NEW MEXICO

PUBLIC SCHOOLS INSURANCE AUTHORITY

PROGRAM GUIDE • JULY 2018

New Mexico Public Schools Insurance Authority

NMPSIA CUSTOMER SERVICE TELEPHONE NUMBERS & WEBSITES

ELIGIBILITY/ENROLLMENT PREMIUM BILLING/COBRA	TOLL FREE	WEBSITE
Erisa Administrative Services, Inc.	1-800-233-3164	nmpsiaonline.nmpsia.com *(click on "Contact Us")*

View your enrollment information by logging in to https://nmpsiaonline.nmpsia.com

MEDICAL	TOLL FREE	WEBSITE
BlueCross and BlueShield of New Mexico	1-888-966-7742	bcbsnm.com
Video Visits: mdlive.com/NMPSIA (or visit bcbsnm.com; log in as a member to locate the link)		
Presbyterian	1-888-275-7737	phs.org
Video Visits: visit phs.org and click on "Login to MyPres" to locate link		

PRESCRIPTION DRUGS Express Scripts	1-800-498-4904	express-scripts.com
DENTAL United Concordia	1-888-898-0370	unitedconcordia.com
VISION Davis Vision	1-800-999-5431	davisvision.com
LONG-TERM DISABILITY CLAIMS The Standard	1-888-609-9763	nmpsia.com *Click on "Insurance Carriers" tab to locate The Standard"*
LIFE INSURANCE CLAIMS The Standard	1-888-609-9763	nmpsia.com *Click on "Insurance Carriers" tab to locate The Standard"*

NMPSIA ADMINISTRATIVE OFFICE
Customer Service for Administrative Matters/Claim Issues/Appeals
410 Old Taos Highway . Santa Fe, NM 87501
1-800-548-3724 . 505-988-2736 . 505-983-8670 fax . **nmpsia.com**

New Mexico Public Schools Insurance Authority

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New Mexico Public Schools Insurance Authority

Greetings from the Executive Director!

This is the 2018 Program Guide to your employee benefits offered through the New Mexico Public Schools Insurance Authority (NMPSIA). NMPSIA was created by the Legislature in 1986 to purchase insurance benefits for all New Mexico public school districts (except for Albuquerque Public Schools). Other educational entities and charter schools also participate in the NMPSIA Program.

As a participant in NMPSIA, you may be entitled to a Basic Life Insurance Policy if you work at least 15 hours per week. Your employer covers the full cost of this valuable life insurance benefit. You may apply for, and purchase, additional life insurance at your own cost. You and your employer share the cost for the medical, dental, vision, and long term disability plans. Your payroll deduction represents only about one-third of the total cost to fund the plans.

The **High Option Medical Plan** is administered by Blue Cross and Blue Shield of New Mexico (BCBSNM) and Presbyterian Health Plan. The plan's calendar year (January 1 – December 31) deductible must be met before certain services are covered (20% coinsurance then applies). This means the plan will cover 80% of allowable expenses once you meet the deductible, and you will be responsible for 20% of the cost under the High Option Medical Plan for certain services. Many services have a copayment with the deductible waived. Although the High Option Plan design is the same under both BCBSNM and Presbyterian Health Plan, the difference is the network of providers available for members.

The **Low Option Plan** is also administered by BCBSNM and Presbyterian Health Plan. This plan has a lower premium but it includes a higher deductible and requires higher out-of-pocket expenses for services. This plan may work well for an individual with minimal health care needs. Although the Low Option Plan design is the same under both BCBSNM and Presbyterian Health Plan, the difference is the network of providers available for members.

In addition, there is an **Exclusive Provider Organization (EPO) Plan** option administered by BCBSNM. This EPO Plan has a lower deductible and lower out-of-pocket costs in comparison to the High Option Plan and Low Option Plan. This plan provides in-network coverage in **certain communities in New Mexico.** There are some contracted providers in El Paso and Lubbock.

NMPSIA continues to cover your in-network, routine/preventive services at 100% under each of the medical plans. These medical plans have a calendar year out-of-pocket maximum (limit), which is the cap on the total expenses you pay in copays, deductible, and coinsurance during the calendar year. It is important to know that these plans, while requiring member cost-sharing, still provide you with invaluable protection from catastrophic medical expenses.

We encourage you to review the side-by-side medical plan comparison chart at nmpsia.com and to visit each insurance carrier's link at nmpsia.com to assist you in making a decision about your medical coverage enrollment. Also, please review the important employment benefit program notices included in this Program Guide.

The NMPSIA Board may be required to make additional plan and premium changes as needed during the 2018-2019 school year should NMPSIA experience unexpected (increased) claims costs or any budget shortfalls as a result of legislative action. Any changes made will be reflected as an addendum to the electronic version of the 2018 Program guide at nmpsia.com and will also be posted at nmpsia.com under the "Benefit Plan Changes" section.

Please do not miss the opportunity to enroll for insurance. If you do not apply to enroll for coverage within 31 days of becoming eligible, you may not have the chance to apply to enroll for medical, dental or vision coverage until the next established open enrollment period in the fall. Further, if you do not enroll timely for additional life coverage or long term disability coverage, you will have to apply through evidence of insurability through The Standard Insurance Company (and there is no guarantee coverage will be approved).

We are happy to announce that we are offering wellness benefits under the medical plans listed in this Program Guide. Further, BCBSNM and Presbyterian Health Plan offer telehealth (virtual video visits) for a $0 copayment. These visits are intended to provide you additional access to healthcare. This is a great opportunity for you to seek non-emergent care at NO COST!

We encourage you to make every effort to take advantage of participating in the wellness programs so you can stay as healthy as possible in order to keep your claim costs down. Visit the medical plan websites to become familiar with these programs. Becoming a good consumer of your health care needs will contribute to help us maintain the great benefits we are currently able to offer you under our self-insured Group Plan.

Have a great school year!

Sammy J. Quintana, Esq.
Executive Director

Employer Plan Matrix

EMPLOYER	Basic Life	Medical Plan Choices	Dental	Vision	Disability Plan	Add. Life
ACADEMY FOR TECHNOLOGY AND THE CLASSICS	$25,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
ACE LEADERSHIP HIGH SCHOOL	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	60 days	YES
AFT NEW MEXICO	$10,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	N/A
ALAMOGORDO PUBLIC SCHOOLS	$25,000	BCBSNM and PRESBYTERIAN	YES	YES	90 days	YES
ALBUQUERQUE CHARTER ACADEMY	$10,000	BCBSNM and PRESBYTERIAN	YES	YES	N/A	YES
ALBUQUERQUE COLLEGIATE CHARTER SCHOOL	$25,000	BCBSNM and PRESBYTERIAN	YES	YES	60 days	YES
ALBUQUERQUE INSTITUTE OF MATH & SCIENCE	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	90 days	YES
ALBUQUERQUE SCHOOL OF EXCELLENCE	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
ALBUQUERQUE SIGN LANGUAGE ACADEMY	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	60 days	YES
ALDO LEOPOLD CHARTER SCHOOL	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	60 days	YES
ALICE KING COMMUNITY SCHOOL	$25,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
ALMA D ARTE CHARTER HIGH SCHOOL	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
ALTURA CHARTER SCHOOL	$25,000	BCBSNM and PRESBYTERIAN	YES	YES	60 days	YES
AMY BIEHL CHARTER HIGH SCHOOL	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	60 days	YES
ANANSI CHARTER SCHOOL	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
ANIMAS PUBLIC SCHOOLS	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
ARTESIA PUBLIC SCHOOLS	$25,000	BCBSNM and PRESBYTERIAN	YES	N/A	N/A	YES
ASSOCIATION OF CHARTER SCHOOLS EDUCATIONAL SERVICES	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
AZTEC MUNICIPAL SCHOOLS	$25,000	BCBSNM and PRESBYTERIAN	YES	YES	90 days	YES
BELEN CONSOLIDATED SCHOOLS	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	N/A	YES
BERNALILLO PUBLIC SCHOOLS	$25,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
BLOOMFIELD MUNICIPAL SCHOOLS	$25,000	BCBSNM and PRESBYTERIAN	YES	YES	N/A	YES
CAPITAN MUNICIPAL SCHOOLS	$10,000	BCBSNM and PRESBYTERIAN	YES	YES	N/A	YES
CARLSBAD MUNICIPAL SCHOOLS	$50,000	BCBSNM and PRESBYTERIAN	N/A	N/A	30 days	YES
CARRIZOZO MUNICIPAL SCHOOLS	$10,000	BCBSNM and PRESBYTERIAN	YES	YES	N/A	YES
CENTRAL CONSOLIDATED SCHOOLS	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
CESAR CHAVEZ COMMUNITY SCHOOL	$25,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
CHAMA VALLEY INDEPENDENT SCHOOLS	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	90 days	YES
CHRISTINE DUNCAN HERITAGE ACADEMY	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
CIEN AGUAS INTERNATIONAL SCHOOL	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
CIMARRON MUNICIPAL SCHOOLS	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	60 days	YES
CLAYTON PUBLIC SCHOOLS	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
CLOUDCROFT MUNICIPAL SCHOOLS	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	N/A	YES
CLOVIS MUNICIPAL SCHOOLS	$50,000	BCBSNM and PRESBYTERIAN	N/A	N/A	30 days	YES
COBRE CONSOLIDATED SCHOOLS	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
COOPERATIVE EDUCATIONAL SERVICES	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	N/A	YES
CORAL COMMUNITY CHARTER SCHOOL	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	60 days	YES
CORONA MUNICIPAL SCHOOLS	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	60 days	N/A
CORRALES INTERNATIONAL SCHOOL	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	60 days	YES
COTTONWOOD CLASSICAL PREPARATORY SCHOOL	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
COTTONWOOD VALLEY CHARTER SCHOOL	$25,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
CUBA INDEPENDENT SCHOOLS	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
DEMING CESAR CHAVEZ CHARTER HIGH SCHOOL	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	60 days	YES

Employer Plan Matrix

EMPLOYER	Basic Life	Medical Plan Choices	Dental	Vision	Disability Plan	Add. Life
DEMING PUBLIC SCHOOLS	$50,000	BCBSNM and PRESBYTERIAN	YES	N/A	60 days	YES
DES MOINES MUNICIPAL SCHOOLS	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	N/A	YES
DEXTER CONSOLIDATED SCHOOLS	$25,000	BCBSNM and PRESBYTERIAN	YES	YES	N/A	YES
DIGITAL ARTS AND TECHNOLOGY ACADEMY	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
DORA CONSOLIDATED SCHOOLS	$25,000	BCBSNM and PRESBYTERIAN	YES	YES	N/A	YES
DREAM DINE' CHARTER SCHOOL	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
DULCE INDEPENDENT SCHOOLS	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
DZIT DIL LOOL SCHOOL OF EMPOWERMENT, ACTION, & PERSEVERANCE	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	90 days	YES
EAST MOUNTAIN HIGH SCHOOL	$10,000	BCBSNM and PRESBYTERIAN	YES	YES	N/A	YES
EL CAMINO REAL ACADEMY	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	60 days	YES
ELIDA MUNICIPAL SCHOOLS	$25,000	BCBSNM and PRESBYTERIAN	N/A	N/A	N/A	YES
ENMU – PORTALES	$25,000	BCBSNM and PRESBYTERIAN	YES	N/A	60 days	YES
ENMU – ROSWELL	$25,000	BCBSNM and PRESBYTERIAN	YES	YES	60 days	YES
ESPANOLA PUBLIC SCHOOLS	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
ESTANCIA MUNICIPAL SCHOOLS	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	N/A	YES
ESTANCIA VALLEY CLASSICAL ACADEMY	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
EUNICE MUNICIPAL SCHOOLS	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
EXPLORE ACADEMY	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
FARMINGTON MUNICIPAL SCHOOLS	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	N/A	N/A
FLOYD MUNICIPAL SCHOOLS	$25,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
FORT SUMNER MUNICIPAL SCHOOLS	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
GADSDEN INDEPENDENT SCHOOLS	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
GALLUP-MCKINLEY COUNTY PUBLIC SCHOOLS	$25,000	BCBSNM and PRESBYTERIAN	YES	YES	N/A	YES
GILBERT L. SENA CHARTER HIGH SCHOOL	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	90 days	YES
GORDON BERNELL CHARTER SCHOOL	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
GRADY MUNICIPAL SCHOOLS	$25,000	BCBSNM and PRESBYTERIAN	YES	YES	60 days	YES
GRANTS/CIBOLA COUNTY SCHOOLS	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
HAGERMAN MUNICIPAL SCHOOLS	$25,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
HATCH VALLEY MUNICIPAL SCHOOLS	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
HEALTH LEADERSHIP HIGH SCHOOL	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	60 days	YES
HOBBS MUNICIPAL SCHOOLS	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	N/A	YES
HONDO VALLEY PUBLIC SCHOOLS	$10,000	BCBSNM and PRESBYTERIAN	YES	YES	N/A	YES
HORIZON ACADEMY WEST CHARTER SCHOOL	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	60 days	YES
HOUSE MUNICIPAL SCHOOLS	$25,000	BCBSNM and PRESBYTERIAN	YES	YES	N/A	YES
HOZHO ACADEMY	$25,000	BCBSNM and PRESBYTERIAN	YES	YES	60 days	YES
J. PAUL TAYLOR ACADEMY	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
JAL PUBLIC SCHOOLS	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
JEFFERSON MONTESSORI ACADEMY	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
JEMEZ MOUNTAIN PUBLIC SCHOOLS	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
JEMEZ VALLEY PUBLIC SCHOOLS	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
LA ACADEMIA DE ESPERANZA CHARTER SCHOOL	$25,000	BCBSNM and PRESBYTERIAN	YES	YES	60 days	YES
LA ACADEMIA DOLORES HUERTA	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
LA PROMESA EARLY LEARNING CENTER	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
LA RESOLANA LEADERSHIP ACADEMY	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
LA TIERRA MONTESSORI SCHOOL OF THE ARTS AND SCIENCES	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
LAKE ARTHUR MUNICIPAL SCHOOLS	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
LAS CRUCES PUBLIC SCHOOLS	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
LAS MONTANAS CHARTER SCHOOL	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
LAS VEGAS CITY PUBLIC SCHOOLS	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES

