employee** | Increments of $10,000 up to $400,000 | APS pays 50% and the employee pays 50% |
| **Spouse**** | Increments of $10,000 up to $400,000* | Employee pays 100% |
| **Child(ren)** | $10,000 | Employee pays 100% |

* AD&D is for the employee only

** Spouse life insurance amounts over $30,000 require Evidence of Insurability. The total amount of life insurance for your spouse cannot exceed the amount of the employee's life insurance.

Note: The Employee must be enrolled in Additional Life Insurance coverage in order to elect Basic or Additional Dependent Life Insurance (for spouse or child(ren) coverage)

## LONG-TERM DISABILITY (LTD)

| Benefit Waiting Period | 90 days | |
|---|---|---|
| **Monthly Benefit** | 60% of first $8,333 of your Predisability Earnings reduced by deductible income | APS pays 50%<br>and the employee pays 50% |
| **Maximum Benefit** | $5,000 before reduction by Deductible Income | |
| **Minimum Benefit** | $100 | |

## QUESTIONS OR ADDITIONAL INFORMATION ABOUT LIFE INSURANCE OR LTD

For more information about these benefits or to apply for coverage, please call the APS Benefits Department or contact **888-609-9763** or visit https://www.standard.com/employee-benefits/aps

## NEW MEXICO EDUCATIONAL RETIREMENT BOARD PLAN (NMERB)

- The mission of the NMERB is to provide secure retirement benefits for New Mexico's past, present and future educational employees. The New Mexico Educational Retirement Board Plan (NMERB) is one of the highest-ranking public pension plans in the country in terms of return on investment.
- Employees who work more than 25% of the time (.25 full-time equivalents) are mandated by the New Mexico Educational Retirement Act to participate in the NMERB Plan. Participation begins on the date of hire. Both APS and the employee are required by the state legislature to contribute to this pension plan.
- Details regarding employee and employer contributions, vesting, administration, and investment are provided in the Member Handbook and Annual Reports, which are available on the NMERB website at www.nmerb.org.
- For information regarding the balance in your NMERB account or to receive retirement estimates, please use the Benefit Calculator tool on the NMERB website at www.nmerb.org or contact the New Mexico Educational Retirement Board at 866-691-2345, 505-827-8030 or in Albuquerque at 505-888-1560. You may also schedule an appointment with the NMERB Albuquerque office at 8500 Menaul Blvd NE, Suite B450, Albuquerque, NM 87112, or visit their office in Santa Fe at 701 Camino De Los Marquez, Santa Fe, NM 87505.

## STATE OF NEW MEXICO PERA SMART SAVE DEFERRED COMPENSATION PLAN

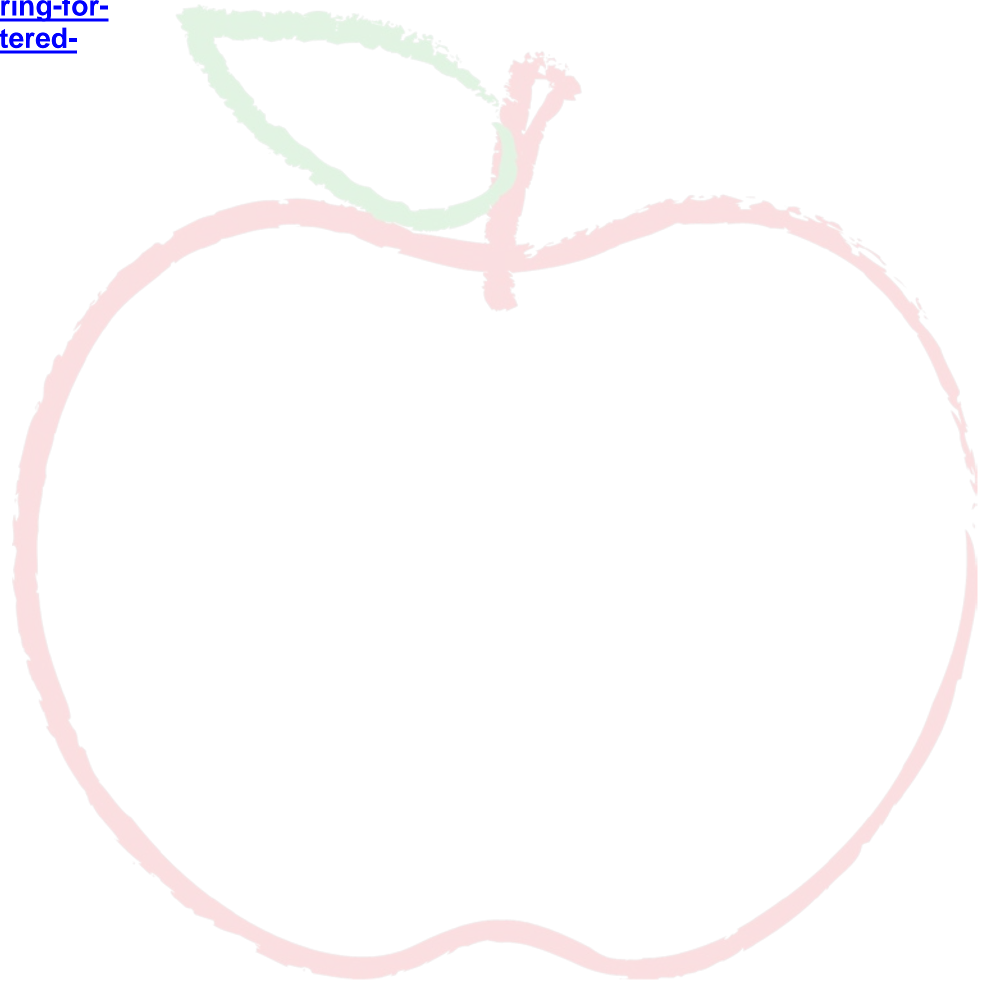
- The State of New Mexico PERA Smart Save Deferred Compensation Plan is a 457(b) plan. All employees, whether full-time, part-time, or on an hourly status, are eligible to participate in the 457(b) Plan, which gives employees a way to supplement their NMERB pension.
- This tax-advantaged, deferred-compensation, voluntary retirement plan is available to all APS employees who are willing to contribute at least $240 annually to the plan. Effective October 2019 the plan is administered by Voya Financial.
- Employees may contribute as little as $240 a calendar year and as much as $20,500 a calendar year; employees who are 50 or older may make additional "catch-up" contributions of $6,500 per year. APS offers both the traditional 457 plan (pre-tax contributions) and the Roth 457 plan (after-tax contributions).
- If you come to APS with retirement accounts from previous employment, such as a 401(k), 403(b), 457(b) or a traditional IRA, you may rollover those funds into your 457(b) plan.
- The 457(b) plan offers employees the opportunity to invest in a variety of well-known funds, as well as a Personal Choice Retirement Account available through Charles Schwab & Company (Member SIPC).
- Visit PERASmartSave.voya.com or call 833-424-SAVE (833-424-7283) to request plan highlights or prospectuses. Before investing, carefully consider the fund's investment objectives, risks, charges and expenses.

## 403(B) RETIREMENT SAVINGS PLAN

- APS also offers employees the opportunity to contribute to a 403(b) voluntary Retirement Savings Plan, which is a tax-sheltered plan. The 403(b) is administered for APS by TCG Administrators.
- All employees, whether full-time, part-time, or on an hourly status, are eligible to participate in the 403(b) Plan, which gives employees a way to supplement their NMERB pension.
- If you elect to participate in the 403(b) Plan, you first need to select an investment fund vendor and complete any necessary paperwork (or on-line or in person enrollment) with that vendor. The list of investment fund vendors is

available on the TCG Administrators website at **www.tcgservices.com.** Some of the investment fund vendors offer the Roth 403(b) option.

- Before investing, carefully consider the investment fund's objectives, risks, charges and expenses.
- Employees make voluntary retirement plan contributions to the 403(b) Plan through payroll deduction. The minimum contribution to the Plan is $180 per year or $7.50 per pay period. The maximum contribution is $20,500 per calendar year in tax-deferred contributions, employees age 50 or older may make up to $6,500 per year in "catch-up" contributions.
- You may enroll throughout the year and payroll contributions will generally start with the first payroll of the month following your enrollment.
- For more information, log on to **https://www.aps.edu/human-resources/benefits/preparing-for-retirement/403-b-tax-sheltered-annuity-plan**



## THE EDUCATION PLAN (529 COLLEGE SAVINGS PLAN)

- New Mexico's 529 College Savings Plan is called "The Education Plan." The Education Plan is a savings account that helps you pay for future college expenses. Money that's put into an Education Plan Account has tax advantages, is professionally managed, and may benefit from the power of compounded growth. You can start an account at any time with as little as $25.
- Account holders may choose among several investment options for their contributions, including stock mutual funds, bond mutual funds, and money market funds, as well as age-based portfolios that automatically shift toward more conservative investments as the beneficiary gets closer to college age. Before investing in the Plan, investors should carefully consider the investment objectives, risks, charges and expenses associated with the plan.
- **It pays to live in New Mexico!** If you live in New Mexico, you can deduct contributions to The Education Plan dollar for dollar from your state taxable income. New Mexico is one of only four states to offer an unlimited deduction to its residents.
- For more information, contact The Education Plan at **877-337-5268** to speak with a representative or visit **www.theeducationplan.com**.

