ALBUQUERQUE PUBLIC SCHOOLS (APS)
Important Employee Benefit Program Notices

Updated September 25, 2024 for the APS benefit plan that will be effective January 1, 2025

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 https://www.aps.edu/human-resources/benefits/required-notices/aps-all-important-compliance-notices.pdf

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MEDICARE NOTICE OF CREDITABLE COVERAGE REMINDER

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 21 for more details.

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 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 via the Winocular system. 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).

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 in a benefits-eligible position 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 Employee Benefits Department or contact the department with a status of the missing information.

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 two 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 BENEFITS 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 Employee Benefits Department website at https://www.aps.edu/human-resources/benefits/benefit-information

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 Plan administered by Presbyterian Health Plan and the EPO Medical Plan administered by Blue Cross Blue Shield of New Mexico:

- The self-funded **EPO 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 EPO 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 **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 APS 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. The wellness program 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 2024 Wellness Program and program incentives can be found on the APS employee wellness website at https://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 employees who do so will receive the incentive.

If you elect to complete a Personal Health Assessment as one of 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.

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 when an individual no longer meets 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 or 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 Employee Benefits Department 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 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 at 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 Coverage Notice
- Your Rights and Protections Against Surprise Medical Bills Notice
- HIPAA Notice of Privacy Practices
- Medicare Part D Notice
- Notice about Premium Assistance with Medicaid and CHIP
- Voluntary Retirement Savings Plan Annual Notice (403(b) and 457(b) Plans notice)

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

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 in your geographic area.

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

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the 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 is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[1,2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.

[2] An employer-sponsored or other employment-based 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. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/gettingmedicaid-chip/ for more details.

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 **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

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 **Albuquerque Public Schools**		4. Employer Identification Number (EIN) **85-6000101**
5. Employer address **6400 Uptown Blvd. NE, Suite 115E**		6. Employer phone number **505-880-3700**
7. City **Albuquerque**	8. State **NM**	9. ZIP code **87110**
10. Who can we contact about employee health coverage at this job? **Employee Benefits Department**		
11. Phone number (if different from above) **505-889-4859**	12. Email address **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.

  ☒ 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:**

  ☒ 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.

☒ 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, HealthCare.gov will guide you through the process. Contact the APS Employee Benefits Department for the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.

- Generally, your health plan must:
  - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").

  - Cover emergency services by out-of-network providers.

  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.

  - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed:

- Contact Customer Service for your medical plan at the phone number on your medical plan ID Card.
- You may also contact the State of New Mexico Office of the Superintendent of Insurance at (855) 427-5674 (1-855-4 ASK OSI) or http://www.OSI.state/nm.us.
- The federal phone number for information and complaints is: 1-800-985-3059.
- Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

APS Surprise Medical Bills Notice updated 9/25/2024

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 September 25, 2024.

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 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 insurance carriers 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 insurance carriers 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 Blue Cross Blue Shield of New Mexico	Blue Cross Blue Shield of New Mexico (BCBSNM) Director of Member Services P.O. Box 27630 Albuquerque, NM 87125-7630 1(888) 371-1928 www.bcbsnm.com
Self-Insured Medical EPO Plan Presbyterian Health Plan	Presbyterian Health Services (PHS) Plan Director of Member Services P.O. Box 27489 Albuquerque, NM 87125-7489 1(888) 275-7737 www.phs.org
Self-Insured Prescription Drug Plan Express Scripts	Express Scripts Director of Member Services P.O. Box 66567, St. Louis, MO 63166 1(866) 563-9297 www.express-scripts.com
Self-Insured Dental PPO Plan Delta Dental	Delta Dental of New Mexico One Sun Plaza 100 Sun Avenue NE, Suite 400 Albuquerque, NM 87109 1(505) 855-7111 www.DeltaDentalNM.com
Self-Insured Vision Plan Davis Vision	Davis Vision, Inc. Privacy Office c/o Versant Health, Inc. 500 Jordan Road Troy, NY 12180 1(800) 571-3366 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.

APS has determined that the prescription drug coverage is "CREDITABLE" under the following APS-sponsored medical plan options:

- **Blue Cross Blue Shield of New Mexico EPO Plan**
- **Presbyterian Health Plan 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).