Employer Plan Matrix

EMPLOYER	Basic Life	Medical Plan Choices	Dental	Vision	Disability Plan	Add. Life
LEA REGIONAL EDUCATIONAL # 7	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	N/A	YES
LINDRITH AREA HERITAGE CHARTER	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
LOGAN MUNICIPAL SCHOOLS	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
LORDSBURG MUNICIPAL SCHOOLS	$25,000	BCBSNM and PRESBYTERIAN	YES	YES	N/A	YES
LOS ALAMOS PUBLIC SCHOOLS	$10,000	BCBSNM and PRESBYTERIAN	YES	YES	90 days	YES
LOS ALAMOS SCHOOLS CREDIT UNION	$10,000	BCBSNM and PRESBYTERIAN	YES	YES	N/A	YES
LOS LUNAS PUBLIC SCHOOLS	$25,000	BCBSNM and PRESBYTERIAN	YES	N/A	30 days	YES
LOS PUENTES CHARTER SCHOOL	$25,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
LOVING MUNICIPAL SCHOOLS	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
LOVINGTON PUBLIC SCHOOLS	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	60 days	YES
LUNA COMMUNITY COLLEGE	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
MAGDALENA MUNICIPAL SCHOOLS	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	90 days	YES
MAXWELL MUNICIPAL SCHOOLS	$25,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
MCCURDY CHARTER SCHOOL	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
MEDIA ARTS COLLABORATIVE CHARTER SCHOOL	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
MELROSE PUBLIC SCHOOLS	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	N/A	YES
MESA VISTA CONSOLIDATED SCHOOLS	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
MESALANDS COMMUNITY COLLEGE	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
MIDDLE COLLEGE HIGH SCHOOL	$25,000	BCBSNM and PRESBYTERIAN	YES	YES	N/A	YES
MISSION ACHIEVEMENT AND SUCCESS CHARTER SCHOOL	$25,000	BCBSNM and PRESBYTERIAN	YES	YES	60 days	YES
MONTE DEL SOL CHARTER SCHOOL	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
MONTESSORI OF THE RIO GRANDE	$25,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
MORA INDEPENDENT SCHOOLS	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	60 days	YES
MORENO VALLEY CHARTER SCHOOL	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
MORIARTY-EDGEWOOD SCHOOL DISTRICT	$25,000	BCBSNM and PRESBYTERIAN	YES	YES	60 days	YES
MOSAIC ACADEMY	$25,000	BCBSNM and PRESBYTERIAN	YES	YES	90 days	YES
MOSQUERO MUNICIPAL SCHOOLS	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
MOUNTAIN MAHOGANY COMMUNITY SCHOOL	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	90 days	YES
MOUNTAINAIR PUBLIC SCHOOLS	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	N/A	YES
NATIVE AMERICAN COMMUNITY ACADEMY	$10,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
NEA	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	60 days	YES
NEW MEXICO ASSOCIATION OF SCHOOL BUSINESS OFFICIALS	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
NEW MEXICO COALITION FOR CHARTER SCHOOLS	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
NEW MEXICO CONNECTIONS ACADEMY	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
NEW MEXICO JUNIOR COLLEGE	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	90 days	YES
NEW MEXICO SCHOOL FOR THE ARTS	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
NM ACTIVITIES ASSOCIATION	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
NM COALITION OF EDUCATIONAL LEADERS	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
NM SCHOOL BOARD ASSOCIATION	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
NM SCHOOL FOR THE DEAF	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
NM VIRTUAL ACADEMY	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	90 days	YES
NMPSIA	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
NORTH VALLEY ACADEMY	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	60 days	YES
NORTHERN NEW MEXICO COLLEGE	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	N/A	YES
NUESTROS VALORES CHARTER SCHOOL	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	90 days	YES
PECOS CONNECTIONS ACADEMY	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES

Employer Plan Matrix

EMPLOYER	Basic Life	Medical Plan Choices	Dental	Vision	Disability Plan	Add. Life
PECOS INDEPENDENT SCHOOLS	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
PECOS VALLEY REC #8	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
PENASCO INDEPENDENT SCHOOLS	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
POJOAQUE VALLEY PUBLIC SCHOOLS	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
PORTALES MUNICIPAL SCHOOLS	$25,000	BCBSNM and PRESBYTERIAN	YES	YES	N/A	YES
PUBLIC ACADEMY FOR PERFORMING ARTS	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	60 days	YES
QUAY SCHOOLS FEDERAL CREDIT UNION	$25,000	BCBSNM and PRESBYTERIAN	YES	YES	N/A	YES
QUEMADO INDEPENDENT SCHOOLS	$25,000	BCBSNM and PRESBYTERIAN	YES	YES	N/A	YES
QUESTA INDEPENDENT SCHOOLS	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
RATON PUBLIC SCHOOLS	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	N/A	YES
REC #2	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
RED RIVER VALLEY CHARTER SCHOOL	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	N/A	N/A
REGIONAL EDUCATIONAL CENTER #6	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
RESERVE INDEPENDENT SCHOOLS	$25,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
RIO GALLINAS SCHOOL FOR ECOLOGY AND THE ARTS	$25,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
RIO RANCHO PUBLIC SCHOOLS	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
ROBERT F. KENNEDY CHARTER SCHOOL	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
ROOTS AND WINGS COMMUNITY SCHOOL	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
ROSWELL INDEPENDENT SCHOOLS	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
ROY MUNICIPAL SCHOOLS	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
RUIDOSO MUNICIPAL SCHOOLS Eff. 10.1.18	$10,000 $50,000	BCBSNM and PRESBYTERIAN	YES	YES	N/A	YES
SAN DIEGO RIVERSIDE CHARTER SCHOOL	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
SAN JON MUNICIPAL SCHOOLS	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
SANDOVAL ACADEMY OF BILINGUAL EDUCATION	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
SANTA FE COMMUNITY COLLEGE	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	90 days	YES
SANTA FE PUBLIC SCHOOLS	$25,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
SANTA ROSA CONSOLIDATED SCHOOLS	$25,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
SCHOOL OF DREAMS ACADEMY	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
SIDNEY GUTIERREZ MIDDLE SCHOOL	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
SIEMBRA LEADERSHIP HIGH SCHOOL	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	60 days	YES
SILVER CITY CONSOLIDATED SCHOOLS	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	60 days	YES
SIX DIRECTIONS INDIGENOUS SCHOOL	$25,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
SOCORRO CONSOLIDATED SCHOOLS	$25,000	BCBSNM and PRESBYTERIAN	YES	YES	N/A	YES
SOUTH VALLEY ACADEMY	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	N/A	N/A
SOUTH VALLEY PREPARATORY SCHOOL	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
SOUTHWEST AERONAUTICS, MATHEMATICS & SCIENCE ACADEMY	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
SOUTHWEST PRIMARY LEARNING CENTER	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
SOUTHWEST SECONDARY LEARNING CENTER	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
SPRINGER MUNICIPAL SCHOOLS	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
STUDENT ATHLETIC HEADQUARTERS	$50,000	BCBSNM and PRESBYTERIAN	YES	YS	30 days	YES
TAOS ACADEMY CHARTER SCHOOL	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	60 days	YES
TAOS CHARTER SCHOOL	$10,000	BCBSNM and PRESBYTERIAN	YES	YES	N/A	N/A
TAOS INTEGRATED SCHOOL OF ARTS	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
TAOS INTERNATIONAL SCHOOL	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
TAOS MUNICIPAL SCHOOLS	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
TATUM MUNICIPAL SCHOOLS	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
TECHNOLOGY LEADERSHIP HIGH SCHOOL	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	60 days	YES
TEXICO MUNICIPAL SCHOOLS	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	N/A	YES

Employer Plan Matrix

EMPLOYER	Basic Life	Medical Plan Choices	Dental	Vision	Disability Plan	Add. Life
THE ALBUQUERQUE TALENT DEVELOPMENT	$25,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
THE ASK ACADEMY	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
THE GREAT ACADEMY	$25,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
THE INTERNATIONAL SCHOOL	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
THE MASTERS PROGRAM	$25,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
THE MONTESSORI ELEMENTARY SCHOOL	$10,000	BCBSNM and PRESBYTERIAN	YES	YES	N/A	YES
THE NEW AMERICA SCHOOL	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
THE NEW AMERICA SCHOOL - LAS CRUCES	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
THE NEW MEXICO INTERNATIONAL SCHOOL	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
TIERRA ADENTRO OF NEW MEXICO	$25,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
TIERRA ENCANTADA CHARTER HIGH SCHOOL	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	90 days	YES
TRUTH OR CONSEQUENCES MUNICIPAL SCHOOLS	$25,000	BCBSNM and PRESBYTERIAN	YES	YES	N/A	YES
TUCUMCARI PUBLIC SCHOOLS	$25,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
TULAROSA MUNICIPAL SCHOOLS	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
TURQUOISE TRAIL CHARTER SCHOOL	$25,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
TWENTY FIRST CENTURY PUBLIC ACADEMY	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	60 days	YES
VAUGHN MUNICIPAL SCHOOLS	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
VISTA GRANDE HIGH SCHOOL	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
WAGON MOUND PUBLIC SCHOOLS	$25,000	BCBSNM and PRESBYTERIAN	YES	YES	N/A	YES
WALATOWA CHARTER HIGH SCHOOL	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	90 days	YES
WEST LAS VEGAS PUBLIC SCHOOLS	$25,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
WESTERN NM UNIVERSITY	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
WILLIAM W. AND JOSEPHINE DORN CHARTER SCHOOL	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	30 days	YES
ZUNI PUBLIC SCHOOLS	$50,000	BCBSNM and PRESBYTERIAN	YES	YES	90 days	YES

Actively serving school board member options are subject to plans offered by the school district/entity the board member is representing. Board members may apply for additional life insurance equal to the basic life amount available to the school district/entity employees. Basic life and disability coverage is not available to board members.

New Mexico
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EMPLOYEE BENEFITS RULES AND REGULATIONS SUMMARY

ELIGIBLE EMPLOYEE

You are eligible to participate in the New Mexico Public Schools Insurance Authority (NMPSIA) Employees Benefits Program if you are actively at work and work the minimum qualifying number of hours established by your employer. *(In most cases, employees qualify for basic life insurance coverage because they work 15 hours or more per week. In most cases, employees qualify for all other lines of coverage because they work a minimum of 20 or more hours per week. If you work fewer than 20 hours per week but at least 15 hours per week, you may also be eligible to participate if your employer has passed a part-time employee resolution which has been approved by the NMPSIA Board of Directors).*

If you are eligible, you may participate only in the lines of NMPSIA employee benefits coverage offered by your employer. Independent contractors *(with the exception of one-bus owner operators)* and fleet bus drivers ARE NOT eligible to participate in the NMPSIA Employee Benefits Program.

Your employer determines the rate of basic life insurance coverage ($10,000, $25,000, or $50,000) for its eligible employees. If you are eligible for this basic life insurance coverage, it will be provided to you by your employer at no charge. This coverage goes into effect on the first day of the month following your hire date provided you are actively at work on the day your basic life coverage is scheduled to go into effect.

You have 31 days from your date of hire to apply for all other lines of coverage. We will consider that you have applied when you complete, sign, and turn in your application to your employer's benefits office, or when you or your employer enter your enrollment in the NMPSIA online benefit enrollment system at https://nmpsiaonline.nmpsia.com. NMPSIA does not accept retroactive effective dates, **so please apply for coverage prior to the effective date being requested**.

In most cases, all other lines of NMPSIA coverage will become effective on the first day of the month following the day you apply, provided you are actively at work on your effective date of coverage *(and you have authorized in writing that your premium is to be withheld and/or adjusted from your payroll check)*. Your effective date of coverage is determined by your employer *(based on your payroll deductions)*, but this coverage can never go into effect retroactively and never any sooner than the first day of the month FOLLOWING your first day actively at work. *(For example, if your date of hire is August 2, September 1 is the soonest your coverage can go into effect.)*

NOTE: If you are a variable hour or seasonal employee *(or a substitute)*, your employer determines if you are eligible for medical coverage under the Affordable Care Act guidelines. *(This classification of employees is only eligible for medical coverage).*

BOARD MEMBER

Actively serving *(publicly elected)* board members of participating school districts or colleges/universities are eligible to enroll to the NMPSIA benefit plans *(except for basic life and long term disability coverage)* offered at the entity they represent. Board members have 31 days from being sworn into office to apply for benefits. The additional life insurance amount available is equal to the basic life insurance amount offered to the employees at the entity. Charter school board members **are not** eligible to enroll for NMPSIA Benefits because they are not publicly elected.