## NUSENDA CREDIT UNION

- APS employees and their family members are eligible to join Nusenda Credit Union, where your financial wellness is our priority. You will have access to affordable financial services and up-to-the-minute information needed to make positive financial decisions.
- In addition to lower loan interest rates, higher savings rates, fewer fees and member savings on auto and home insurance, Nusenda offers:
  - Online education and workshops
  - Financial tools designed to help achieve your goals
  - Mobile/internet banking
  - Money management apps
  - Mobile deposit
  - Telephone, text banking and bill pay scheduling
- For your school or classroom, Nusenda offers a portfolio of practical information, useful teaching tools, and financial workshops that can be provided for both students and their families. These include:
  - Teacher financial literacy curriculum and resources for grades K-12
  - Classroom financial literacy workshops
  - No cost ½ credit summer financial literacy classes for high school students
  - Dual credit Financial Services Career Exploration class
  - Family Engagement – Family Connect financial literary partnership
- In addition, Nusenda supports the APS Education Foundation with classroom innovation grants, in-service teacher education and training, financial capability resources, and student scholarships.
- For a full list of Nusenda Credit Union branch locations and operating hours visit: **https://www.nusenda.org/about/branch-atm-locations**.

## ALBUQUERQUE PUBLIC SCHOOLS (APS) IMPORTANT EMPLOYEE BENEFIT PROGRAM NOTICES

Updated December 2021

This document contains important employee benefit program notices of interest to you and your family. Please share this information with your family members. Some of the notices in this document are required by law and other notices contain helpful information. These notices are updated from time to time and some of the federal notices are updated each year. Be sure you are reviewing an updated version of this important notices document.

***Si no comprendes la información contenida en este documento por favor póngase en contacto con el Departamento de Beneficios en (505) 889-4859.***

To contact the APS Employee Benefits Department with questions about any of these notices, or if you need additional information:

Visit our office at 6400 Uptown Blvd NE, Suite 115E, Albuquerque, NM 87110

Website: http://www.aps.edu/human-resources/benefits

Email: employee.benefits@aps.edu

Phone: (505) 889-4859 (refer to the contact list on the Employee Benefits page of the APS website for additional phone numbers and email addresses)

Fax: (505) 889-4882

Regular mail: Albuquerque Public Schools, Attn: Employee Benefits Department, PO Box 25704, Albuquerque, NM 87125-0704

The notices discussed in this document are available on the Employee Benefits Department website at http://www.aps.edu/human-resources/benefits/required-notices/2021-documents/aps-important-compliancenotices

## MID-YEAR CHANGES TO YOUR HEALTH CARE BENEFIT ELECTIONS

IMPORTANT: After the open enrollment period is completed (or, if you are a new hire, after your initial enrollment election period is over), generally you **will not** be allowed to change your benefit elections or add/delete dependents until next years' open enrollment, unless you have a Special Enrollment Event or a Mid-year Permitted Election Change Event as outlined below:

### SPECIAL ENROLLMENT EVENT:

**Loss of Other Coverage Event**: If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must **enroll within 60 days** after your or your dependents' other coverage ends (or after the employer stops contributing towards the other coverage).

**Marriage, Birth, Adoption Event**: 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 yourself and your dependents. However, you must **enroll within 60 days** after the marriage, birth, adoption, or placement for adoption.

**Medicaid/CHIP Event**: You and your eligible dependents may also enroll in this plan if you (or your dependents):

- have coverage through Medicaid or a State Children's Health Insurance Program (CHIP) and you (or your dependents) lose eligibility for that coverage. However, you must **enroll within 60 days** after the Medicaid or CHIP coverage ends.
- become eligible for a premium assistance program through Medicaid or CHIP. However, you must **enroll within 60 days** after you (or your dependents) are determined to be eligible for such assistance.

To request special enrollment or obtain more information, contact the APS Employee Benefits Department.

## MID-YEAR PERMITTED ELECTION CHANGE EVENT:

Because the District pre-taxes many benefits for active employees, we are required to follow Internal Revenue Service (IRS) regulations on if and when benefits can be changed in the middle of a plan year. The following are some of the events that **may** allow certain changes in benefits mid-year, **if** permitted by the IRS:

- Change in legal marital status (e.g. marriage, divorce/legal separation, death of spouse).
- Change in number or status of dependents (e.g. birth, adoption, death of dependent).
- Change in employee/spouse/dependent's employment status, work schedule, or residence that affects their eligibility for benefits.
- Coverage of a child due to a Qualified Medical Child Support Order (QMCSO).
- Entitlement or loss of entitlement to Medicare or Medicaid.
- Certain changes in the cost of coverage, composition of coverage or curtailment of coverage of the employee or spouse's plan.
- Changes consistent with Special Enrollment Event rights and FMLA leaves.

You must notify the plan in writing within **60 days** of the mid-year election change event by contacting the APS Employee Benefits Department. The Plan will determine if your change request is permitted and if so, have you complete the appropriate Enrollment/Change Form. Changes become effective prospectively, on the first day of the month following the approved mid-year election change event (except for newborn and adopted children, who are covered back to the date of birth, adoption, or placement for adoption).

Refer to pages 13-15 of this guide for more information.

## IF YOU DECLINE MEDICAL PLAN COVERAGE OFFERED THROUGH ALBUQUERQUE PUBLIC SCHOOLS

**The medical plan option(s) offered by Albuquerque Public Schools (APS) are considered to be minimum essential coverage (MEC) and meets the government's minimum value standard. Additionally, the cost of medical plan coverage is intended to be affordable to employees, based on employee wages.**

If you are a benefit eligible employee and choose not to be covered by one of the APS medical plan options, you must maintain medical plan coverage elsewhere, or you can purchase health insurance through a Marketplace (www.healthcare.gov), typically at the Marketplace annual enrollment in the fall each year.

In December 2017 Congress passed a new law (the Tax Cuts and Jobs Act) that reduced the federal Individual Mandate penalty to zero starting in 2019. This means that starting in 2019 there will no longer be a federal Individual Mandate penalty for failure to maintain medical plan coverage.

Note that if you are a resident of the District of Colombia or certain states, such as Massachusetts, New Jersey, Vermont, California or Rhode Island, you may be subject to a state income tax penalty if you fail to maintain medical plan coverage that meets that state's minimum coverage requirements. Consult with your own state's insurance department for information on whether your state has adopted or will be adopting a state Individual Mandate penalty.

If you choose to not be covered by a medical plan sponsored by **Albuquerque Public Schools (APS)** at your enrollment time, your next opportunity to enroll for APS medical plan coverage is at the next annual open enrollment time, unless you have a mid-year change event that allows you to add coverage in the middle of the APS plan year.

### IMPORTANT REMINDER TO PROVIDE THE PLAN WITH THE TAXPAYER IDENTIFICATION NUMBER (TIN) OR SOCIAL SECURITY NUMBER (SSN) OF EACH ENROLLEE IN A HEALTH PLAN

Employers are required by law to collect the taxpayer identification number (TIN) or social security number (SSN) of each medical plan participant and provide that number on reports that will be provided to the IRS each year. Employers are required to make at least two consecutive attempts to gather missing TINs/SSNs.

If a dependent does not yet have a social security number, you can go to this website to complete a form to request a SSN: http://www.socialsecurity.gov/online/ss-5.pdf. Applying for a social security number is FREE.

The SSN will also be used to help fulfill mandatory reporting requirements to the Centers for Medicare and Medicaid (CMS) for the purposes of permitting Medicare to coordinate benefits for individuals enrolled in both an employer-sponsored medical plan and Medicare.

If you have not yet provided the social security number (or other TIN) for each of your dependents that you have enrolled in the health plan, please provide that information to the APS Benefits Dept. or contact the department with a status of the missing information.

### MEDICARE NOTICE OF CREDITABLE COVERAGE REMINDER

If you or your eligible dependents are currently Medicare eligible, or will become Medicare eligible during the next 12 months, you need to be sure that you understand whether the prescription drug coverage under the APS-sponsored Medical Plan options available to you are/are not creditable with (as valuable as) Medicare's prescription drug coverage.