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).

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.

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. • 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). • 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**. 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. 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: • for Medicare eligible Retirees and their Medicare eligible Dependents, Medicare Part D coverage pays primary and the group health plan pays secondary. • for Medicare eligible Active Employees and their Medicare eligible Dependents, the group health plan pays primary and Medicare Part D coverage pays secondary. 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. Note that each Medicare prescription drug plan (PDP) may differ. Compare coverage, such as: • PDPs may have different premium amounts; • PDPs cover different brand name drugs at different costs to you; • PDPs may have different prescription drug deductibles and different drug copayments; • PDPs may have different networks for retail pharmacies and mail order services.

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 www.socialsecurity.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 www.socialsecurity.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 September 25, 2024) is intended to serve as your Medicare Notice of Creditable Coverage for the APS prescription drug plan that will be effective January 1, 2025, 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, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**INDIANA – Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/healthinsurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-partyliability/childrens-health-insurance-program-reauthorizationact-2009-chipra Phone: 678-564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaida-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-andfamilies/health-care/health-care-programs/programs-andservices/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP	RHODE ISLAND – Medicaid and CHIP
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPPProgram.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premiumassistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-andeligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2024, 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

Albuquerque Public Schools
403(b) Voluntary Retirement Savings Plan Annual Notice

To All APS Employees:
This notice is to make you aware of your eligibility to participate in the APS 403(b) retirement plan. All APS employees are eligible to participate, regardless of whether your status is full-time, part-time or hourly. The 403(b) plan (often called a "tax-sheltered annuity" or TSA) is a voluntary plan that allows you to defer a portion of your paycheck to a retirement plan. The 403(b) plan is administered for APS by TCG Administrators.

The 403(b) plan is a benefit offered by APS to help you bridge your retirement income gap and lower your taxes. Under Federal tax law, you do not have to pay income taxes on your contributions or account earnings until you take the money out of the plan.

Please read below for details on how to enroll and how easy it is to start saving now.

Why would I want to participate if I am already saving through the Education Retirement Board plan?

The ERB plan may not replace all of your income in retirement. The average retiree receives 60-65 percent of their income at retirement. For example, if your current salary is $5,000 per month and your retirement benefit equals 65 percent of your current salary, you will receive $3,250 each month. However, research by one of the largest state teacher retirement systems indicates that retirees must receive 90-95 percent of their income in retirement to maintain their current standard of living. In the above example the individual has a shortfall of $1,750 per month.

Why would I contribute to a 403(b) plan?

Bridge your retirement income gap Lower your taxes Automatic saving - payroll deducted

Important points about the 403(b) plan:
A. **You may start, stop or change your payroll deduction contribution to the 403(b) plan at the first of any month*.** The deadline for enrollment or changes is generally the Thursday before the last Friday of the month preceding the month you want to start or change your contributions. (*Please note that winter break and summer payroll schedules and deadlines can impact the start, stop or contribution amount change date.)

B. If you elect to enroll in the 403(b) plan, your first step is to select an investment fund vendor and complete any necessary paperwork (or on-line or in-person enrollment) to set up an account with that vendor. The list of investment fund vendors is available by emailing employee.benefits@aps.edu or calling the APS Employee Benefits Department at (505) 889-4821. It is also available on the TCG Administrators website at www.tcgservices.com. TCG Administrators is the administrator for the APS 403(b) plan.

B. You may contribute up to $23,000 (in 2024) if you are under age 50, and up to $30,500 if you are age 50 or over.
C. All APS employees are eligible to participate in the 403(b) plan. The minimum contribution amount to the plan is $7.50 per pay period. There are no other restrictions on your right to make contributions to the Plan. Contributions are deducted from 24 pay periods per year.