New Mexico Public Schools Insurance Authority

EMPLOYEE BENEFITS RULES AND REGULATIONS SUMMARY

ELIGIBLE DEPENDENTS

You may apply to enroll your eligible dependents *(spouse and children)* to your NMPSIA Group coverage if your dependents meet NMPSIA's eligibility requirements. You will be required to present the original supportive documentation to your employer's benefits office to prove that your dependents meet NMPSIA's eligibility requirements. A copy of the appropriate supportive documentation must accompany your application or change card (*or be presented to your employer, or uploaded, prior to your coverage going into effect*); otherwise your dependents will experience a delayed effective date of coverage.

As a new hire, you are granted 61 days from the day your coverage goes into effect to provide the appropriate supportive documentation proving that your dependents are eligible for NMPSIA coverage. In cases of changes in status, you are granted 61 days from the qualifying event to provide the appropriate supportive documentation. In either case, coverage for your dependents will go into effect on the first day of the month following the day you turn in the appropriate supportive documentation to your employer's benefits office or upload your documents (*provided you apply timely and meet the 61-day timeline for supportive documentation*). The effective date of coverage for your dependents will not be made retroactive to your effective date of coverage, except for newborns and adopted children who are enrolled timely. See the following details:

NEWBORN	CHILDREN PLACED FOR ADOPTION OR ADOPTED
You are granted 61 days from the first of the month following your newborn's birth to provide appropriate supportive documentation to your employer's benefits office.	You are granted 61 days from the first of the month following your child's date of placement for adoption or date of adoption *(whichever comes first)* to provide appropriate supportive documentation to your employer's benefits office.
Coverage for a newborn begins on the newborn's date of birth, provided that you are enrolled in NMPSIA family medical coverage. Any claims associated with your newborn cannot be processed until you apply to enroll your newborn.	Coverage for an adopted child begins on date of placement or adoption *(whichever comes first)* provided that you are enrolled in NMPSIA family medical coverage. Any claims associated with your adopted child, or child placed for adoption cannot be processed until you apply to enroll your child.
If you are not enrolled in NMPSIA family medical coverage, your newborn will not be automatically covered from date of birth. You must apply to enroll your newborn within 31 days from the newborn's date of birth. If you miss this 31-day enrollment period, your newborn will not be eligible for coverage until January 1 *(coverage may begin sooner if you have a qualifying event occur and you apply within 31 days from the event).*	If you are not enrolled in NMPSIA family medical coverage, your adopted child or child placed for adoption will not be automatically covered from date of adoption or placement. You must apply to enroll your child within 31 days from date of placement or adoption *(whichever comes first)* in order for your child's coverage to be effective from date of placement or adoption. If you miss this 31-day enrollment period, your child will not be eligible for coverage until January 1 *(coverage may begin sooner if you have a qualifying event occur and you apply within 31 days from the event).*

New Mexico Public Schools Insurance Authority

EMPLOYEE BENEFITS RULES AND REGULATIONS SUMMARY

The following is a list of dependents that are eligible to participate in your NMPSIA Group coverage. This list also specifies the supportive documentation required to prove your dependent's eligibility:

ELIGIBLE DEPENDENT	SUPPORTIVE DOCUMENTATION REQUIRED
• **Legal Spouse**	Original official state publicly filed marriage certificate from the County Clerk's Office or from the Bureau of Vital Statistics *(chapel certificate is also acceptable)*
• **Domestic Partner** *(Only if employer has elected this option)*	Notarized affidavit of domestic partnership
• **Child UNDER the age of 26 as follows:**	
• Natural Child or Stepchildren	Original official state publicly filed birth certificate from the Bureau of Vital Statistics *(hospital birth registration form is also acceptable)*
• Legally adopted child	Evidence of placement by a state licensed agency, governmental agency or a court order/decree (*notarized statement and power of attorney are not acceptable*)
• Child for whom you have obtained legal guardianship and whom is primarily dependent on the eligible employee for maintenance and support	Legal Guardianship Document if evidenced in a court order or decree *(notarized statement and power of attorney or kinship documents are not acceptable)*
• Foster child living in the same household as a result of placement by a state licensed placement agency, provided that the foster home is appropriately licensed.	Placement order AND foster home license
• Dependent child with qualified medical child support order.	Medical Child Support Order
• **Child enrolled in the NMPSIA Group Plan who reaches age 26 while covered under the NMPSIA Group Plan***, who is wholly dependent on the eligible employee for maintenance and support, who is incapable of self-sustaining employment because of mental or physical impairment. (*If your child is not enrolled and covered under the NMPSIA Group Plan prior to reaching age 26, your child is not an eligible dependent.)	Evidence of incapacity and dependency in the form of a physician statement indicating diagnosis and prognosis and application must be provided 31 days **before the child reaches age 26** or within 31 days from the date the child becomes incapacitated **while covered under the NMPSIA Group Plan** *(final determination is made by each insurance carrier)*

EMPLOYEE BENEFITS RULES AND REGULATIONS SUMMARY

INELIGIBLE DEPENDENTS

The following **ARE NOT ELIGIBLE** for NMPSIA Group Coverage:

- Ex-spouses (*even if stipulated in a final divorce decree; the employee will be responsible for repaying NMPSIA for losses)*
- Common law relationships of the same or opposite sex which are not recognized by New Mexico Law. (We will accept legally issued common law marriage certificates issued by and recognized by other states.)
- Dependents while in active military service
- Children left in the care of an eligible employee without evidence of legal guardianship
- Parents, aunts, uncles, brothers, sisters, or any other person not defined as eligible dependent under NMPSIA Rules
- Domestic partners unless your employer has elected this option

ENROLLMENT REQUIREMENTS

You are required to provide Social Security or ITIN numbers for you and your dependents to enroll in the NMPSIA Group Plan. If you are in the process of applying for a social security number or ITIN number, provide proof to your employer's benefits office.

You may choose to apply to enroll in single coverage. If you choose to apply to enroll one eligible dependent, you must enroll ALL eligible dependents *(under age 18)* unless one of the following applies:

1. the eligible dependent for which you are requesting to exclude from a particular line of NMPSIA coverage is covered for that particular line of coverage under another plan (*individual, group, Medicaid, Medicare, VA, Indian Health Services, etc.*);
2. your enrollment is due to a special enrollment event for medical coverage *(see Special Enrollment section)*; or
3. a divorce decree states that the ex-spouse is to provide a particular coverage for a dependent child.

Supportive documentation in the form of a letter from the other plan or employer verifying other coverage is required when #1 applies. (*A current insurance identification card is an acceptable form of supportive documentation if it lists the dependent's name and the type of his or her coverage.)*

Supportive documentation as determined by NMPSIA is required when #2 or #3 apply (*i.e., evidence of involuntary loss of coverage that specifies who lost what coverage, on what date and why the coverage was lost; original official state publicly filed birth certificate or marriage certificate; divorce decree; etc.*).

DEADLINES FOR EMPLOYEE AND DEPENDENT ENROLLMENT

You may apply to enroll yourself and your eligible dependents for NMPSIA employee benefits within 31 days from your date of hire *(first day you report to work)* or within 31 days from a qualifying event that changes your status. If you are an actively serving board member, you must apply to enroll within 31 days from the date you are sworn into office.

If you miss the 31-day enrollment period or decline coverage, the following will apply:

Medical/Prescription Drug Coverage - You may apply during the established open enrollment period in the fall, and your coverage will go into effect January 1 (*coverage may begin sooner if you have a qualifying or special event occur and you apply within 31 days from the event*). ***Exception:*** You have 60 days from the date of involuntary loss of Medicaid coverage or the Children's Health Insurance Program (CHIP) coverage to apply.

EMPLOYEE BENEFITS RULES AND REGULATIONS SUMMARY

DEADLINES FOR EMPLOYEE AND DEPENDENT ENROLLMENT (Cont.)

- **Dental Coverage** – You may apply during the established open enrollment period in the fall, and your coverage will go into effect January 1 (*coverage may begin sooner if you have a qualifying event occur and you apply within 31 days from the event*).
- **Vision Coverage** – You may apply during the established open enrollment period in the fall, and your coverage will go into effect January 1 (*coverage may begin sooner if you have a qualifying event occur and you apply within 31 days from the event*).
- **Long Term Disability Coverage (LTD) and/or Additional Life Coverage (ADL)** – There is no open enrollment for these coverages. You may apply for ADL and LTD coverage *(or increase your ADL coverage)* through the evidence of insurability process *(children are exempt from going through evidence of insurability)*. The Life and LTD Insurance Carrier will review your health statement and may request medical records in order to make a final decision on your application.

  Evidence of insurability does not apply if you are promoted to a new job classification with a salary increase or if your part-time employment status changes to full-time with a salary increase, provided you apply within 31 days from this qualifying event. If you are enrolled for ADL and your spouse involuntarily loses other life insurance coverage, you may apply for spouse ADL within 31 days from this qualifying event (*you are required to provide proof of the involuntary loss on a timely basis*).

CHANGE OF STATUS

If you (*or in some cases, your dependents*) have a change of status due to the following qualifying events, you must report this change in status by completing, signing, and turning a change card to your employer's benefits office within 31-days from the qualifying event (*or when you and your employer enter your enrollment on the NMPSIA online benefit system at https://nmpsiaonline.nmpsia.com*):

Qualifying Events:

- Birth
- Marriage
- Adoption of a child or child placement order in anticipation of adoption
- Incapacity of a child covered under the NMPSIA Group Plan
- Legal guardianship of a child
- Promotion with a salary increase to a new job classification; or employment status change from a part-time position to a full-time position with a salary increase *(provided you are fulfilling the actively-at-work requirement)*
- Divorce or Annulment (not a legal separation)
  - You cannot cancel a spouse or any enrolled dependents when a divorce is in progress.
  - You are required to cancel an ex-spouse effective on the last day of the month your divorce becomes final (*you will be required to provide certain pages of your final divorce decree or provide proof the divorce became final; you are required to report the divorce timely even if you do not have the proof readily available*)
  - If you lose other health insurance coverage as a result of divorce, you may apply to enroll in the coverage(s) lost by providing the appropriate supportive documentation listed on the next page.

New Mexico Public Schools Insurance Authority

EMPLOYEE BENEFITS RULES AND REGULATIONS SUMMARY

Qualifying Events (cont.):

- Involuntary loss of group or individual coverage through no fault of the person having the group or individual insurance coverage (*This may include an involuntary loss of medical insurance, dental insurance, vision insurance, exhaustion of COBRA, etc.)* Please be advised that voluntarily cancelling other coverage is not considered a qualifying event.
    - For example, it is not a qualifying event if you decide to cancel your other coverage because of plan design or premium changes, or for any other reason when your other coverage is still available to you.
    - For example, It is also not a qualifying event if your coverage is cancelled by your other plan because you did not pay premium due.

    IMPORTANT: You will be required to provide your employer's benefits office with a loss of coverage letter specifying who lost coverage, what type of coverage was lost, what day coverage was lost, and why coverage was lost. If the letter does not address each of these factors, we cannot determine the loss of coverage to be an involuntary loss of coverage and your enrollment may not be accepted coverage. *(See the Special Enrollment Events section on this same page regarding medical coverage opportunities.)*

- Loss (*including retirement, resignation, termination, etc.*)
- Establishment or termination through affidavit of domestic partnership *(If this option is available through your employer and provided all requirements listed in the affidavit apply.)*
- Death

Special Enrollment Events for MEDICAL COVERAGE Only:

Special enrollment events mandated by state and federal laws permit you to apply to enroll in medical coverage within 31 days from the occurrence of a special event.

If you meet eligibility requirements for medical coverage and you and/or any of your eligible family members have a special event occur, the following are your options:

1) **You are not enrolled in the NMPSIA Medical Plan**, a special event allows you to enroll yourself only or yourself and one or more eligible dependents for NMPSIA medical coverage *(or switch medical plans)* within 31 days from the occurrence of a special event.

2) **You are enrolled in the NMPSIA Medical Plan**, a special event allows you to enroll one or more eligible dependents for NMPSIA medical coverage *(or switch medical plans)* within 31 days from the occurrence of a special event.

Special events include the following (as well as any other special event defined by law):

- You suffer an involuntary loss of coverage because coverage of your spouse *(or domestic partner, if your employer allows domestic partner enrollment)* or child under another plan is terminated as a result of divorce, death, termination of employment, reduction in hours, legal separation, termination of employer contributions or COBRA continuation coverage is exhausted
- You get married or you establish domestic partnership by affidavit *(if your employer participates in offering domestic partnership coverage)*
- A child is born to you or your spouse
- You adopt a child or a child is placed in your home for adoption
- You or any eligible dependent suffer an involuntary loss of Medicaid or CHIP coverage (*you have 60 days from date of this type of loss to apply, and proof is required)*

EMPLOYEE BENEFITS RULES AND REGULATIONS SUMMARY

To report your change of status due to a qualifying event or a special enrollment event you are required to complete, sign and turn in a change card and supportive documentation, or you and your employer may enter your change and upload the supportive documentation on the NMPSIA online enrollment system at https://nmpsiaonline.nmpsia.com within 31 days from the date of your qualifying or special event. If you do not meet this 31 day deadline, you may apply for coverage during the established open enrollment in the fall with an effective date of January 1.