To find out whether the prescription drug coverage under the medical plan option(s) offered by APS are/are not creditable you should review the Plan's Medicare Part D Notice of Creditable Coverage on pages 65 – 68 of this Employee Benefits Enrollment Guide and also available from the APS Employee Benefits Department.

### PRIVACY NOTICE REMINDER

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires health plans to comply with privacy rules. These rules are intended to protect your personal health information from being inappropriately used and disclosed. The rules also give you additional rights concerning control of your own healthcare information.

This Plan's HIPAA Privacy Notice explains how the group health plan uses and discloses your personal health information. You are provided a copy of this Notice when you enroll in the Plan. The notice is also available in this document or you can get another copy from the APS Employee Benefits Department.

### WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA) ANNUAL NOTICE REMINDER

You or your dependents may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles, copayment and coinsurance applicable to other medical and surgical benefits provided under the various medical plans offered by APS. For more information on WHCRA benefits, contact your medical plan (see the phone number on your ID card) or contact the APS Employee Benefits Department.

## *AVAILABILITY OF SUMMARY OF BENEFIT AND COVERAGE (SBC) DOCUMENT(S)*

The health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury. In accordance with law, our plan provides you with a **Summary of Benefits and Coverage (SBC)** as a way to help you understand and compare medical plan benefits. The SBC summarizes and compares important information including what is covered, what you need to pay for various benefits, what is not covered, and where to get answers to questions.

SBC documents are updated when there is a change to the benefits information displayed on an SBC. To get a free copy of the most current Summary of Benefits and Coverage (SBC) documents for our medical plan options, and the Uniform Glossary that defines many terms in the SBC, contact your medical plan (see the phone number on your medical plan ID card), or visit the APS Benefits Department website at http://www.aps.edu/human-resources/benefits.

## *NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT NOTICE*

**Hospital Length of Stay for Childbirth:** Under federal law, group health plans generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the Plan may pay for a shorter stay if the attending Physician (e.g., Physician, or Health Care Practitioner), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, the Plan may not, under federal law, require that a Physician or other Health Care Practitioner obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification for a length of stay longer than 48 hours for vaginal birth or 96 hours for c-section, contact your medical plan (phone number is on your ID card) to pre-certify the extended stay. If you have questions about this notice, contact the APS Employee Benefits Department.

## *PATIENT PROTECTION RIGHTS OF THE AFFORDABLE CARE ACT*

**Designation of a Primary Care Provider (PCP) and Direct Access to OB/GYN Providers Related to the EPO Medical Plans administered by Presbyterian Health Plan and by True Health New Mexico, the PPO Medical Plan administered by Blue Cross Blue Shield of New Mexico and the OAP Medical Plan administered by Cigna:**

The self-funded **PPO medical plan** offered by APS and administered by **Blue Cross Blue Shield of New Mexico (BCBS)** generally **requires** the designation of a primary care provider (PCP).

You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. For children in the BCBS PPO plan, you may designate a pediatrician as the primary care provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the medical plan at their phone number listed on your ID card.

The self-funded medical Open Access Plus (OAP) plan offered by APS and administered by **Cigna does not require** the selection or designation of a primary care provider (PCP). You have the ability to visit any OAP network or non-network health care provider; however, payment by the Plan may be less for the use of a non-network provider. To locate an in-network provider, contact the medical plan (refer to your ID card for contact information).

The self-funded **EPO medical plan** offered by APS and administered by **True Health New Mexico does not require** the selection or designation of a primary care provider (PCP). You have the ability to visit any in-network provider. To locate an In-Network provider, contact the medical plan (refer to your ID card for contact information).

(Continued on next page)

## PATIENT PROTECTION RIGHTS OF THE AFFORDABLE CARE ACT (CONTINUED)

The self-funded EPO medical plan administered by **Presbyterian Health Plan does not require the selection or designation of a Primary Care Provider** (PCP). You have the ability to visit any in-network health care provider. To locate an in-network provider, contact the medical plan (refer to your ID card for contact information).

## DIRECT ACCESS TO OB/GYN PROVIDERS

You do not need prior authorization (pre-approval) from the medical plans or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological (OB/GYN) care from an in-network health care professional who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the medical plans at their phone number listed on your ID card.

## IMPORTANT INFORMATION ABOUT THE EMPLOYEE WELLNESS PROGRAM

Our APS Employee Wellness Program is **voluntary** and is designed to **promote health, reduce risk of chronic illness and prevent disease**. The term Employee Wellness Program includes both:

a. ways that we help individuals identify and reduce health risk factors, like elevated blood pressure or excess weight, along with

b. ways to help individuals easily access resources to achieve behavior change in order to live a healthier life, both at the workplace and at home.

The Employee Wellness Program offers a point reward system (*wellness incentive points*) for participation. A wide range of voluntary fitness, nutrition and wellness activities, along with preventive screens, annual exams, disease management programs and participation in community events count toward wellness incentive points. ***All full-time APS employees have the opportunity to participate in the Employee Wellness Program.***

This is an annual, year-long program that runs January-December. Incentives are able to be achieved **at least once a year**. **The time commitment required to achieve incentives in our Employee Wellness Program is reasonable.** Information about our Wellness Program is available at https://www.aps.edu/staff/employee-wellness/wellness-incentive-program.

The Employee Wellness Program incentives have been reviewed and in accordance with law, do not exceed 30% of the total cost of employee-only coverage under the plan (including employee and employer contributions) and the tobacco cessation incentive does not exceed 50% of the total cost of employee-only coverage.

**Reasonable Alternative Standard:** If you think you might be unable to meet a standard for a certain reward under our Employee Wellness Incentive Program, you might qualify for an opportunity to earn the same reward by a different means. If it is unreasonably difficult due to a medical condition for you to achieve the standards for the reward under the Wellness program, or if it is medically inadvisable for you to attempt to achieve the standards of the Wellness Program, then a reasonable alternative standard will be made available upon request. Contact the APS Employee Wellness Department or The Solutions Group (the third-party administrator for the ASP wellness program) for information on reasonable alternative standards and accommodations and the Employee Wellness Incentive Program. The Solutions Group will work with you and, if you wish, your doctor, to find an alternative Wellness Program standard with the same reward that is right for you in light of your health status. If your personal doctor states that the alternative is not medically appropriate, a more accommodating alternative will be provided.

## NOTICE REGARDING THE EMPLOYEE WELLNESS PROGRAM

The APS Employee Wellness Incentive Program is a **voluntary** wellness program, available to all full-time employees, and is designed to **promote health, reduce risk of chronic illness, and prevent disease.** The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others.

More information about our 2022 Wellness Program and program incentives will be described on the APS employee wellness website at http://www.aps.edu/staff/employee-wellness. If you choose to participate in the **APS Employee Wellness Incentive Program**, you will be asked to:

a. select from a list of approximately 30 wellness incentive menu items, including the option to complete a Personal Health Assessment about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You may also earn points by completing an annual exam with your primary care physician, having an eye examination, and/or having a dental exam.
b. complete the steps for the items you selected;
c. log your completion of those steps on the Wellness at Work dashboard; and
d. once you reach a specified point level, redeem points via the Wellness at Work dashboard to receive the applicable reward.

You are not required to complete or participate in any components of the Wellness Incentive Program. However, individuals who choose to participate in the Wellness Incentive program will earn incentives in the form of points, which can be redeemed for rewards. Although you are not required to complete any steps for the wellness program, only employee who do so will receive the incentive.

If you elect to complete a Personal Health Assessment as one of the wellness incentive menu items, it will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the Wellness Program, such as information about ongoing wellness program events and resources. If you complete a Personal Health Assessment, you are encouraged to share your results or concerns with your own doctor.

If you are unable to participate in any of the health-related activities in order to achieve the incentives, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting the APS Employee Wellness Department at (505) 889-4895. The Solutions Group (the third-party administrator for the APS wellness program) will work with you and your Physician to determine what is possible for you to be able to participate in the APS Employee Wellness Incentive Program.

**Protections from Disclosure of Medical Information**

Our APS group health plan is required by law to maintain the privacy and security of your personally identifiable health information.

Information collected from APS Employee Wellness Incentive Program participants will only be received by your employer (APS) in aggregate form. Although the Employee Wellness Incentive Program and APS may use aggregate information it collects to design a program based on identified health risks in the workplace, APS's group health plan will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the Employee Wellness Program, or as expressly permitted by law.

Medical information that personally identifies you that is provided in connection with the Employee Wellness Incentive Program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the Employee Wellness Incentive Program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the Employee Wellness Incentive Program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the Employee Wellness Incentive Program will abide by the same confidentiality requirements.