Once you have a 403(b) account set up with an investment fund vendor, set up your salary reduction election:
1. Go to www.tcgservices.com
2. Click on "Enroll" (top right on the menu bar)
3. Enter "Albuquerque Public Schools" in the search box, and then click "Search"
4. Click the orange "Enroll" button
5. Scroll down and locate your investment fund vendor from the list of APS 403(b) vendors. **After you have contacted that vendor and opened your 403(b) account with that firm**, click the "Enroll Now" button next to the vendor name.
6. You now need to set up your payroll contribution account with TCG Administrators.
    - Enter your Social Security Number (without dashes) and click "Next"
    - Set up a username, password and security questions, then enter your personal information and click "Next".
7. Check the appropriate box to indicate whether you want a pretax deferral or a Roth (after-tax) deferral. (Note: only some of the investment fund vendors offer a Roth option. Refer to the investment fund vendor list for those vendors.)
    - Indicate your contribution amount (per pay period deferral amount) in the box across from your selected investment fund vendor.
8. Review and confirm that all information is correct, including your investment fund vendor name, type of deferral (pre-tax or Roth) and per paycheck deferral amount. Click "Submit" to confirm or "Back" if you need to make corrections.
9. Your six-digit Confirmation Number will be shown
10. You may also call TCG Administrators at (800) 943-9179 and they will assist you by phone.

Albuquerque Public Schools Employee Benefits Department (updated 9/25/2024) **TCG Administrators**

Albuquerque Public Schools
457(b) Voluntary Retirement Savings Plan Annual Notice

To All APS Employees:

This notice is to make you aware of your eligibility to participate in the APS 457(b) retirement plan. All APS employees are eligible to participate, regardless of whether your status is full-time, part-time, or hourly. The 457(b) plan (often called a deferred compensation plan) is a voluntary plan that allows you to defer a portion of your paycheck to a retirement plan. The 457(b) plan is administered for New Mexico employees by PERA SmartSave/Voya Financial.

The 457(b) plan is a benefit offered by APS to help you bridge your retirement income gap and lower your taxes. Under Federal tax law, you do not have to pay income taxes on your contributions or account earnings until you take the money out of the plan.

Please read below for details on how to enroll and how easy it is to start saving now.

Why would I want to participate if I am already saving through the Education Retirement Board plan?

The ERB plan may not replace all of your income in retirement. The average retiree receives 60-65 percent of their income at retirement. For example, if your current salary is $5,000 per month and your retirement benefit equals 65 percent of your current salary, you will receive $3,250 each month. However, research by one of the largest state teacher retirement systems indicates that retirees must receive 90-95 percent of their income in retirement to maintain their current standard of living. In the above example the individual has a shortfall of $1,750 per month.

Why would I contribute to a 457(b) plan?

Bridge your retirement income gap Lower your taxes Automatic saving - payroll deducted

Important points about the 457(b) plan:

A. **You may start, stop or change your payroll deduction contribution to the 457(b) plan at the first of any month*.** The deadline for enrollment or changes is generally the second to the last day of the month preceding the month you want to start or change your contributions. (*Please note that winter break and summer payroll schedules and deadlines can impact the start, stop or contribution amount change date.)

B. You may contribute up to $23,000 (in 2024) if you are under age 50, and up to $30,500 if you are age 50 or over.

C. All APS employees are eligible to participate in the 457(b) plan. The minimum contribution amount to the plan is $10.00 per pay period. There are no other restrictions on your right to make contributions to the 457(b) plan. Contributions are deducted from 24 pay periods per year.

D. For more information about the APS 457(b) plan, call the APS Employee Benefits Department at (505) 889-4821, visit https://my.voya.com/voyassoui/index.html?domain=perasmartsave.voya.com#/login-pweb or call Voya Customer Service at (833) 424-7283.

To enroll in the 457(b) plan:

Visit the above website and select “Enroll Here: Get Started” on the right side of the PERA SmartSave webpage. At the next screen, start typing Albuquerque Public Schools in the search box and select “Albuquerque Public Schools PERA SmartSave”, click Continue, and then follow the instructions to enroll. Be prepared to indicate your per pay period contribution amount, your investment elections (refer to the PERASmartSave site), and your beneficiaries.

After you have completed your enrollment, Voya will send you a Personal Identification Number (PIN) in the mail. Once you enroll and receive your PIN, it is important to register your account at PERASmartSave.voya.com, and to create a Username and Password. This will allow you to access your account going forward (including to make any changes to your contribution amount in the future).