Further, if you do not report a change of status that causes your spouse or child to become ineligible either within 60 days from the qualifying event or within 60 days from the day coverage would end; your spouse or child will not be eligible for COBRA continuation coverage under the NMPSIA Group Plan. When a spouse or child becomes ineligible, coverage under NMPSIA Group Plan ends for him/her on the last day of the month for which he/she becomes ineligible. (Even though you have 60 days to report this change as it pertains to COBRA continuation coverage, NMPSIA Rules require that you report this change of status within 31-days from the qualifying event. This alerts NMPSIA to notify the carriers about your spouse's or child's ineligibility to avoid unnecessary claim payments. This also allows your employer to make the necessary premium adjustments, if any, to your payroll check.) NMPSIA will retract or collect claim overpayments from you (the employee) when you are late in reporting an ineligible ex-spouse or ineligible dependent.

> **Example #1:** You divorce *(or terminate your domestic partnership)* on July 12th; this causes your ex-spouse *(or ex-domestic partner)* to become ineligible effective July 31st. You should immediately visit your employee benefits office to drop your ex-spouse *(or ex-domestic partner)* and any enrolled step-children *(or your domestic partner's children)*, if applicable, from the NMPSIA Group Plan. Provide your employee benefits office with a copy of your divorce decree *(or termination of domestic partner affidavit)* and a "signed" change card. (Your employer has the right to report a divorce to NMPSIA if you do not report as required.) Your ex-spouse *(or ex-domestic partner)* may apply for COBRA continuation coverage provided that you report this change of status within the timeframe listed above. (***REMINDER***: *Review your beneficiary designation and make any changes you wish. Life insurance proceeds may not be payable to an ex-spouse unless the ex-spouse is re-designated as beneficiary after the divorce becomes final.*)

When you are electing NMPSIA Group coverage, you will be required to complete, sign, and turn in the appropriate application, or you and your employer may enter your enrollment and upload the supportive documentation on the NMPSIA online benefit system at https://nmpsiaonline.nmpsia.com. In the event of a dependent enrollment, your employer's benefits office is required to view the supportive documentation you have presented. Without the appropriate supportive documentation, your dependent's effective date of coverage will be delayed. **If supportive documentation is not provided by the established deadline** (*61 days from your effective date or 61 days from the qualifying event*), **your dependent will not be eligible for coverage until January 1** *(unless you have a qualifying event occur and you apply timely).*

BENEFICIARY CHANGES

You may change your beneficiary (*as often as you wish*) for your basic life insurance coverage and your additional life insurance coverage. Contact your employer's benefits office for a "Beneficiary Designation Form". Once you complete, sign, and turn in this form to your employer's benefits office, the form will be forwarded to the NMPSIA Eligibility Administrative Office. When a life claim is filed, the life insurance carrier verifies the latest beneficiary information in your membership file. (*Be sure to designate a beneficiary for your basic life insurance coverage even if you decline or are not eligible to participate in the additional life coverage.*) Visit https://www.standard.com/eforms/17041.pdf to view frequently asked questions about naming a beneficiary.

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EMPLOYEE BENEFITS RULES AND REGULATIONS SUMMARY

TERMINATION OF COVERAGE EFFECTIVE DATES

Coverage terminates for NMPSIA Group participation as follows:

- ***Employees*** – Coverage terminates at the end of the period for which deductions are made from your payroll check. **This termination date is determined by your employer.**
- ***Actively Serving Board Members*** – Coverage terminates on the last day of the month in which the board member's term expires.
- ***Dependents (spouse/domestic partner and dependent child)*** – Coverage terminates on the last day of the month in which the eligible dependent becomes ineligible (*i.e., coverage for an ex-spouse and step-children or the ex-domestic partner's children terminates on the last day of the month in which the divorce becomes final or domestic partnership terminates; coverage for any other dependent child ends on the last day of the month in which the child reaches the limiting age of 26*).
- ***Employees on an extended leave of absence (LOA)*** – Your employer determines when your coverage ends under the active plan. Your employer's policy **may allow** you to remain on the active plan for no more than one year from the date your LOA was approved, so be sure to contact your employer's benefit office one month prior to reaching this 12-month period to discuss your coverage options. **ALSO**, be sure to contact your employer's benefits office **WITHIN 31 DAYS** from returning from your LOA to discuss your benefits or premiums that may have been suspended while you were on LOA. *(Further, if you are on LOA due to disability, be sure to review information regarding benefits you may be eligible for under your life or disability coverage provided by The Standard.)*

GENERAL INFORMATION

- **The Two-Year Vision Enrollment Rule** – Once enrolled in vision, you may not drop vision until you and each of your covered dependents have been enrolled two years.
- **Open Enrollment** – NMPSIA offers open enrollment each fall for medical, dental, and vision coverage. Once you apply (*prior to January 1*), the change becomes effective on January 1.
- **Switch Enrollment** – NMPSIA offers switch enrollment each fall for medical coverage and for dental coverage. Once you apply (*prior to January 1*) to switch plans, the change becomes effective on January 1.
- **The No NMPSIA Double Coverage Rule** – If both you and your spouse work for a NMPSIA participating employer, you and your spouse may not enroll each other as a spouse, nor may you both cover your children. If your child is also an employee of a NMPSIA participating entity and enrolled for employee coverage, you may not cover your child as a dependent for the lines of coverage your child is enrolled as an employee. Double coverage outside of the NMPSIA Group Plan is allowed.
- **Confirmation of Enrollment –**
  - The NMPSIA Eligibility Administrative Office will mail or email you a Confirmation of Enrollment (*or a Notice of Incomplete Enrollment if you are missing information or documentation*). Review these notices carefully and report any discrepancies to your Employee Benefits office. Failure to act may cause coverage to be postponed or denied.
  - Check your enrollment online at https://nmpsiaonline.nmpsia.com.

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EMPLOYEE BENEFITS
RULES AND REGULATIONS SUMMARY

ADDRESS AND PHONE NUMBER CHANGES

In order for each insurance carrier affiliated with your NMPSIA coverage to process your address and/or phone number changes, you must report address and phone number changes directly to your employer's benefits office on the appropriate form, or you may enter these changes online at https://nmpsiaonline.nmpsia.com.

INSURANCE FRAUD (*Federal and State Insurance Laws will Apply*) — Under NMPSIA Rules and Regulations, anyone who knowingly or willfully makes any false or fraudulent statement or representation shall forfeit all employee and dependent rights to coverage or benefits. In the event of prohibited actions by an official or employee of a participating school district or other educational entity, the employer shall take the appropriate disciplinary action against the offending official or employee. If such appropriate disciplinary action is not so taken, NMPSIA reserves the right to terminate coverage for the participating school district or other education entity.

**IF YOU HAVE ANY QUESTIONS ABOUT THE NMPSIA ELIGIBILITY RULES,
CONTACT YOUR EMPLOYER'S BENEFITS OFFICE
OR NMPSIA AT 1-800-548-3724,
or you may contact the NMPSIA ELIGIBILITY ADMINISTRATIVE OFFICE at 1-800-233-3164.**

The NMPSIA Rule and Regulations at www.nmpsia.com supersede any information contained in this Summary or Frequently Asked Questions Section of this Program Guide. You may also log on to www.nmpsia.com to find the links to contact NMPSIA staff.

FREQUENTLY ASKED QUESTIONS

Q. If I decline medical coverage during my 31-day window of opportunity (31 days from date of hire or 31 days from a qualifying event), may I enroll to NMPSIA medical coverage at a later date?

A. If you do not apply during your 31-day window of opportunity, you may apply for medical coverage during the established open enrollment period in the fall. Medical coverage will then go into effect on January 1. You may have other opportunities to enroll within 31 days from a qualifying or special event *(you would also have 60 days to apply to enroll for medical coverage within 60 days of involuntarily losing Medicaid or CHIP coverage.)*

Q. I declined NMPSIA medical coverage because my family and I are covered under my spouse's plan. His plan may be increasing the deductible and premiums. Can we cancel our other coverage and enroll under NMPSIA if we no longer want to continue coverage under my spouse's plan?

A. No; voluntarily cancelling other coverage is not a qualifying event. You may apply for medical coverage during the established open enrollment period in the fall. Medical coverage will then go into effect on January 1. You may have other opportunities to enroll within 31 days from a qualifying or special event *(you would also have 60 days to apply to enroll for medical coverage within 60 days of involuntarily losing Medicaid or CHIP coverage.)*

Q. How often does NMPSIA have an open enrollment for benefits?

A. NMPSIA offers open enrollment in the fall for medical, dental, and vision coverage. You may apply during the established open enrollment period in the fall. Coverage goes into effect on January 1.

There is no open enrollment for additional life coverage (ADL) or long term disability (LTD) coverage. If you decline these coverages during your 31-day window from your date of hire, you may apply (anytime) through evidence of insurability with The Standard Insurance Company. This application can be found at nmpsia.com.

However, you can enroll for ADL or LTD without evidence of insurability when you apply for these coverages within 31 days from going from part-time to full time with a salary increase or within 31 days from being promoted to a new employment position with a salary increase.

Further, if you are enrolled in ADL and your spouse involuntarily loses other life insurance coverage, you may apply to enroll your spouse to ADL coverage within 31 days from this qualifying event. You will be required to provide evidence of your spouse involuntarily losing other life insurance coverage.

Q. If I select a medical plan, will I have the opportunity to switch medical or dental plans at a later date?

A. Yes, NMPSIA offers switch enrollment for medical and for dental coverage each fall with an effective date of January 1. You may apply during the established switch enrollment period in the fall.

FREQUENTLY ASKED QUESTIONS

Q. I am a return to work retiree. I am currently enrolled for benefits under the New Mexico Retiree Health Care Authority (NMRHCA). Do I need to cancel my NMRHCA coverage and enroll under NMPSIA?

A. The NMRHCA requires retirees who return to work to enroll in their employer's group plan (if eligible to participate). You should discuss further with the NMRHCA at 1-800-233-2576 to ensure you are complying with the NMRHCA Rules and Regulations.

Q. If I enroll in the NMPSIA Vision Plan, may I cancel vision coverage whenever I wish?

A. No. As a safeguard to protect the utilization of the Vision Plan, NMPSIA has a 2-year enrollment requirement under this plan. You and each member of your family have to fulfill the 2-year enrollment requirement before you can drop vision coverage. If you are enrolled in a Section 125 Plan, other rules may apply. Please check with your benefits office for clarification.

Q. How will I know that my application for NMPSIA benefits has been processed and that my enrollment has been accepted?

A. Upon receipt of your enrollment application, NMPSIA's Eligibility Administrative Office will mail or email you a Confirmation Notice or a Notice of Incomplete Enrollment. Review your notices carefully and immediately provide your employer's benefits office with any documentation requested to finalize your enrollment. Do this to avoid a delay or denial of coverage for your eligible dependents. You may contact your employer's benefits office for assistance or for clarification. You may also check your enrollment at https://nmpsiaonline.nmpsia.com.

Q. I am a new hire and am applying for family coverage (employee + spouse + natural child + natural child), but I have not been able to locate my marriage certificate and birth certificate for one of my children. Will you still cover my wife and both children?

A. We will initially cover you and the one child for whom you have provided a birth certificate. We will cover your spouse and your other child effective on the first day of the month following the date you provide this missing documentation to your employer's benefits office. (We will not cover these dependents retroactive to your initial effective date.) You will have 61 days from your effective date of coverage as a new hire or 61 days from your qualifying event to provide these missing documents. If you do not meet this deadline, your dependents will be considered late and ineligible for coverage until January 1. You will have an opportunity apply to enroll them during the established open enrollment period in the fall, and their medical, dental, or vision coverage will go into effect January 1.

Q. Both my husband and I are employed with NMPSIA school districts. He carries family medical, dental and vision coverage. Can I enroll in family medical, dental and vision coverage with my employing school district to double-cover my eligible dependents?

A. No, NMPSIA Rules do not permit double coverage within the NMPSIA Group Plan if both you and your spouse (or your child) are employed by a NMPSIA participating school district/entity. You can have double coverage outside of the NMPSIA Group Plan. The employee's plan is considered the primary plan for the employee. You should contact your insurance carriers to determine which plan would primary for your spouse and other covered dependents.

Basic Term Life Insurance and Accidental Death and Dismemberment (AD&D)

100% Employer Paid

Employee Coverage

You are eligible for coverage if you are an active employee regularly working at least the minimum number of hours per week required by your employer, but not less than 15 hours per week.

Coverage is effective on the first day of the month following the date you become eligible.

The Accelerated Benefit option allows for payment of up to 75% of your insurance (Basic and Additional combined) if you are terminally ill with a life expectancy of 12 months or less. The maximum Accelerated Benefit amount is $500,000.

The Specified Disease Benefit option allows for payment of up to 25% of your Basic Life insurance if you are diagnosed with certain specified diseases. Specified Disease means you have been diagnosed by a Physician as having one of the following:

- Life Threatening Cancer
- Myocardial Infarction (Heart Attack)
- Coronary Artery Bypass Procedure
- Renal Failure
- Stroke
- Major Organ Transplant
- Acquired Immune Deficiency Syndrome (AIDS)

Payment of Life premium may be waived if you are totally disabled, you are less than 60 years old when the disability begins, and you continue to be totally disabled. Waiver of premium begins when you complete the waiting period.