(continued on next page)

The only individual(s) who will receive information that identifies you as a participant in the APS Employee Wellness Incentive Program is the APS Employee Benefits Department and APS Employee Wellness Coordinator who will receive confirmation that you have completed the wellness incentive requirements and will then oversee that any incentives you have earned are correctly distributed to you.

In addition, any medical information obtained through the APS Employee Wellness Program will be maintained separate from your personnel records, and no information you provide as part of the Employee Wellness Program will be used in making any employment decision. Appropriate precautions will be taken by the APS group health plan and The Solutions Group to avoid any data breach, and in the event a HIPAA data breach occurs involving information you provide in connection with the Employee Wellness Program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the Employee Wellness Program, nor may you be subjected to retaliation if you choose not to participate. If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact the APS Employee Wellness Department.

## KEEP THE PLAN NOTIFIED OF CHANGES IN ELIGIBILITY FOR BENEFITS

**YOU ARE REQUIRED TO PROVIDE TIMELY NOTICE**

You or your Dependents must promptly furnish to the APS Employee Benefits Department information regarding marriage, divorce or legal separation, change in Domestic Partnership status, death of any covered family member, birth or change in status of a Dependent Child, Medicare enrollment or disenrollment, or an individual no longer meeting the eligibility provisions of the Plan. Proof of legal documentation will be required for certain changes.

You must promptly furnish to the APS Human Resources (HR) Department information regarding a change of name, address, or phone number.

Notify the Plan (or the HR Department, as applicable) preferably within 31 days, but no later than 60 days, after any of the above noted events.

**Failure to give the APS Employee Benefits Department or HR Department a timely notice of the above noted events may:**

a. cause you, your Spouse and/or Dependent Child(ren) to lose the right to obtain COBRA Continuation Coverage,
b. cause the coverage of a Dependent Child to end when it otherwise might continue because of a disability,
c. cause claims to not be able to be considered for payment until eligibility issues have been resolved,
d. result in your liability to repay the Plan if any benefits are paid to on behalf of an ineligible person. The Plan has the right to offset the amounts paid against the participant’s future medical, dental, and/or vision benefits.

In accordance with the requirements in the Affordable Care Act, your employer will not retroactively cancel coverage (a rescission) except when premiums are not timely paid, or in cases when an individual performs an act, practice or omission that constitutes fraud, or makes an intentional misrepresentation of material fact that is prohibited by the terms of the Plan. Keeping an ineligible dependent enrolled (for example, an ex-spouse, overage dependent child, etc.) is considered fraud. If you have questions about eligibility for dependent benefits, contact the APS Employee Benefits Department.

## *COBRA COVERAGE REMINDER*

In compliance with a federal law referred to as COBRA Continuation Coverage, this plan offers its eligible employees and their covered dependents (known as qualified beneficiaries) the opportunity to elect temporary continuation of their group health coverage when that coverage would otherwise end because of certain events (called qualifying events).

Qualified beneficiaries are entitled to elect COBRA when certain events occur, and, as a result of the event, coverage of that qualified beneficiary ends (together, the event and the loss of coverage are called a qualifying event). Qualified beneficiaries who elect COBRA Continuation Coverage must pay for it at their own expense.

Qualifying events may include termination of employment, reduction in hours of work making the employee ineligible for coverage, death of the employee, divorce/legal separation, or a child ceasing to be an eligible dependent child under the terms of the plan, if a loss of coverage results.

In addition to considering COBRA as a way to continue coverage, there may be other coverage options for you and your family. You may want to look for coverage through the Health Care Marketplace. See https://www.healthcare.gov/. In the Marketplace, you could be eligible for a tax credit that lowers your monthly premiums for Marketplace coverage, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for Marketplace coverage or for the tax credit. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan) if you request enrollment within 30 days, even if the plan generally does not accept late enrollees.

The maximum period of COBRA coverage is generally either 18 months or 36 months, depending on which qualifying event occurred.

In order to have the chance to elect COBRA coverage after a divorce/legal separation or a child ceasing to be a dependent child under the plan, **you and/or a family member must inform the Plan of that event and an Enrollment/Change Form must be completed no later than 60 days after that event occurs**. Notice must be mailed, emailed or hand-delivered to the APS Benefits Dept. and is to include the employee's name, the qualifying event, the date of the event, and the appropriate documentation in support of the qualifying event (such as divorce documents). An Enrollment Form must be completed and submitted to the APS Benefits Department no later than 60 days from the qualifying event for any qualified beneficiary to elect COBRA Continuation Coverage. (Please do not email Social Security Numbers or other sensitive information.)

If you have questions about COBRA, contact the APS Employee Benefits Department of employee.benefits@aps.edu or (505) 889-4859.

## *IMPORTANT NOTICES INCLUDED*

The following pages include important notices for you and your family:

Health Insurance Marketplace Notice

HIPAA Privacy Notice

Medicare Part D Notice

Notice about Premium Assistance with Medicaid and CHIP

## HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

### PART A: General Information

When key parts of the health care law took effect in 2014, there was a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the Marketplace and employment based health coverage offered by your employer.

### What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace opens in November 2022 for coverage starting as early as January 1st the following year.

### Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

### Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. [1]

**Note:** If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

### How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact **Albuquerque Public Schools (APS) Employee Benefits Department at (505) 889-4859**.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit https://www.healthcare.gov/ for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

## PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

| | | |
|---|---|---|
| 3. Employer name<br>**Albuquerque Public Schools** | | 4. Employer Identification Number (EIN)<br>**85-6000101** |
| 5. Employer address<br>**6400 Uptown Blvd. NE, Suite 115E** | | 6. Employer phone number |
| 7. City<br>**Albuquerque** | 8. State<br>**NM** | 9. ZIP code<br>**87110** |
| 10. Who can we contact about employee health coverage at this job?<br>**Employee Benefits Department** | | |
| 11. Phone number (if different from above)<br>**505-889-4859** | 12. Email address<br>**employee.benefits@aps.edu** | |

Here is some basic information about health coverage offered by this employer:

- **As your employer, we offer a health plan to:**

  [ ] All employees.

  [X] Some employees

  Eligible employees are those averaging 30 hours of service or more per week, as measured and determined by APS. Certain other categories of APS employees may also be offered the opportunity to enroll for benefits. Board of Education members in active duty are also offered the opportunity to enroll for benefits.

- **With respect to dependents:**

  [X] We do offer coverage. Eligible dependents are noted here: a legally married Spouse, Domestic Partner, and the following categories of children to the end of the month in which the child reaches age 26: natural child, adopted child or child placed for adoption, stepchild, child under a legal guardianship order, foster child, child of a Domestic Partner, and child under a Qualified Medical Child Support Order (QMCSO). An adult disabled child age 26 and older may continue eligibility if the child is unmarried, is permanently and totally disabled, is dependent (chiefly relies on the employee or spouse for support and maintenance), and has a disability that existed prior to age 26. Proof of dependent status is required.

  [ ] We do not offer coverage.

  [X] If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, https://www.healthcare.gov/ will guide you through the process. Contact the APS Employee Benefits Department for the employer information you'll enter when you visit https://www.healthcare.gov/ to find out if you can get a tax credit to lower your monthly premiums.

## ALBUQUERQUE PUBLIC SCHOOLS HIPAA NOTICE OF PRIVACY PRACTICES

## NOTICE OF ALBUQUERQUE PUBLIC SCHOOLS EMPLOYEE BENEFITS PLAN HEALTH INFORMATION PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

**The effective date of this Notice of Albuquerque Public Schools Employee Benefits Plan Health Information Privacy Practices (the "Notice") is December 22, 2021.**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on employer health plans concerning the use and disclosure of individual health information. This information, known as "Protected Health Information" ("PHI"), includes virtually all individually identifiable health information held by the Plan, regardless of form (oral, written, or electronic). **This notice describes the privacy practices of the Albuquerque Public Schools Employee Benefits Plan,** which includes the following APS self-insured health plans: the medical PPO and EPO plan options, Dental plan, Vision plan, APS Employee Wellness program, and medical Flexible Spending Plan (FSA).

The plans/programs covered by this notice may share health information with each other to carry out Treatment, Payment, or Health Care Operations. Under HIPAA, these plans are collectively known as an Organized Health Care Arrangement. For the purposes of this notice, unless otherwise specified, they are referred to as the "Plan". (Employees enrolled in an insured medical, dental or vision plan may also receive a privacy notice directly from those companies.)

Albuquerque Public Schools Employee Benefits Plan (the "Plan") provides health benefits to eligible employees of Albuquerque Public Schools ("APS") and their eligible dependents as described in the summary plan description(s) for the Plan. The Plan creates, receives, uses, maintains and discloses health information about participating employees and dependents in the course of providing these health benefits.

For ease of reference, in the remainder of this Notice, the words "you," "your," and "yours" refers to any individual with respect to whom the Plan receives, creates or maintains Protected Health Information, including employees and COBRA qualified beneficiaries, if any, and their respective dependents.

The Plan is required by law to take reasonable steps to protect your Protected Health Information from inappropriate use or disclosure.

Your "Protected Health Information" (PHI) is information about your past, present, or future physical or mental health condition, the provision of health care to you, or the past, present, or future payment for health care provided to you, but only if the information identifies you or there is a reasonable basis to believe that the information could be used to identify you. Protected health information includes information of a person living or deceased (for a period of fifty years after the death).

The Plan is required by law to provide notice to you of the Plan's duties and privacy practices with respect to your PHI, and is doing so through this Notice. This Notice describes the different ways in which the Plan uses and discloses PHI. It is not feasible in this Notice to describe in detail all of the specific uses and disclosures the Plan may make of PHI, so this Notice describes all of the categories of uses and disclosures of PHI that the Plan may make and, for most of those categories, gives examples of those uses and disclosures.

The Plan is required to abide by the terms of this Notice until it is replaced. The Plan may change its privacy practices at any time and, if any such change requires a change to the terms of this Notice, the Plan will revise and re-distribute this Notice according to the Plan's distribution process. Accordingly, the Plan can change the terms of this Notice at any time. The Plan has the right to make any such change effective for all of your PHI that the Plan creates, receives or maintains, even if the Plan received or created that PHI before the effective date of the change.

The Plan is distributing this Notice, and will distribute any revisions, only to participating employees and COBRA qualified beneficiaries, if any. If you have coverage under the Plan as a dependent of an employee or COBRA qualified beneficiary, you can get a copy of the Notice by requesting it from the contact named at the end of this Notice.

Please note that this Notice applies only to your PHI that the Plan maintains. It does not affect your doctor's or other health care provider's privacy practices with respect to your PHI that they maintain.

**Receipt of Your PHI by APS and its Business Associates**

The Plan may disclose your PHI to, and allow use and disclosure of your PHI by, APS and its Business Associates without obtaining your authorization.

**Plan Sponsor:** APS is the Plan Sponsor and Plan Administrator. The Plan may disclose to APS, in summary form, claims history and other information so that APS may solicit premium bids for health benefits, or to modify, amend or terminate the Plan. This summary information omits your name and Social Security Number and certain other identifying information. The Plan may also disclose information about your participation and enrollment status in the Plan to APS and receive similar information from APS. If APS agrees in writing that it will protect the information against inappropriate use or disclosure, the Plan also may disclose to APS a limited data set that includes your PHI, but omits certain direct identifiers, as described later in this Notice.

The Plan may disclose your PHI to APS for plan administration functions performed by APS on behalf of the Plan, if APS certifies to the Plan that it will protect your PHI against inappropriate use and disclosure.

**Example:** APS may review and decide appeals of claim denials under the Plan. The Claims Administrator provides PHI regarding an appealed claim to APS for that review, and APS uses PHI to make the decision on appeal.

**Business Associates:** The Plan and APS hire third parties, such as a third party administrator (the "Claims Administrator"), to help the Plan provide health benefits. These third parties are known as the Plan's "Business Associates." The Plan may disclose your PHI to Business Associates, like the Claims Administrator, who are hired by the Plan or APS to assist or carry out the terms of the Plan. In addition, these Business Associates may receive PHI from third parties or create PHI about you in the course of carrying out the terms of the Plan. The Plan and APS must require all Business Associates to agree in writing that they will protect your PHI against inappropriate use or disclosure, and will require their subcontractors and agents to do so, too.

For purposes of this Notice, all actions of APS and the Business Associates that are taken on behalf of the Plan are considered actions of the Plan. For example, health information maintained in the files of the Claims Administrator is considered maintained by the Plan. So, when this Notice refers to the Plan taking various actions with respect to health information, those actions may be taken by APS or a Business Associate on behalf of the Plan.

**How the Plan May Use or Disclose Your PHI**

The Plan may use and disclose your PHI for the following purposes without obtaining your authorization. And, with only limited exceptions, we will send all mail to you, the employee. This includes mail relating to your spouse and other family members who are covered under the Plan. If a person covered under the Plan has requested Restrictions or Confidential Communications, and if the Plan has agreed to the request, the Plan will send mail as provided by the request for Restrictions or Confidential Communications.

**Your Health Care Treatment:** The Plan may disclose your PHI for treatment (as defined in applicable federal rules) activities of a health care provider.

**Example:** If your doctor requested information from the Plan about previous claims under the Plan to assist in treating you, the Plan could disclose your PHI for that purpose.

**Example:** The Plan might disclose information about your prior prescriptions to a pharmacist for the pharmacist's reference in determining whether a new prescription may be harmful to you.

**Making or Obtaining Payment for Health Care or Coverage:** The Plan may use or disclose your PHI for payment (as defined in applicable federal rules) activities, including making payment to or collecting payment from third parties, such as health care providers and other health plans.

**Example:** The Plan will receive bills from physicians for medical care provided to you that will contain your PHI. The Plan will use this PHI, and create PHI about you, in the course of determining whether to pay, and paying, benefits with respect to such a bill.

**Example:** The Plan may consider and discuss your medical history with a health care provider to determine whether a particular treatment for which Plan benefits are or will be claimed is medically necessary as defined in the Plan.

The Plan's use or disclosure of your PHI for payment purposes may include uses and disclosures for the following purposes, among others.

- Obtaining payments required for coverage under the Plan
- Determining or fulfilling its responsibility to provide coverage and/or benefits under the

Plan, including eligibility determinations and claims adjudication

- Obtaining or providing reimbursement for the provision of health care (including coordination of benefits, subrogation, and determination of cost sharing amounts)
- Claims management, collection activities, obtaining payment under a stop-loss insurance policy, and related health care data processing
- Reviewing health care services to determine medical necessity, coverage under the Plan, appropriateness of care, or justification of charges
- Utilization review activities, including precertification and preauthorization of services, concurrent and retrospective review of services

The Plan also may disclose your PHI for purposes of assisting other health plans (including other health plans sponsored by APS), health care providers, and health care clearinghouses with their payment activities, including activities like those listed above with respect to the Plan.

**Health Care Operations:** The Plan may use and disclose your PHI for health care operations (as defined in applicable federal rules) which includes a variety of facilitating activities.

**Example:** If claims you submit to the Plan indicate that you have diabetes or another chronic condition, the Plan may use and disclose your PHI to refer you to a disease management program.

**Example:** If claims you submit to the Plan indicate that the stop-loss coverage that APS has purchased in connection with the Plan may be triggered, the Plan may use or disclose your PHI to inform the stop-loss carrier of the potential claim and to make any claim that ultimately applies.

The Plan's use and disclosure of your PHI for health care operations purposes may include uses and disclosures for the following purposes.

- Quality assessment and improvement activities
- Disease management, case management and care coordination
- Activities designed to improve health or reduce health care costs
- Contacting health care providers and patients with information about treatment alternatives
- Accreditation, certification, licensing or credentialing activities
- Fraud and abuse detection and compliance programs

The Plan also may use or disclose your PHI for purposes of assisting other health plans (including other plans sponsored by APS), health care providers and health care clearinghouses with their health care operations activities that are like those listed above, but only to the extent that both the Plan and the recipient of the disclosed information have a relationship with you and the PHI pertains to that relationship.

- The Plan's use and disclosure of your PHI for health care operations purposes may include uses and disclosures for the following additional purposes, among others.
- Underwriting (with the exception of PHI that is genetic information) premium rating and performing related functions to create, renew or replace insurance related to the Plan
- Planning and development, such as cost-management analyses
- Conducting or arranging for medical review, legal services, and auditing functions
- Business management and general administrative activities, including implementation of, and compliance with, applicable laws, and creating de-identified health information or a limited data set

The Plan also may use or disclose your PHI for purposes of assisting other health plans for which APS is the plan sponsor, and any insurers and/or HMOs with respect to those plans, with their health care operations activities similar to both categories listed above.

**Limited Data Set:** The Plan may disclose a limited data set to a recipient who agrees in writing that the recipient will protect the limited data set against inappropriate use or disclosure. A limited data set is health information about you and/or others that omits your name and Social Security Number and certain other identifying information.

**Legally Required:** The Plan will use or disclose your PHI to the extent required to do so by applicable law. This may include disclosing your PHI in compliance with a court order, or a subpoena or summons. In addition, the Plan must allow the U.S. Department of Health and Human Services to audit Plan records.