Coverage will end due to termination of your employment; however, the effective date of termination of coverage will be determined by your employer. You may convert your insurance to an individual life insurance policy with The Standard within 60 days from the date your group coverage terminates.

You may also have the option to continue your group insurance coverage through a portability provision, if you terminate employment for reasons other than disability and are less than age 65. You may port your insurance to an individual life insurance policy with The Standard within 60 days from the date your group coverage terminates. (You may port the maximum of $300,000 of Basic Life and Additional Life combined.)

AD&D benefits may be paid in addition to Basic Life benefits. In the event of a covered accidental death, your AD&D benefit is equal to your Basic Life amount. Lesser amounts are paid for other specific accidental losses. See page 20 and your certificate for details.

AD&D Exclusions

No AD&D insurance benefit is payable if the accident or loss is caused or contributed to by war or act of war; suicide or other intentionally self-inflicted injury while sane or insane; committing or attempting to commit an assault or felony; actively participating in a violent disorder or riot; voluntary use or consumption of any poison, chemical compound, alcohol or drug, unless used or consumed according to the directions of a physician; sickness or pregnancy existing at the time of the accident; heart attack or stroke; or medical or surgical treatment for any of the above.

Death benefits will be reduced if an Accelerated Benefit is paid. Receipt of this benefit may be taxable and may affect your eligibility for Medicaid or other government benefits or entitlement. However, if you meet the definition of “terminally ill individual” according to the Internal Revenue Code Section 101, your Accelerated Benefit may be non-taxable. You should consult your personal tax and/or legal advisor before you apply for an Accelerated Benefit.

Additional Term Life Insurance
100% Employee Paid

If your employer chooses to offer Additional Life, you are eligible if you are an active employee working at least the minimum number of hours per week required by your employer, but not less than 20 hours per week, or with a NMPSIA Board-approved Annual Part-time Resolution 15 or more hours per week.

Coverage is available in amounts equal to 1, 2 or 3 times your base annual earnings (excludes special increments or pay for extracurricular activities). Annual earnings are rounded to the next higher multiple of $1,000 if not already a multiple of $1,000. The maximum amount available is $600,000. Amounts in excess of $500,000 will require proof of good health (satisfactory evidence of insurability).

If you apply for coverage within 31 days after your date of eligibility, no proof of good health is required. If you apply for coverage more than 31 days after your date of eligibility, or if you wish to increase your coverage, proof of good health is required.

The Accelerated Benefit option allows for payment of up to 75% of your insurance (Basic and Additional combined) if you are terminally ill with a life expectancy of 12 months or less. The maximum Accelerated Benefit amount is $500,000. Your death benefit will be reduced by the amount you elect under this provision.

Payment of premium may be waived if you are totally disabled, you are less than 60 years old when the disability begins, and you continued to be totally disabled. Waiver of premium begins when you complete the waiting period.

Coverage will end due to termination of your employment; however, the effective date of termination of coverage will be determined by your employer. You may convert your insurance to an individual life insurance policy with The Standard within 60 days from the date coverage terminates.

You may also have the option to continue your group insurance coverage through a portability provision, if you terminate employment for reasons other than retirement or disability. If coverage ends due to retirement, you may continue up to $300,000 of Additional Life, on a self-pay basis, up to age 65. (You may port the maximum of $300,000 of Basic Life and Additional Life combined.)

Dependent Term Life Insurance
100% Employee Paid

Spouse Coverage
If your employer chooses to offer Additional Life and you are insured for Additional Life, you may apply for Dependent Life Insurance for your spouse. The Accelerated Benefit described above also is available to your spouse.

Spouse includes a domestic partner, if that option is selected by your employer.

The benefit amount is the lesser of (a) 50% of your Additional Life amount, or (b) 1 times your annual earnings. Annual earnings are rounded to the next higher multiple of $1,000 if not already a multiple of $1,000.

Proof of your spouse's good health (satisfactory evidence of insurability) is required if you apply for the benefit more than 31 days after you become eligible for Dependents Life insurance.

Spouse coverage will end upon termination of your Additional Life insurance; however, insurance may be converted to an individual policy with The Standard. In some cases, portable group insurance is also available.

Suicide Exclusion Additional and Dependent Spouse Life Insurance - If death results from suicide or other intentionally self-inflicted Injury, while sane or insane, the amount payable will exclude the amount of Life Insurance which is subject to this suicide exclusion and which has not been continuously in effect for at least 2 years on the date of death. In computing the 2-year period, we will include time insured under the Prior Plan. We will refund all premiums paid for that portion of Life Insurance which is excluded from payment under this suicide exclusion.

Child Coverage

Child Life coverage has one premium rate that covers all eligible children. Your dependent children are eligible if you are insured for Additional Life. Coverage begins at birth and continues to age 26.

Coverage is available for your eligible children in the amount of $5,000. No evidence of good health is required.

Child coverage will end upon termination of your Additional Life insurance; however, insurance may be converted to an individual policy with The Standard. In some cases, portable group insurance is also available.

Premiums: Please see page 55 or go to nmpsia.com and use “Calculate LTD and ALF Premiums”.

Basic and Additional Life Accidental Death and Dismemberment (AD&D)

Employee Only Coverage

You are automatically enrolled for this coverage if you are insured for Basic and/or Additional Life. Your coverage amount is equal to your Basic and/or Additional Life coverage amount. When payable, benefits are paid in addition to Basic and/or Additional Life benefits. Coverage will end due to termination of your employment or your retirement. AD&D terminates when Waiver of Premium begins or the date life insurance is continued under Continuation During Total Disability.

Benefits are paid at a percentage of your coverage amount for the specific loss as shown in the chart below. No more than 100% of your coverage amount will be paid for all losses due to the same accident.

Loss	% Payable
Life Sight in both eyes Both hands or both feet One hand and one foot One hand or foot and sight in one eye Speech and hearing in both ears Quadriplegia	**100%**

Loss	% Payable
Paraplegia	**75%**
Hemiplegia One hand or one foot Sight in one eye Speech Hearing in both ears	**50%**
Thumb and index finger on the same hand	**25%**

Seat Belt Benefit: The plan pays the lesser of (1) $25,000; or (2) the amount of the AD&D insurance benefit payable for loss of your life.

Air Bag Benefit: The plan pays the lesser of (1) $10,000; or (2) the amount of the AD&D insurance benefit payable for the loss of your life.

Additional AD&D Benefits:

- Exposure and Disappearance Benefit
- Coma Benefit
- Occupational Assault Benefit
- Career Adjustment Benefit (for your spouse)
- Higher Education Benefit (for your children)
- Child Care Benefit

AD&D Exclusions

No AD&D insurance benefit is payable if the accident or loss is caused or contributed to by war or act of war; suicide or other intentionally self-inflicted injury while sane or insane; committing or attempting to commit an assault or felony; actively participating in a violent disorder or riot; voluntary use or consumption of any poison, chemical compound, alcohol or drug, unless used or consumed according to the directions of a physician; sickness or pregnancy existing at the time of the accident; heart attack or stroke; or medical or surgical treatment for any of the above.

Additional Benefits – Basic and Additional Life

Repatriation Benefit: For the covered employee only. This benefit pays for expenses incurred to transport the body (if more than 150 miles from the primary residence) to a mortuary near the employee's primary place of residence, not to exceed $5,000 or 10% of the Life insurance benefit; whichever is less.

Funeral Assignment: This benefit allows the adult beneficiary to assign payment from the Life Insurance proceeds to the funeral home for expenses. The funeral home is paid directly by The Standard and the remaining Life Insurance benefits are paid to the beneficiary.

Life Services Toolkit: This benefit provides online tools and services that can help the employee create a will, make advance funeral plans and put their finances in order. After a loss, beneficiaries can consult experts by phone or in person, and obtain other helpful information online. To access call 800.378.5742 or go online at www.standard.com.mytoolkit with the username "support".

Travel Assist: For the covered employee and covered dependents.

- Pre-Trip Assistance
- Medical Assistance Services
- Emergency Transportation Services
- Travel Assistance Services
- Personal Security Services
- Medical Supplies

Continuation of Benefits for Dependents: If the employee dies and had Spouse and Child Life enrollment, the Spouse and Child Life will continue for five months without premium payment.

Basic Life, Accidental Death and Dismemberment, Additional Life, Dependents Additional Life and Accidental Death and Dismemberment coverages are underwritten by Standard Insurance Company. This is intended to be a summary of your benefits and does not include all plan provisions, exclusions and limitations. A certificate, with complete plan information, including limitations and exclusions, will be provided, if there is a discrepancy between this document and the certificate issued by The Standard, the terms of the certificate will govern.

Long Term Disability (LTD)

Benefits Begin: 30, 60, or 90 days following the onset of your disability due to physical disease, mental disorder, injury, or pregnancy, depending on the benefit waiting period selected by your employer. You must satisfy the definition of disability as determined by The Standard.

Benefit Amount: 66 2/3% of the first $7,500 monthly covered earnings (Insured Pre-disability Earnings) to a maximum of $5,000 less deductible sources of income and disability work earnings. The minimum monthly benefit is $100.

Pre-disability Earnings: Gross base monthly earnings that exclude: bonuses, commissions, overtime, stipends, any other extra pay, and employer pension contributions.

Deductible Sources of Income: Deductible income includes but is not limited to benefits you receive or are eligible to receive from statutory plans; Social Security amounts you, your spouse, or your children under age 18 receive or are eligible to receive because of your disability or your retirement; worker's compensation; and sick pay. Your disability benefit and other sources of income cannot exceed your indexed pre-disability earnings. See your certificate for full details.

Definition of Disability: You are considered disabled if, as a result of physical disease, injury, pregnancy or mental disorder, you are unable to perform with reasonable continuity the material duties of your own occupation, and you suffer a loss of at least 20% in your indexed pre-disability earnings when working in your own occupation. After the first 24 months for which LTD benefits are paid, you are considered disabled if, as a result of physical disease, injury, pregnancy, or mental disorder, you are unable to perform with reasonable continuity the material duties of any occupation.

Maximum Benefit Period: Up to your normal retirement age under the Social Security Act. However, if you become disabled at or after age 65, benefits are payable according to an age-based schedule. (See certificate for details.)

Limited Pay Periods: Disabilities caused or contributed to by mental disorder, substance abuse and some other conditions are limited to 24 months of benefits for any one or more during your lifetime. Examples of mental disorders include, but are not restricted to, schizophrenia, depression, manic-depressive illness, bipolar affective disorder, and/or anxiety disorders. Substance Abuse means use of alcohol, alcoholism, use of any drug, including hallucinogens, or drug addiction.

Examples of other limited conditions include, but are not restricted to, chronic fatigue conditions, allergy or sensitivity to chemicals or the environment, chronic pain conditions, and/or carpal tunnel syndrome.

Return to Work Part-time: The return to work incentive provision allows you to remain eligible for benefits while you are working part-time and are still disabled. Your monthly benefits may be reduced by a portion of your disability work earnings.

Assistance with Rehabilitation: While you are disabled, you may qualify to participate in a written plan, program or course of vocational training or education that is intended to prepare you to return to work. An approved rehabilitation plan may include payment by The Standard of some or all of the expenses you incur in connection with the plan, including training and education expenses, family care expenses, job-related expenses, and job search expenses.

Assistance with Social Security Benefits: The Standard will forward LTD claims to an external provider who will assist the employee with the application process, reconsideration actions and hearing level at no cost to the employee.

Tax Payments: The Standard will pay FICA and Medicare taxes for the employee up to 6 months from the date of disability. Upon request by the employee, The Standard will make Federal and State tax payments from the LTD benefit for the employee.

Reasonable Accommodation Expense Benefit: If approved in advance and in writing, The Standard will reimburse an employer (up to $25,000 not to exceed the expenses incurred) for a reasonable accommodation that enables the employee to return to work, reduce time off of work and reduce the duration of LTD benefits.

Assisted Living Benefit: An additional benefit of 13 1/3% of the first $7,500 of Predisability Earnings that is not reduced by Deductible Income, not to exceed $1,000 per month. This benefit is extended to the severely disabled for a total benefit of 80% of Predisability Earnings.

Lifetime Security Benefit: If an employee has been receiving the Assisted Living Benefit and the LTD benefits end solely due to reaching the end of the Maximum Benefit Period, they may be eligible for the Lifetime Security Benefit that will continue to pay LTD benefits beyond the end of the Maximum Benefit Period.

If your LTD Benefits are continued beyond the end of the Maximum Benefit Period by the Lifetime Security Benefit, no Survivors Benefit will be paid if you die.

Survivors Benefit: If you die while LTD benefits are payable, and on the date you die you have been continuously disabled for at least 180 days, $1,000 is payable to any one or more of your eligible surviving dependents, as determined by The Standard.

Waiver of Premium: While you are collecting disability benefits you do not have to pay premiums.

Exclusions: You are not covered for a disability caused or contributed to by war or any act of war, an intentionally self-inflicted injury while sane or insane, active participation in a riot, or committing or attempting to commit an assault or felony. You are not covered for a disability caused or contributed to by the loss of your professional license, occupational license or certification. **Also, during the first 12 months of coverage, no LTD benefits will be paid for a disability caused or contributed to by a pre-existing condition or medical or surgical treatment of a pre-existing condition, as defined by The Standard.**

Premiums: Please see page 55 or go to nmpsia.com and use “Calculate LTD and ALF Premiums”. Your employer shares the cost of this benefit based on your contracted annual salary.