**Health or Safety:** When consistent with applicable law and standards of ethical conduct, the Plan may disclose your PHI if the Plan, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or the health and safety of others.

**Law Enforcement:** The Plan may disclose your PHI to a law enforcement official if the Plan believes in good faith that your PHI constitutes evidence of criminal conduct that occurred on the premises of the Plan. The Plan also may disclose your PHI for limited law enforcement purposes.

**Lawsuits and Disputes:** In addition to disclosures required by law in response to court orders, the Plan may disclose your PHI in response to a subpoena, discovery request or other lawful process, but only if certain efforts have been made to notify you of the subpoena, discovery request or other lawful process or to obtain an order protecting the information to be disclosed.

**Workers' Compensation:** The Plan may use and disclose your PHI when authorized by and to the extent necessary to comply with laws related to workers' compensation or other similar programs.

**Emergency Situation:** The Plan may disclose your PHI to a family member, friend, or other person, for the purpose of helping you with your health care or payment for your health care, if you are in an emergency medical situation and you cannot give your agreement to the Plan to do this.

**Personal Representatives:** The Plan will disclose your PHI to your personal representatives appointed by you or designated by applicable law (a parent acting for a minor child, or a guardian appointed for an incapacitated adult, for example) to the same extent that the Plan would disclose that information to you. The Plan may choose not to disclose information to a personal representative if it has reasonable belief that: 1) you have been or may be a victim of domestic abuse by your personal representative; or 2) recognizing such person as your personal representative may result in harm to you; or 3) it is not in your best interest to treat such person as your personal representative.

**Public Health:** To the extent that other applicable law does not prohibit such disclosures, the Plan may disclose your PHI for purposes of certain public health activities, including, for example, reporting information related to an FDA-regulated product's quality, safety or effectiveness to a person subject to FDA jurisdiction.

**Health Oversight Activities:** The Plan may disclose your PHI to a public health oversight agency for authorized activities, including audits, civil, administrative or criminal investigations; inspections; licensure or disciplinary actions.

**Coroner, Medical Examiner, or Funeral Director:** The Plan may disclose your PHI to a coroner or medical examiner for the purposes of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, the Plan may disclose your PHI to a funeral director, consistent with applicable law, as necessary to carry out the funeral director's duties.

**Organ Donation.** The Plan may use or disclose your PHI to assist entities engaged in the procurement, banking, or transplantation of cadaver organs, eyes, or tissue.

**Specified Government Functions:** In specified circumstances, federal regulations may require the Plan to use or disclose your PHI to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the president and others, and correctional institutions and inmates.

**Research:** The Plan may disclose your PHI to researchers when your individual identifiers have been removed or when an institutional review board or privacy board has reviewed the research proposal and established a process to ensure the privacy of the requested information and approves the research.

**Disclosures to You:** When you make a request for your PHI, the Plan is required to disclose to you your medical records, billing records, and any other records used to make decisions regarding your health care benefits. The Plan must also, when requested by you, provide you with an accounting of disclosures of your PHI if such disclosures were for any reason other than Treatment, Payment, or Health Care Operations (and if you did not authorize the disclosure).

**Authorization to Use or Disclose Your PHI**

Except as stated above, the Plan will not use or disclose your PHI unless it first receives written authorization from you. If you authorize the Plan to use or disclose your PHI, you may revoke that authorization in writing at any time, by sending notice of your revocation to the Privacy Officer named at the end of this Notice. To the extent that the Plan has taken action in reliance on your authorization (entered into an agreement to provide your PHI to a third party, for example) you cannot revoke your authorization.

Furthermore, we will not: (1) supply confidential information to another company for its marketing purposes (unless it is for certain limited Health Care Operations); (2) sell your confidential information (unless under strict legal restrictions) (to sell means to receive direct or indirect remuneration); (3) provide your confidential information to a potential employer with whom you are seeking employment without your signed authorization; or (4) use or disclose psychotherapy notes unless required by law.

Additionally, if a state or other law requires disclosure of immunization records to a school, written authorization is no longer required. However, a covered entity still must obtain and document an agreement which may be oral and over the phone.

**The Plan May Contact You**

The Plan may contact you for various reasons, usually in connection with claims and payments and usually by phone or mail. You should note that the Plan may contact you about treatment alternatives or other health-related benefits and services that may be of interest to you.

**Your Rights With Respect to Your PHI**

**Confidential Communication by Alternative Means:** If you feel that disclosure of your PHI could endanger you, the Plan will accommodate a reasonable request to communicate with you by alternative means or at alternative locations. For example, you might request the Plan to communicate with you only at a particular address. If you wish to request confidential communications, you must make your request in writing to the Privacy Officer named at the end of this Notice. (You may need to contact the applicable third-party administrator instead of APS.) You do not need to state the specific reason that you feel disclosure of your PHI might endanger you in making the request, but you do need to state whether that is the case. Your request also must specify how or where you wish to be contacted. The Plan will notify you if it agrees to your request for confidential communication. You should not assume that the Plan has accepted your request until the Plan confirms its agreement to that request in writing.

**Request Restriction on Certain Uses and Disclosures:** You may request the Plan to restrict the uses and disclosures it makes of your PHI. This request will restrict or limit the PHI that is disclosed for Treatment, Payment, or Health Care Operations, and this restriction may limit the information that the Plan discloses to someone who is involved in your care or the payment for your care. The Plan is not required to agree to a requested restriction, but if it does agree to your requested restriction, the Plan is bound by that agreement, unless the information is needed in an emergency situation. There are some restrictions, however, that are not permitted even with the Plan's agreement. To request a restriction, please submit your written request to the Privacy Officer identified at the end of this Notice. (You may need to contact the applicable third-party administrator instead of APS.) In the request please specify: (1) what information you want to restrict; (2) whether you want to limit the Plan's use of that information, its disclosure of that information, or both; and (3) to whom you want the limits to apply (a particular physician, for example). The Plan will notify you if it agrees to a requested restriction on how your PHI is used or disclosed. You should not assume that the Plan has accepted a requested restriction until the Plan confirms its agreement to that restriction in writing. You may request restrictions on our use and disclosure of your confidential information for the treatment, payment and health care operations purposes explained in this Notice. Notwithstanding this policy, the plan will comply with any restriction request if (1) except as otherwise required by law, the disclosure is to the health plan for purposes of carrying out payment or health care operations (and it is not for purposes of carrying out treatment); and (2) the PHI pertains solely to a health care item or service for which the health care provider has been paid out-of-pocket in full.

**Right to Be Notified of a Breach:** You have the right to be notified in the event that the plan (or a Business Associate) discovers a breach of unsecured protected health information.

**Electronic Health Records:** You may also request and receive an accounting of disclosures of electronic health records made for treatment, payment, or health care operations during the prior three years for disclosures made on or after (1) January 1, 2014 for electronic health records acquired before January 1, 2009; or (2) January 1, 2011 for electronic health records acquired on or after January 1, 2009.

The first list you request within a 12-month period will be free. You may be charged for providing any additional lists within a 12-month period.

**Paper Copy of This Notice:** You have a right to request and receive a paper copy of this Notice at any time, even if you received this Notice previously, or have agreed to receive this Notice electronically. To obtain a paper copy please call or write the Privacy Officer named at the end of this Notice.

**Right to Access Your PHI:** You have a right to access your PHI in the Plan's enrollment, payment, claims adjudication and case management records, or in other records used by the Plan to make decisions about you, in order to inspect it and obtain a copy of it. Your request for access to this PHI should be made in writing to the Privacy Officer named at the end of this Notice. (You may need to contact the applicable insurance carriers instead of APS.) The Plan may deny your request for access, for example, if you request information compiled in anticipation of a legal proceeding. If access is denied, you will be provided with a written notice of the denial, a description of how you may exercise any review rights you might have, and a description of how you may complain to Plan or the Secretary of Health and Human Services. If you request a copy of your PHI, the Plan may charge a reasonable fee for copying and, if applicable, postage associated with your request.

**Right to Amend:** You have the right to request amendments to your PHI in the Plan's records if you believe that it is incomplete or inaccurate. A request for amendment of PHI in the Plan's records should be made in writing to the Privacy Officer named at the end of this Notice. The Plan may deny the request if it does not include a reason to support the amendment. The request also may be denied if, for example, your PHI in the Plan's records was not created by the Plan, if the PHI you are requesting to amend is not part of the Plan's records, or if the Plan determines the records containing your health information are accurate and complete. If the Plan denies your request for an amendment to your PHI, it will notify you of its decision in writing, providing the basis for the denial, information about how you can include information on your requested amendment in the Plan's records, and a description of how you may complain to Plan or the Secretary of Health and Human Services.