Annual Earnings	Employer’s Share	Your Share
$25,000 or more	60%	40%
$20,000-$24,999	65%	35%
$15,000-$19,999	70%	30%
Less than $15,000	75%	25%

Long Term Disability coverage is provided by Standard Insurance Company. Please refer to the certificate for all plan details, including any exclusions, limitations and restrictions which may apply.

Dual-Option PPO and Blue Preferred EPO Plans

NMPSIA's Medical Plan offers you versatile options — High Option, Low Option and Blue Preferred EPO Option

BlueCross BlueShield of New Mexico

NMPSIA's comprehensive and versatile Dual-Option PPO and Blue Preferred EPO Plans administered by Blue Cross and Blue Shield of New Mexico (BCBSNM) let you choose any physician without a referral and give you the security of a health plan that is recognized around the world.

When choosing the High-Option or Low-Option Plan

- Both feature In-Network and Out-of-Network benefits with no required referrals.
- Both include In-Network preventive health benefits with no copays or deductibles.
- Both include Virtual Visits through MDLIVE® at no cost
- The Low-Option Plan offers a lower premium with a deductible and coinsurance for most benefits.

When choosing the Blue Preferred EPO

- Features a wide range of benefits to help control your care with no referrals required.
- Blue Preferred EPO offers an exclusive statewide network of providers but at a lower cost when compared to the larger PPO network.
- Select a primary care provider (PCP) and you may benefit from PCP-guided care.
- You must use Blue Preferred EPO providers to receive benefits (except in a medical emergency).
- Includes Virtual Visits through MDLive at no cost.

For more information call
1-888-966-7742

Or go to **bcbsnm.com**, and under **Large Groups** select *New Mexico Public Schools Insurance Authority* from the drop-down menu.

The telehealth program from MDLIVE, an independent company, is offered to you by your employer as a participant in your employer's group health plan, and is neither insured through or underwritten by BCBSNM.

MDLIVE, an independent company, provides virtual visit services for Blue Cross and Blue Shield of New Mexico. MDLIVE operates and administers the virtual visit program and is solely responsible for its operations and that of its contracted providers.

MDLIVE and the MDLIVE logo are registered trademarks of MDLIVE, Inc. and may not be used without written permission.

MDLIVE is not an insurance product nor a prescription fulfillment warehouse. MDLIVE operates subject to state regulations and may not be available in certain states. MDLIVE does not guarantee that a prescription will be written. MDLIVE does not prescribe DEA-controlled substances, non-therapeutic drugs and certain other drugs that may be harmful because of their potential for abuse. MDLIVE physicians reserve the right to deny care for potential misuse of services.

The MDLIVE language does not have to be on the first, but should be included in the document.

Blue Cross®, Blue Shield® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

Blue Cross and Blue Shield of New Mexico, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

bcbsnm.com

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The Value of Blue– Meeting your Health Care Needs

Comprehensive statewide provider network

Choose from more than 25,000 quality health care providers in our statewide Preferred Provider network. The BCBSNM network includes the only Gamma Knife technology center in New Mexico for treatment of neurological brain diseases, the only women's hospital in the state, and award-winning cancer treatment and cardiology programs.

BlueCard®: Coverage around the world

This innovative benefit—available to only Blue Cross and Blue Shield members—helps you access more than 97 percent of hospitals and 92 percent of physicians throughout the United States contracted with BCBS Plans, plus those in over 200 countries when you need medical care.

You can find a contracted provider online at bcbs.com or by calling the BlueCard program directly at **1-800-810-BLUE (2583)**. Present your member ID card at the provider's office and you'll have the same benefits that you have when you see a contracted provider in your hometown. In the United States you'll pay the same deductible, copayments, and coinsurance amounts and won't have to file claims. (In some foreign countries, you may have to pay for services and then file a claim.)

Blue Access for Members℠: Your online resource

Blue Access for Members (BAM℠) is the secure, online member account and information area of our website just for our members. You can log in to BAM and:

- Check your claim status
- View your explanations of benefits (EOBs)
- Confirm who is covered under your plan
- Locate a doctor, hospital, or pharmacy in your plan's network with the Provider Finder®
- Access health and wellness information, including preventive health guidelines, news, and health-related web tools to help you manage your health
- Request a replacement ID card or print a temporary ID card

Access new and improved tools in Provider Finder®

- Estimate your costs: Use the member liability estimator to research the cost of a provider's procedures, treatments, and tests and help evaluate your out-of-pocket expenses.
- Use the robust search engine: Find a network primary care physician, specialist, or hospital.
- Filter results: Narrow your search results by doctor, specialty, ZIP code, language, and gender.
- Learn more about providers: View certifications and recognitions for doctors. Also, view feedback or add your own review for a provider.

24/7 Nurseline

Health happens – good or bad, 24 hours a day, seven days a week.

That is why we have registered nurses waiting to talk to you whenever you call our 24/7 Nurseline. Our nurses can answer your health questions and try to help you decide whether you should go to the emergency room or urgent care center or make an appointment with your doctor. You can also call the 24/7 Nurseline whenever you or your covered family members need answers to health questions about:

- Asthma
- Diabetes
- High fever
- Cuts or burns
- And much more
- Back pain
- Dizziness or severe headaches
- A baby's nonstop crying
- Sore throat

Plus, when you call, you can access an audio library of more than 1,000 health topics – from allergies to surgeries – with more than 500 topics available in Spanish

Call the 24/7 Nurseline with any health questions.
Toll-free: **800- 973- 6329** Hours.of Operation: **Anytime**

No cost Virtual Visits Powered by MDLIVE® On-demand health care at your fingertips

Getting sick is never convenient and finding time to get to the doctor can be hard. MDLIVE's telehealth program provides you and your covered dependents access to care for non-emergency medical and behavioral health needs.

Whether you're in the city, a rural area or you're on a weekend camping trip, access to a board-certified MDLIVE doctor is available 24 hours a day/seven days a week. You can speak to a doctor immediately or schedule an appointment based on your availability. Virtual Visits can also be a better alternative than going to the emergency room or urgent care.* Activate your account online or by phone: **MDLIVE.com/nmpsia** or (**800) 770-4622**.

Out-of-state coverage

You and your covered dependents can get health care when traveling out of state under the BlueCard® PPO program for emergencies and accidents. Blue Cross and Blue Shield Plans throughout the country have established PPO networks of independently contracted doctors, hospitals and other health care providers. Get additional information by calling the Customer Service phone number on the back of your ID card. You can also call the BlueCard phone number at **800-810-BLUE (2583)**. All you need to do is show your ID card with the suitcase logo to the doctor or hospital.

You will be responsible for any copayment or deductible and coinsurance amounts, as well as any services that are not covered or not approved by Blue Cross and Blue Shield of New Mexico (BCBSNM).

Get support and tools to make informed health care choices:

- Visit bcbsnm.com to access Blue Access for Members℠ (BAM) - a safe, online tool where you can:
  - Get private claims data, view Explanation of Benefits statements and check your coverage
  - Search for a doctor, hospital or other provider
  - Get estimated costs for procedures and compare estimated rates between providers
- BCBSNM's Customer Service team can answer your questions and help you understand and use your health care benefits

Take advantage of health and wellness programs, such as:

- Blue365® Member Discount Program* The Blue365 Discount Program offers health and wellness deals to BCBSNM members, including discounts from top national and local retailers on fitness gear, family activities, healthy eating options and much more.
- Lifestyle Management** Our Lifestyle Management programs give you tools and facts, which may help you lose weight, quit smoking or lower your risk for heart disease, stroke or diabetes.

Why Blue Preferred EPO Works

- Offers an exclusive statewide network of providers but at a lower cost when compared to the larger PPO network.
- A full range of other services, such as home health care, hospice, private duty nursing, surgery and skilled nursing centers
- Self-directed care with the option of guided care
- Health and wellness programs
- Web and mobile tools

*Blue365 is a discount program only for BCBSNM members. This is NOT insurance. Some of the services offered through this program may be covered under your health plan. Please check your benefit booklet or call the customer service number on the back of your ID card for specific benefit facts. Use of Blue365 does not change your monthly payment, nor do costs of the services or products count toward any maximums and/or plan deductibles. Discounts are only given through vendors who take part in this program. BCBSNM does not guarantee or make any claims or recommendations about the program's services or products. You may want to talk to your doctor before using these services and products. BCBSNM reserves the right to stop or change this program at any time without notice.

**Review your benefit booklet to determine the specific benefits offered under your health plan. Lifestyle Management is part of BCBSNM's Blue Care Connection®.

Weight Management Program

Personal coaching over the phone. A Lifestyle Management Specialist who is a health care professional is assigned to you. You and your Specialist come up with a personalized plan to reach your weight loss goals. He or she can show you how different choices affect your health and offer you the support you need. You'll have regular phone calls until you reach your goals.

Access to online, self-directed courses
You can also take online courses at your own pace to learn more about weight management, nutrition, fitness and stress.

To enroll, call 866-412-8795 and choose Lifestyle Management

Well onTarget®

Well onTarget offers personalized tools and resources to help all members no matter where you may be on the path to health and wellness. The heart of Well onTarget is the member portal, available at wellontarget.com. It uses the latest technology to offer you an enhanced online experience. This engaging portal links you to a suite of innovative programs and tools. These tools include the following:

- Online courses designed to help you work at your own pace to reach your health goals
- A health and wellness content library
- Tools and trackers
- An online health assessment you can take to get a personal wellness report

Behavioral health program

BCBSNM members have access to a full range of behavioral health care services, including inpatient, partial hospitalization, and outpatient behavioral health care management; 24-hour referral assistance; support for behavioral health disorders such as anxiety, depression, and eating disorders; and referrals to other BCBSNM medical management programs.

Managing your chronic condition

Take control and be the boss of your health. If you have a chronic condition, managing your health better can pay off later on. So take the first step to a healthier tomorrow and join the Condition Management program.

Call Condition Management if you or any of your covered family members have:

- Asthma
- Chronic obstructive pulmonary disease (COPD)
- Congestive heart failure (CHF)
- Coronary artery disease (CAD)
- Depression
- Diabetes
- Low back pain

Condition Management is available to you and your covered family members through your Blue Cross and Blue Shield of New Mexico (BCBSNM) benefits at no additional cost. It's easy to join; just call **866-874-0912** and select "Blue Care Connection®" to enroll.

A Blue Care Advisor℠ will call you

A Blue Care Advisor is a licensed clinician with special training to help you manage your health condition. Your Advisor will schedule regular phone calls with you to try to help you set and reach health goals.

You will work together to figure out if there are any obstacles to taking better care of yourself and how to overcome them. Your Advisor will also work with your doctors to make sure you are getting the care you need.

*In the event of an emergency, this service should not take place of an emergency room or urgent care facility. Proper diagnosis should come from your doctor and medical advice is between you and your doctor.

BlueCross BlueShield of New Mexico

The purpose of this communication is to provide you with additional information about certain types of assistance and other rights that are available to you; however, this communication is not part of your Summary of Benefits and Coverage (SBC).

Health care coverage is important for everyone.
We provide free communication aids and services for anyone with a disability or who needs language assistance.
We do not discriminate on the basis of race, color, national origin, sex, gender identity, age or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator
300 E. Randolph St.
35th Floor
Chicago, Illinois 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960
Email: CivilRightsCoordinator@hcsc.net

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building 1019
Washington, DC 20201

Phone: 800-368-1019
TTY/TDD: 800-537-7697
Complaint Portal: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint Forms: http://www.hhs.gov/ocr/office/file/index.html

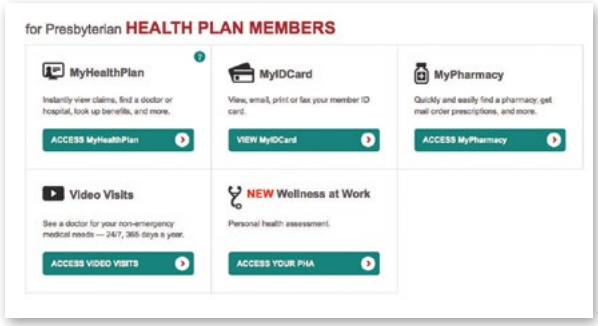
If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 866-236-1702.

العربية Arabic	إن كان لديك أو لدى شخص تساعده أسئلة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم فوري، اتصل على الرقم 866-236-1702.
繁體中文 Chinese	如果您，或您正在協助的對象，對此有疑問，您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員，請撥電話 號碼 866-236-1702。
Français French	Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 866-236-1702.
Deutsch German	Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 866-236-1702 an.
हिंदी Hindi	यदि आपके, या आप जिसकी सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपको अपनी भाषा में निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुवादक से बात करने के लिए 866-236-1702 पर कॉल करें।
Italiano Italian	Se tu o qualcuno che stai aiutando avete domande, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare il numero 866-236-1702.
日本語 Japanese	ご本人様、またはお客様の身の回りの方でも、ご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、 866-236-1702 までお電話ください。
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 통역사가 필요하시면 866-236-1702 로 전화하십시오.
Diné Navajo	T'áá ni, éí doodago ła'da bíká anánílwo'ígíí, na'ídíłkidgo, ts'ídá bee ná ahóóti'i' t'áá níík'e níká a'doolwoł dóó bína'ídíłkidígíí bee nił hodoonih. Ata'dahalne'ígíí bich'į' hodíílnih kwe'é 866-236-1702.
فارسی Persian	اگر شما، یا کسی که شما به او کمک می کنید، سؤالی داشته باشید، حق این را دارید که به زبان خود، به طور رایگان کمک و اطلاعات دریافت نمایید. جهت گفتگو با یک مترجم شفاهی، با شماره 866-236-1702 تماس حاصل نمایید.
Русский Russian	Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы связаться с переводчиком, позвоните по телефону 866-236-1702.
Español Spanish	Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 866-236-1702.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa 866-236-1702.
ไทย Thai	หากคุณ หรือคนที่คุณกาลังช่วยเหลือมีข้อสงสัยใด ๆ คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย พูดคุยกับล่ามโดยติดต่อที่หมายเลข 866-236-1702.
Tiếng Việt Vietnamese	Nếu quý vị, hoặc người mà quý vị đang giúp đỡ, có câu hỏi, thì quý vị có quyền được giúp và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 866-236-1702.

PRESBYTERIAN
Health Plan, Inc.

Membership has its benefits.

Online convenience. Manage your insurance and medical care online though *myPRES*, an easy-to-use, secure website just for Presbyterian members.



- Look up your benefit information securely
- Pay a physician or hospital bill
- View your medical claims and explanation of benefits
- View your ID card or request a replacement
- Access Wellness at Work, a web-based application offering personal health assessments, health education tools, and more.

Talk to a nurse 24/7. Members have access to the PresRN nurse advice line that gives you a direct link to our experienced registered nurses (RN) for answers to your health questions and concerns. Call (505) 923-5570 or 1-866-221-9679 any day, including holidays.

Locally based customer service. Our friendly representatives, located in Albuquerque, are available to answer benefit questions Monday through Friday from 7:00 a.m. to 6:00 p.m. or via email at any time to info@phs.org.

Full access to Presbyterian's system. With more than 800 doctors and eight hospitals across New Mexico, Presbyterian offers specialized healthcare in the areas of women's health, pediatric services, heart wellness, cancer care and more.

(505) 923-5600, 1-888-ASK-PRES (1-888-275-7737) **www.phs.org**

PRESBYTERIAN
Health Plan, Inc.

Wherever you go, we've got you covered.

Presbyterian has a long tradition of serving the employees of New Mexico Public Schools Insurance Authority (NMPSIA) and their families.

Peace of mind comes with knowing that Presbyterian has been caring for New Mexicans since 1908 and is committed to helping our patients and members live healthier lives.

- **A growing statewide network.** As a Presbyterian Health Plan member, you have access to an integrated health system of eight hospitals, a large medical group, and a health plan network of nearly 20,000 providers and facilities throughout New Mexico and border communities. Visit phs.org/directory for the most current list.
- **National coverage.** You also receive in-network benefits outside of New Mexico with nearly 900,000 providers through our partnership with the national MultiPlan/PHCS network. Specific providers are listed at multiplan.com/presbyterian.

As the provider of healthcare benefits to more than 460,000 New Mexicans, Presbyterian Health Plan offers the coverage you need to live the life you want – anytime, anywhere.

Presbyterian complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (505) 923-5420, 1-855-592-7737 (TTY: 711).
Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih (505) 923-5420, 1-855-592-7737 (TTY: 711).

(505) 923-5600, 1-888-ASK-PRES (1-888-275-7737) **www.phs.org**

PRESBYTERIAN
Health Plan, Inc.

Supporting you in your wellness journey.

We want to be the healthiest we can be. Presbyterian's *Wellness at Work* is an online tool, available through *myPRES*, that can help you create a personalized health improvement plan. It also features a powerful Personal Health Assessment (PHA) tool that helps members identify personal health risks, provides recommendations for improving those risks, and offers easy-to-use tools to help make healthy lifestyle changes.

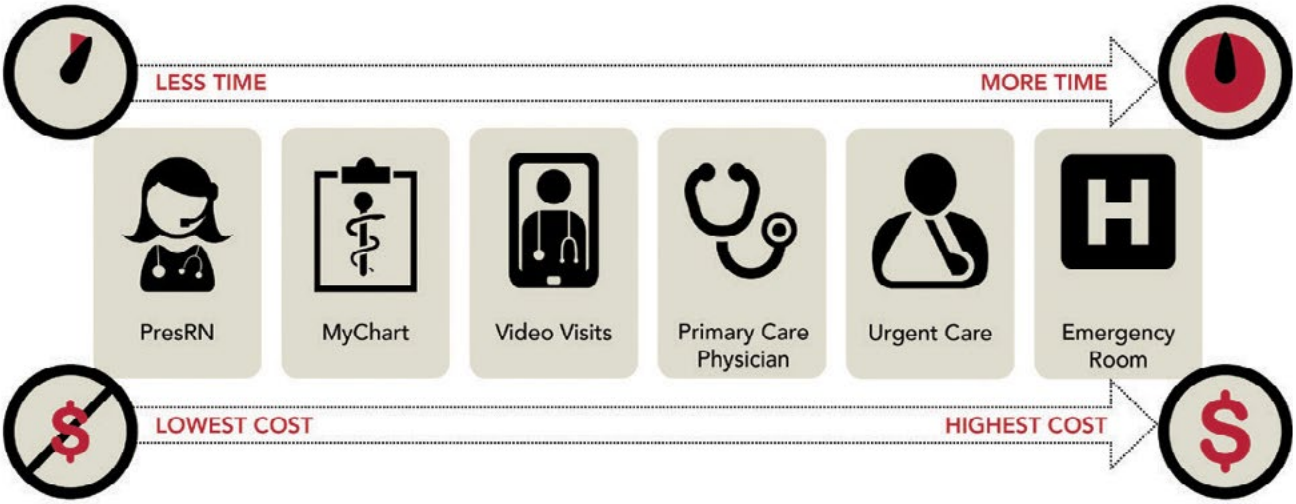
Wellness at WORK

Other ways we help manage your care

- Disease management – A lifestyle coach provides telephonic or video coaching to assist you in managing your chronic condition of Diabetes, Asthma, Heart Failure, COPD, and Coronary Artery Disease.
- Case management – Nurses and social workers help you manage your complex medical needs and will help link you with appropriate providers that will work to keep you out of the hospital or emergency room.
- Utilization management reviews – Pre-service, urgent, concurrent, and post-service reviews ensure you are receiving the most appropriate covered treatments and services for you.

(505) 923-5600, 1-888-ASK-PRES (1-888-275-7737) **www.phs.org**

Convenient Ways to Access Care



PRESBYTERIAN
Health Plan, Inc.

Direct access to medical advice 24 hours a day, 365 days a year. The PresRN nurse advice line is an easy way to speak with a registered Presbyterian nurse if you're not feeling well and do not know what to do. This service is available at no cost to you 24 hours a day, 7 days a week, including holidays. Our nurses are happy to answer general health questions when you are healthy, too. Call (505) 923-5570 or 1-866-221-9679.

A secure, web-based portal for direct communication to your care team. MyChart allows members with a Presbyterian Medical Group provider to send electronic messages and communicate with their care team, request prescription renewals and schedule office or telephone visits. Members can also conveniently view their medical records, lab and radiology reports, procedures and test results.

See a provider anytime day or night with Video Visits. This convenient option offers you a new way to see a medical provider for non-emergency medical conditions via secure video through your smartphone, tablet or computer webcam. Visits are $0 for all NMPSIA members. For details, visit phs.org/videovisits.

Primary care physicians can treat most health problems. They may be a general/family practice physician, internal medicine physician, gynecologist, physician assistant or nurse practitioner.

Urgent care clinics provide care for minor illness and injuries that are not an emergency. For added convenience, Presbyterian now offers same-day, scheduled appointments.

Emergency rooms are for serious medical emergencies or injuries that require immediate medical attention.

HIGH OPTION - SUMMARY OF BENEFITS

This is only a summary that lists the member cost-sharing amounts and provides a brief description of NMPSIA High Option PPO Health Plan benefits effective July 1, 2018. This plan is available under Blue Cross Blue Shield of New Mexico (BCBSNM) and Presbyterian Health Plan. The Summary Plan Description supersedes any information outlined in this summary.

NMPSIA High Option PPO Benefits There is no overall lifetime maximum benefit. However, certain services have maximum annual limits. See below.	**Member's Share of Covered Charges** (Deductible applies unless specified as "deductible waived.")	
	In-Network Provider	**Out-Of-Network Provider**
Calendar Year Deductible Individual Family	$750 $1,500	$1,500 $3,000
Annual Out-Of-Pocket Limit Individual Family	$3,750 $7,500	$9,000 $18,000
Office Visit/Exam Charge Office and Home visits/Exams or Consultation (Other services received during the office visits and listed under "Other Services," below such as therapy are subject to deductible, copay, and/or coinsurance as listed in the rest of the summary.) **Primary Preferred Provider Office/Home Visit** **Specialist /Office/Home Visit** **Telehealth (Virtual Video Visits)**	*(deductible waived)* Office Visit Copay $30 $50 $0	 30% 30% Not Covered
Office Surgery (including casts, splints, and dressings)	20%	30%
Allergy infections (only),Extract Preparation	No Charge (deductible waived)	30%
Therapeutic infections: Allergy Testing	Office Visit Copay	30%
Routine/Preventive Services Routine Adult Physicals and Gynecological Exams, Routine Tests (including Pap Tests, Cholesterol tests, Urinalysis, Human Papillomavirus (HPV) Screening), Colonoscopies and Mammograms (one covered at 100% annually regardless of diagnosis when in-network), Health Education Counseling (including diabetic and smoking cessation counseling), Family Planning (including insertion/removal of birth control devices, surgical sterilization in office, birth control and therapeutic injections), Immunizations (including travel immunizations); Well-Child Care; Routine Vision or Hearing Screenings through age 19	No Charge (deductible waived)	30% (deductible waived)
Acupuncture, Chiropractic (Spinal Manipulation), Massage Therapy (if medically necessary), **Naprapathy and Rolfing** (combined max. benefit of 30 visits/calendar year)	$50 copay (deductible waived)	30% **Naprapathy Not Covered**
Ambulance Service: Ground and Emergency Air Transport	$30 copay (deductible waived)	$30 copay (deductible waived)
Ambulance Services: Inter-facility Transport	$0 deductible waived	
Autism Spectrum Disorder Diagnosis and Treatment of all children up to age 19 or up to age 22, if still attending school. Up to 90 visits per member per year (in & out-of- network combined) PCP copay for Applied Behavioral Analysis (ABA). Specialist includes outpatient physical therapy occupational therapy & speech therapy.	(deductible waived) PCP $30 copay Specialist $50 copay	30%
Biofeedback (for specified medical conditions only)	$50 copay (deductible waived)	30%
Cardiac and Pulmonary Rehabilitation (office/outpatient)	$50 copay (deductible waived)	30%
Dental/Facial Accident, Oral Surgery & TMJ/CMJ Services	Varies by Services	30%
Emergency Room Treatment Physician and other professional Provider Charges	$150 copay plus 20% per visit	
Hearing Aids and Related Services **(Age 21 & older:** Routine exams testing not covered.)	Hearing Aids: No Charge up to $500; thereafter you pay 90% coinsurance in any 36 month period	
Hearing Aids and Related Services **(Under age 21**: Exam testing subject to usual cost-sharing.)	Hearing Aids: No Charge up to $2,200 per hearing impaired ear; thereafter you pay 90% coinsurance in any 36 month period	
Home Health Care/Home I.V. Services Limitations	20% Unlimited	30% 120 visits/calendar year
Hospice Services including respite care (limited to 10 days for each 6-month per hospice period -2 periods per lifetime) & bereavement counseling (limited to 3 sessions during the hospice benefit period)	No charge (deductible waived)	30%
Infertility: Diagnosis Only - No Treatment	Varies by Services	30%
Lab, X-Ray, and other Basic Diagnostic Tests - non-routine (Office/Freestanding Lab or Radiology)	$30 copay or actual allowable amount, whichever is less per day (deductible waived)	30%
Lab, X-Ray, and other Basic Diagnostic Tests - non-routine (Outpatient Department of Hospital)	$60 copay or actual allowable amount, whichever is less, per day (deductible waived)	30%