**Accounting:** You have the right to receive an accounting of certain disclosures made of your health information. Most of the disclosures that the Plan makes of your PHI are not subject to this accounting requirement because routine disclosures (those related to payment of your claims, for example) generally are excluded from this requirement. Also, disclosures that you authorize or that occurred prior to April 14, 2003 are not subject to this requirement. To request an accounting of disclosures of your PHI, you must submit your request in writing to the Privacy Officer named at the end of this Notice. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the accounting to be provided (for example on paper or electronically). The first list you request within a 12-month period will be free. If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

**Personal Representatives:** You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. The Plan retains discretion to deny a personal representative access to your PHI to the extent permissible under applicable law.

**Complaints**

If you believe that your privacy rights have been violated, you have the right to express complaints to the Plan and to the Secretary of the Department of Health and Human Services. Any complaints to the Plan should be made in writing to the Privacy Officer (noted below). (For an insured health plans, you may need to write to the applicable insurance carrier instead of APS.) The Plan encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

### Contact Information

The Plan has designated a Privacy Officer, located in the Albuquerque Public Schools Employee Benefits Department. The APS Privacy Officer is the contact for all issues regarding the Plan's privacy practices and your privacy rights.
Albuquerque Public Schools Privacy Officer
ATTN: Employee Benefits Department
PO Box 25704 Albuquerque, NM 87125-0704
Telephone: 505-889-4859

**Additional Contact Information:** The following is a list of offices you may contact to exercise your rights under the HIPAA privacy rule related to: Restricted disclosures, Confidential communications, Access to or copies of your health information, Amendment of your health information, and Accounting of disclosures

| | |
|---|---|
| Self-Insured Medical EPO Plan<br><br>Presbyterian Health Plan | Presbyterian Health Services (PHS) Plan<br>Director of Member Services<br>P.O. Box 27489 Albuquerque, NM 87125-7489<br>1(888) 275-7737<br>www.phs.org |
| Self-Insured Medical PPO Plan<br><br>Blue Cross and Blue Shield of New Mexico | Blue Cross and Blue Shield of New Mexico (BCBSNM)<br>Director of Member Services<br>P.O. Box 27630 Albuquerque, NM 87125-7630<br>1(888) 371-1928<br>www.bcbsnm.com |
| Self-Insured Medical OAP Plan<br><br>Cigna | Cigna Privacy Office<br>P.O. Box 188014<br>Chattanooga, TN 37422<br>Via email – privacyoffice@cigna.com Phone: 800-234-4077 |
| Self-Insured Medical EPO Plan<br><br>True Health New Mexico | True Health New Mexico (THNM)<br>2440 Louisiana Blvd NE, Suite 601<br>Albuquerque, NM 87110<br>Customer Service: 1(877) 210-8339<br>https://www.truehealthnewmexico.com/aps.aspx |
| Self-Insured Prescription Drug Plan<br><br>Express Scripts | Express Scripts<br>Director of Member Services<br>P.O. Box 650322 Dallas, TX 75265-9446<br>1(866) 563-9297<br>www.express-scripts.com |
| Self-Insured Dental PPO Plan<br><br>Delta Dental | Delta Dental of New Mexico<br>One Sun Plaza- 100 Sun Ave NE, Suite 400<br>Albuquerque, NM 87109<br>1(505) 855-7111<br>https://www.deltadentalnm.com/ |
| Self-Insured Vision Plan<br><br>Davis Vision | Davis Vision<br>Director of Member Services<br>P.O. Box 1525 Latham, NY 12110<br>1(800) 999-5431<br>http://www.davisvision.com/ |

## Important Notice from Albuquerque Public Schools (APS) about Prescription Drug Coverage for People with Medicare

**This notice is for people with Medicare (or who become eligible for Medicare in the next 12 months).**
**Please read this notice carefully and keep it where you can find it.**

This Notice has information about your current prescription drug coverage with Albuquerque Public Schools (APS) and the prescription drug coverage available for people with Medicare. It also explains the options you have under Medicare's prescription drug coverage and can help you decide whether or not you want to enroll in that Medicare prescription drug coverage. At the end of this notice is information on where you can get help to make a decision about Medicare's prescription drug coverage.

- **If you and/or your family members are not now eligible for Medicare, and will not be eligible during the next 12 months, you may disregard this Notice.**
- **If, however, you and/or your family members are now eligible for Medicare or may become eligible for Medicare in the next 12 months, you should read this Notice very carefully and keep a copy of this Notice.**

This announcement is required by law whether the group health plan's coverage is primary or secondary to Medicare. Because it is not possible for our Plan to always know when a Plan participant or their eligible spouse or children have Medicare coverage or will soon become eligible for Medicare, we have decided to provide this Notice to all plan participants.

Prescription drug coverage for Medicare-eligible people is available through Medicare prescription drug plans (PDPs) and Medicare Advantage Plans (like an HMO or PPO) that offer prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more drug coverage for a higher monthly premium.

**Albuquerque Public Schools (APS) has determined that the prescription drug coverage is "CREDITABLE" under the following APS-sponsored medical plan options:**

- **Blue Cross and Blue Shield of New Mexico PPO Plan**
- **Cigna OAP Plan**
- **Presbyterian Health Plan EPO Plan**
- **True Health New Mexico EPO Plan**

"Creditable" means that the value of this Plan's prescription drug benefit is, on average for all plan participants, expected to pay out as much as or more than the standard Medicare prescription drug coverage will pay.

Because the plan options noted above are, on average, at least as good as the standard Medicare prescription drug coverage, **you can elect or keep prescription drug coverage under the APS sponsored medical plan(s) and you will not pay extra if you later decide to enroll in Medicare prescription drug coverage.** You may enroll in Medicare prescription drug coverage at a later time, and because you maintain creditable coverage, you will not have to pay a higher premium (a late enrollment fee penalty).

### WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

Medicare-eligible people can enroll in a Medicare prescription drug plan at one of the following 3 times:

- when they first become eligible for Medicare; or
- during Medicare's annual election period (from October 15th through December 7th); or
- for beneficiaries leaving employer/union coverage, you may be eligible for a two-month Special Enrollment Period (SEP) in which to sign up for a Medicare prescription drug plan.

When you make your decision whether to enroll in a Medicare prescription drug plan, you should also compare your current prescription drug coverage, (including which drugs are covered and at what cost) with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

### YOUR RIGHT TO RECEIVE A NOTICE

You will receive this notice at least every 12 months and at other times in the future such as if the creditable/non-creditable status of the prescription drug coverage through this plan changes. You may also request a copy of a Notice at any time.

### WHY CREDITABLE COVERAGE IS IMPORTANT (When you will pay a higher premium (penalty) to join a Medicare drug plan)

If you do not have creditable prescription drug coverage when you are first eligible to enroll in a Medicare prescription drug plan and you elect or continue prescription drug coverage under a **non-creditable** prescription drug plan, then at a later date when you decide to elect Medicare prescription drug coverage you may pay a higher premium (a penalty) for that Medicare prescription drug coverage for as long as you have that Medicare coverage.

Maintaining creditable prescription drug coverage will help you avoid Medicare's late enrollment penalty. This **late enrollment penalty** is described below:

> If you go 63 continuous days or longer without creditable prescription drug coverage (meaning drug coverage that is at least as good as Medicare's prescription drug coverage), your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have either Medicare prescription drug coverage or coverage under a creditable prescription drug plan. You may have to pay this higher premium (the penalty) as long as you have Medicare prescription drug coverage.
>
> For example, if 19 months pass where you do not have creditable prescription drug coverage, when you decide to join Medicare's drug coverage your monthly premium will always be at least 19% higher than the Medicare base beneficiary premium. Additionally, if you go 63 days or longer without prescription drug coverage you may also have to wait until the next October to enroll for Medicare prescription drug coverage.

Continued on next page

**REMEMBER TO KEEP THIS NOTICE**

**If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).**

## WHAT ARE MY CHOICES?

You can choose any **one** of the following options:

| Your Choices: | What you can do: | What this option means to you: |
|---|---|---|
| **Option 1** | You can select or keep your current APS-sponsored medical and prescription drug coverage and **you do not have to enroll in a Medicare prescription drug plan.** | You will continue to be able to use your prescription drug benefits through the APS-sponsored medical plan.<br>• You may, in the future, enroll in a Medicare prescription drug plan during Medicare's annual enrollment period (during October 15th through December 7th of each year).<br>• As long as you are enrolled in creditable drug coverage you will not have to pay a higher premium (a late enrollment fee) to Medicare when you do choose, at a later date, to sign up for a Medicare prescription drug plan. |
| **Option 2** | You can select or keep your current APS-sponsored medical and prescription drug coverage **and also enroll in a Medicare prescription drug plan**.<br><br>If you enroll in a Medicare prescription drug plan you will need to pay the Medicare Part D premium out of your own pocket. | Your current medical coverage pays for other health expenses in addition to prescription drugs.<br>If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current medical and prescription drug benefits. Having dual prescription drug coverage under this Plan and Medicare means that this Plan will coordinate its drug payments with Medicare, as follows:<br>• for Medicare eligible Retirees and their Medicare eligible Dependents, Medicare Part D coverage pays primary and the group health plan pays secondary.<br>• for Medicare eligible Active Employees and their Medicare eligible Dependents, the group health plan pays primary and Medicare Part D coverage pays secondary.<br>Note that you may not drop just the prescription drug coverage under an APS-sponsored medical plan. That is because prescription drug coverage is part of the entire medical plan. Generally, you may only drop medical plan coverage at this Plan's next Switch/Open Enrollment period.<br><br>Note that each Medicare prescription drug plan (PDP) may differ. Compare coverage, such as:<br>• PDPs may have different premium amounts;<br>• PDPs cover different brand name drugs at different costs to you;<br>• PDPs may have different prescription drug deductibles and different drug copayments;<br>• PDPs may have different networks for retail pharmacies and mail order services. |

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**FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE'S PRESCRIPTION DRUG COVERAGE**

More detailed information about Medicare plans that offer prescription drug coverage is available in the "Medicare & You" handbook. A person enrolled in Medicare (a "beneficiary") will get a copy of this handbook in the mail each year from Medicare. A Medicare beneficiary may also be contacted directly by Medicare-approved prescription drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number), for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

**Para más información sobre sus opciones bajo la cobertura de Medicare para recetas médicas.**

Revise el manual "Medicare Y Usted" para información más detallada sobre los planes de Medicare que ofrecen cobertura para recetas médicas. Visite www.medicare.gov/ por el Internet o llame GRATIS al 1 800 MEDICARE (1-800-633-4227). Los usuarios con teléfono de texto (TTY) deben llamar al 1-877-486-2048. Para más información sobre la ayuda adicional, visite la SSA en línea en https://www.ssa.gov/ por Internet, o llámeles al 1-800-772-1213 (Los usuarios con teléfono de texto (TTY) deberán llamar al 1-800-325-0778).

**For people with limited income and resources**, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at https://www.ssa.gov/, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

**For more information about this notice or your current prescription drug coverage contact:**

APS Employee Benefits Department
Phone Number: 505-889-4859
Physical address: 6400 Uptown Blvd. NE, Suite 115E Albuquerque, NM 87110
Mailing address: Albuquerque Public Schools
Attn: Employee Benefits Department
PO Box 25704 Albuquerque, NM 87125-0704

As in all cases, Albuquerque Public Schools reserves the right to modify benefits at any time, in accordance with applicable law. This document (dated December 22, 2021) is intended to serve as your Medicare Notice of Creditable Coverage, as required by law.

## Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

**If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2020. Contact your State for more information on eligibility.**

| ALABAMA – Medicaid | COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+) |
|---|---|
| Website: http://myalhipp.com/ Ph one: 1-855-692-5447 | Health First Colorado<br>Website: https://www.healthfirstcolor ado.com/<br>Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711<br>CHP+: https://www.colorado.gov/pacific/hcpf/child- hea lth-plan-plus<br>CHP+ Customer Service: 1-800-359-1991/ State Relay 711 |
| **ALASKA – Medicaid** | **FLORIDA – Medicaid** |
| The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/<br>Phone: 1-866-251-4861<br>Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/de fault.aspx | Website: http://flmedicaidtplrecovery.com/hipp / Phone: 1-877-357-3268 |
| **ARKANSAS – Medicaid** | **GEORGIA – Medicaid** |
| Website: http://myarhipp.com/<br>Phone: 1-855-MyARHIPP (855-692-7447) | Website: https://medicaid.georgia.gov/health-insurance- premium-payment-program-hipp<br>Phone: 678-564-1162 ext 2131 |

| CALIFORNIA – Medicaid | INDIANA – Medicaid |
|---|---|
| Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_co nt.aspx<br>Phone: 1-800-541-5555 | Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/<br>Phone: 1-877-438-4479<br>All other Medicaid<br>Website: http://www.indianamedicaid.com Phone 1-800-403-0864 |
| **IOWA – Medicaid and CHIP (Hawki)** | **NEBRASKA – Medicaid** |
| Medicaid<br>Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki<br>Hawki Phone: 1-800-257-8563 | Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633<br>Lincoln: 402-473-7000<br>Omaha: 402-595-1178 |
| **KANSAS – Medicaid** | **NEVADA – Medicaid** |
| Website: http://www.kdheks.gov/hcf/default.htm Phone: 1-800-792-4884 | Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900 |
| **KENTUCKY – Medicaid** | **NEW HAMPSHIRE – Medicaid** |
| Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP)<br>Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx<br>Phone: 1-855-459-6328<br>Email: KIHIPP.PROGRAM@ky.gov<br><br>KCHIP<br>Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718<br><br>Kentucky Medicaid Website: https://chfs.ky.gov | Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218<br>Toll free number for the HIPP program: 1-800-852-3345, ext 5218 |
| **LOUISIANA – Medicaid** | **NEW JERSEY – Medicaid and CHIP** |
| Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP) | Medicaid<br>Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/<br>Medicaid Phone: 609-631-2392<br>CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 |
| **MAINE – Medicaid** | **NEW YORK – Medicaid** |
| Website: http://www.maine.gov/dhhs/ofi/public- assistance/index.html<br>Phone: 1-800-442-6003<br>TTY: Maine relay 711 | Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831 |
| **MASSACHUSETTS – Medicaid and CHIP** | **NORTH CAROLINA – Medicaid** |
| Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840 | Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100 |

| MINNESOTA – Medicaid | NORTH DAKOTA – Medicaid |
|---|---|
| Website: https://mn.gov/dhs/people-we-serve/children-and- families/health-care/health-care-programs/programs-and- services/medical-assistance.jsp [Under ELIGIBILITY tab, see "what if I have other health insurance?"] Phone: 1-800-657-3739 | Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825 |
| **MISSOURI – Medicaid** | **OKLAHOMA – Medicaid and CHIP** |
| Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005 | Website: http://www.insureoklahoma.org Phone: 1-888-365-3742 |
| **MONTANA – Medicaid** | **OREGON – Medicaid** |
| Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 | Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075 |
| **PENNSYLVANIA – Medicaid** | **RHODE ISLAND – Medicaid and CHIP** |
| Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462 | Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line) |
| **SOUTH CAROLINA – Medicaid** | **VIRGINIA – Medicaid and CHIP** |
| Website: https://www.scdhhs.gov Phone: 1-888-549-0820 | Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282 |
| **SOUTH DAKOTA - Medicaid** | **WASHINGTON – Medicaid** |
| Website: http://dss.sd.gov Phone: 1-888-828-0059 | Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022 |
| **TEXAS – Medicaid** | **WEST VIRGINIA – Medicaid** |
| Website: http://gethipptexas.com/ Phone: 1-800-440-0493 | Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447) |
| **UTAH – Medicaid and CHIP** | **WISCONSIN – Medicaid and CHIP** |
| Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669 | Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002 |
| **VERMONT– Medicaid** | **WYOMING – Medicaid** |
| Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427 | Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531 |

To see if any other states have added a premium assistance program since July 31, 2021, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
**www.dol.gov/agencies/ebsa**
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
**www.cms.hhs.gov**
1-877-267-2323, Menu Option 4, Ext. 61565

### Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

# Appendix B: The 2022 Summaries of Benefits and Coverage for True Health New Mexico, Presbyterian Health Plan, Cigna and Blue Cross Blue Shield of New Mexico are available on the APS Employee Benefits Department website.

Blue Cross Blue Shield of New Mexico Summary of Benefits and Coverage: https://www.aps.edu/human-resources/benefits/documents/2022-summary-of-benefits/BCBS_SummaryofBenefitsandCoverage_a.pdf

Cigna Summary of Benefits and Coverage: https://www.aps.edu/human-resources/benefits/documents/2022-summary-of-benefits/Cigna_SummaryofBenefitsandCoverage_a.pdf

Presbyterian Health Plan Summary of Benefits and Coverage: https://www.aps.edu/human-resources/benefits/documents/2022-summary-of-benefits/PHP_SummaryofBenefitsandCoverage_a.pdf

True Health New Mexico Summary of Benefits and Coverage: https://www.aps.edu/human-resources/benefits/documents/2022-summary-of-benefits/TrueHealthNM_SummaryofBenefitsandCoverage_a.pdf