NMPSIA High Option PPO Benefits There is no overall lifetime maximum benefit. However, certain services have maximum annual limits. See below.	**Member's Share of Covered Charges** (Deductible applies unless specified as "deductible waived.")	
	In-Network Provider	**Out-of-Network Provider**
High Tech Imaging: MRI, MRA, CT Scan, PET Scan	$600 copay or 20%, whichever is less, per day (deductible waived)	30%
Professional Interpretation & Reading (Lab, X-Ray, & High Tech)	No Charge	30%
Prothrombin Time Test	$10 copay (deductible waived)	30%
Sleep Study	20%	30%
Inpatient Hospital/Facility Services (High Option copays are waived if you are re-admitted for the same condition within 15 days of discharge or transferred to a rehab or skilled nursing facility within 15 days of discharge from acute care facility.)		
Medical/Surgical Acute Care, and **Maternity-Related** Room & Board, Covered Ancillaries, Related Professional charges, **Skilled Nursing Facility** (max. **60 days**/calendar year) **Inpatient Physical Rehabilitation**	$500 facility copay per admission plus 20%	30%
Observation Stay including Related Professional Charges	$100 facility copay plus 20%	30%
Maternity Services		30%
Physician/Midwife Services (delivery, pre- and post-natal care, including lab, diagnostic testing, and pre-natal genetic testing, if medically necessary)	Office Visit Copay/Initial visit	
Hospital Admission (including routine newborn nursery charges)	$500 copay per pregnancy plus 20%	
Extended Stay (non-routine) Charges for covered Newborn	$500 facility copay/admission plus 20%	
Home Birth	20%	
Mental Health Services		30%
Office, Home, Outpatient Facility/Physician	$30 copay (deductible waived)	
Inpatient	$500 copay plus 20%	
Partial Hospitalization	$250 copay plus 20%	
Facility-Based Intensive Outpatient Programs (IOP)	$125 copay plus 20%	
Substance Abuse Rehabilitation (Lifetime max of two courses of treatment for all services combined.)		30%
Office, Home, Outpatient Facility/Physician (**max. 30 days**/calendar year)	$30 copay (deductible waived)	
Inpatient (**max. 30 days**/calendar year combined with Partial Hospitalization)	$500 copay plus 20%	
Partial Hospitalization (**max. 30 days**/calendar year combined with Inpatient)	$250 copay plus 20%	
Facility-Based Intensive Outpatient Programs (IOP)	$125 copay plus 20%	
Outpatient Hospital/Facility/Ambulatory Surgery Facility (including Related Professional Charges)	$150 copay plus 20%	30%
Residential Treatment Center (RTC): (for adults age 18 & older only) LIMIT: 60 days/calendar year and 30 days per admit.	$250 copay plus 20%	30%
Short-Term Rehabilitation, Outpatient and Office: Occupational, Physical & Speech Therapy Services (Member pays $50 each visit up to a maximum of $500 per calendar year; thereafter plan pays 100% once met for the remaining calendar year.)	$50 copay (deductible waived) up to $500; thereafter No Charge for the remaining calendar year	30%
Smoking/Tobacco Use Cessation (includes medication, hypnotherapy, acupuncture, related tests, and any counseling programs not eligible under Preventive)	No Charge	50%
	For Prescription Drugs, see your Express Scripts Plan for details.	
Supplies, Durable Medical Equipment, Prosthetics & Functional Orthotics (Support hose limited to **12 pair** (or **24 hose**)' Mastectomy Bras up to 6 per calendar year.) Prior Authorization needed for services over $1,000	20%	30%
Insulin Pump Supplies (insertion sets, reservoirs)	No Charge (deductible waived)	30%
Therapy: Chemotherapy and Radiation Therapy	No Charge (deductible waived)	30%
Therapy: Dialysis	20%	30%
Transplant Services Maximums apply to donor charges and travel and lodging. Must be received at a facility that contracts with the plan or with a national transplant network approved by the plan.	Applicable copays based on place and type of service	Not Covered
Urgent Care (includes all services and supplies such as xray/labs/ physician fees)	$50 copay(deductible waived)	30%

Prescription Drugs, Insulin, Diabetic Supplies, Nutritional Products, Smoking/Tobacco Cessation Products: Administered by Express Scripts. Call Express Scripts Customer Service Center: 1-800-498-4904.

LOW OPTION - SUMMARY OF BENEFITS

This is only a summary that lists the member cost-sharing amounts and provides a brief description of NMPSIA Low Option PPO Health Plan benefits effective July 1, 2018. This plan is available under Blue Cross Blue Shield of New Mexico (BCBSNM) and Presbyterian Health Plan. The Summary Plan Description supersedes any information outlined in this summary.

NMPSIA Low Option PPO Benefits There is no overall lifetime maximum benefit. However, certain services have maximum annual limits. See below.	**Member's Share of Covered Charges** (Deductible applies unless specified as "deductible waived.)	
	In-Network Provider	**Out-Of-Network Provider**
Calendar Year Deductible Individual Family	$2,000 $4,000	$4,000 $8,000
Annual Out-Of-Pocket Limit Individual Family	$3,750 $7,500	$9,000 $18,000
Office Visit/PExam Charge Office and Home visits/Exams or Consultation (Other services received during the office visits and listed under "Other Services," below such as therapy are subject to deductible, copay, and/or coinsurance as listed in the rest of the summary.) **Primary Preferred Provider Office/Home Visit** **Specialist /Office/Home Visit** **Telehealth (Virtual Video Visits)**	(deductible waived) Office Visit Copay $35 $60 $0	 50% 50% Not Covered
Office Surgery (including casts, splints, and dressings)	25%	50%
Allergy infections (only),Extract Preparation	25%	50%
Therapeutic infections: Allergy Testing	25%	50%
Routine/Preventive Services Routine Adult Physicals and Gynecological Exams, Routine Tests (including Pap Tests, Cholesterol tests, Urinalysis, Human Papillomavirus (HPV) Screening), Colonoscopies and Mammograms (one covered at 100% annually regardless of diagnosis when in-network), Health Education Counseling (including diabetic and smoking cessation counseling), Family Planning (including insertion/removal of birth control devices, surgical sterilization in office, birth control and therapeutic injections), Immunizations (including travel immunizations); Well-Child Care; Routine Vision or Hearing Screenings through age 19	No Charge (deductible waived)	50% (deductible waived)
Acupuncture, Chiropractic (Spinal Manipulation), Massage Therapy (if medically necessary), **and Rolfing** (combined max. benefit of 30 visits/calendar year) **Naprapathy** (Limit $500 per year)	25% $50 copay (deductible waived)	50% Not Covered
Ambulance Service: Ground and Emergency Air Transport	25%	25%
Ambulance Services: Inter-facility Transport	$0 deductible waived	
Autism Spectrum Disorder - Diagnosis and Treatment of all children up to age 19 or up to age 22, if still attending school. Up to 90 visits per member per year (in & out-of- network combined) PCP copay for Applied Behavioral Analysis (ABA). Specialist includes outpatient physical therapy occupational therapy & speech therapy.	(deductible waived) PCP $35 copay Specialist $60 copay	50%
Biofeedback (for specified medical conditions only)	25%	50%
Cardiac and Pulmonary Rehabilitation (office/outpatient)	25%	50%
Dental/Facial Accident, Oral Surgery & TMJ/CMJ Services	25%	50%
Emergency Room Treatment Physician and other professional Provider Charges	$150 copay plus 25% per visit	
Hearing Aids and Related Services (**Age 21 & older:** Routine exams testing not covered.)	**Hearing Aids:** No Charge up to $500; thereafter you pay 90% coinsurance in an 36 month period	
Hearing Aids and Related Services (**Under age 21**: Exam testing subject to usual cost-sharing.)	**Hearing Aids:** No Charge up to $2,200 per hearing impaired ear; thereafter you pay90% coinsurance in an 36 month period	
Home Health Care/Home I.V. Services Limitations	25% Unlimited	50% 120 visits/calendar year
Hospice Services including respite care (limited to 10 days or each 6-month per hospice period -2 periods per lifetime) & bereavement counseling (limited to 3 sessions during the hospice benefit period	25%	50%
Infertility: Diagnosis Only No Treatment	Varies by Services	50%
Lab, X-Ray, and other Basic Diagnostic Tests - non-routine (Office/Freestanding Lab or Radiology)	$35 copay or actual allowable amount, whichever is less, per day (deductible waived)	50%
Lab, X-Ray, and other Basic Diagnostic Tests - non-routine (Outpatient Department of Hospital)	$70 copay or actual allowable amount, whichever is less, per day (deductible waived)	50%

NMPSIA Low Option PPO Benefits There is no overall lifetime maximum benefit. However, certain services have maximum annual limits. See below.	**Member's Share of Covered Charges** (Deductible applies unless specified as "deductible waived.)	
	In-Network Provider	**Out-Of-Network Provider**
High Tech Imaging: MRI, MRA, CT Scan, PET Scan	$700 copay or 25%, whichever is less, per day (deductible waived)	50%
Professional Interpretation & Reading (Lab, X-Ray, & High	No Charge	50%
Prothrombin Time Test	$10 copay (deductible waived)	50%
Sleep Study	25%	50%
Inpatient Hospital/Facility Services		
Medical/Surgical Acute Care, and **Maternity-Related Room & Board**, Covered Ancillaries, Related Professional charges, **Skilled Nursing Facility** (**max. 60 days**/calendar year), **Inpatient Physical Rehabilitation**	25%	50%
Observation Stay including Related Professional Charges	25%	50%
Maternity Services		50%
Physician/Midwife Services (delivery, pre- and post-natal care)	25%	
Hospital Admission (including routine newborn nursery charges)	25%	
Extended Stay (non-routine) Charges for covered Newborn	25%	
Home Birth	25%	50%
Mental Health Services		50%
Office, Home, Outpatient Facility/Physician	25%	
Inpatient	25%	
Partial Hospitalization	25%	
Facility-Based Intensive Outpatient Programs (IOP)	25%	
Substance Abuse Rehabilitation (Lifetime max of two course of treatment for all services combined.)		50%
Office, Home, Outpatient Facility/Physician (max. 30 days/calendar year)	25%	
Inpatient (**max. 30 days**/calendar year combined with Partial	25%	
Partial Hospitalization (**max. 30 days**/calendar year combined with Inpatient)	25%	
Facility-Based Intensive Outpatient Programs (IOP)	25%	
Outpatient Hospital/Facility/Ambulatory Surgery Facility (including Related Professional Charges)	25%	50%
Residential Treatment Center (RTC): (for adults age 18 & older only) LIMIT: 60 days/calendar year and 30 days per admit.	25%	50%
Short-Term Rehabilitation, Outpatient and Office: Occupational, Physical & Speech Therapy Services	25%	50%
Smoking/Tobacco Use Cessation (includes medication, hypnotherapy, acupuncture, related tests, and any counseling programs not eligible under Preventive)	No Charge	50%
	For Prescription Drugs, see your Express Scripts Plan for details.	
Supplies, Durable Medical Equipment, Prosthetics & Functional Orthotics (Support hose limited to 12 pair (or 24 hose) Mastectomy Bras up to 6 per calendar year.) Prior Authorization needed for services over $1,000	25%	50%
Insulin Pump Supplies (insertion sets, reservoirs)	No Charge (deductible waived)	50%
Therapy: Chemotherapy and Radiation Therapy	25%	50%
Therapy: Dialysis	25%	50%
Transplant Services Maximums apply to donor charges and travel and lodging. Must be received at a facility that contracts with the plan or with a national transplant network approved by the plan.	Applicable copays based on place and type of service	Not Covered
Urgent Care (includes all services and supplies such as x-ray/labs/ physician fees)	$60 copay (deductible waived)	50%

Prescription Drugs, Insulin, Diabetic Supplies, Nutritional Products, Smoking/Tobacco Cessation Products:
Administered by Express Scripts. Call Express Scripts Customer Service Center: 1-800-498-4904.

Take Advantage of Savings with Blue Preferred EPO℠

Are you looking for an option that gives you similar benefits, quality and services as a PPO plan, but at a more affordable cost? If so, choosing our new Blue Preferred EPO plan may be the best choice for you.

Our Blue Preferred EPO plan offers an exclusive statewide network of providers but at a lower cost when compared to the larger PPO network. With Blue Preferred EPO you select a primary care physician (PCP) to partner with for your health care needs. Having your care coordinated by one doctor may offer several advantages. They get to know you and your health history, allowing them to recognize changes in your health as well as overseeing your routine care. With Blue Preferred EPO, referrals are not needed to see a specialist but your PCP can help you identify specialists.

As a Blue Preferred EPO member, you will only have access to providers that participate in the Blue Preferred℠ network, including contracted doctors, hospitals and other health care professionals in New Mexico. Services from an out-of-network provider are not covered under this plan.

BlueCross BlueShield of New Mexico

Blue Preferred EPO℠

A Lower-Cost Option With a FOCUS ON QUALITY

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

477672.0117

EPO PLAN SUMMARY OF BENEFITS

This is only a summary that lists the member cost-sharing amounts and provides a brief description of the NMPSIA Exclusive Provider Organization (EPO) Plan benefits effective July 1, 2018. This plan is available under Blue Cross and Blue Shield of New Mexico. The Summary Plan Description supersedes any information outlined in this summary. Locate contracted providers at https://www.bcbsnm.com/nmpsia/doctors-and-hospitals.

NMPSIA HMO Benefits There is no overall lifetime maximum benefit. However, certain services have maximum annual limits. See below.	**Member's Share of Covered Charges** (Deductible applies unless specified as "deductible waived.) Preferred Provider
Calendar Year Deductible Individual Family	 $500 $1,000
Annual Out-Of-Pocket Limit Individual Family	 $3,250 $6,500
Office Visit / Exam Charge Office and Home visits/Exams or Consultation (Other services received during the office visits and listed under "Other Services," below such as therapy are subject to deductible, copay, and/or coinsurance as listed in the rest of the summary.)	(deductible waived) Office Visit Copay
Primary Preferred Provider Office/Home Visit **Specialist /Office/Home Visit** **Telehealth (Virtual Video Visits)**	 $25 $35 $0
Office Surgery (including casts, splints, and dressings)	20%
Allergy infections (only),Extract Preparation	No Charge (deductible waived)
Therapeutic infections: Allergy Testing	Office Visit Copay
Routine/Preventive Services Routine Adult Physicals and Gynecological Exams, Routine Tests (including Pap Tests, Cholesterol tests, Urinalysis, Human Papillomavirus (HPV) Screening), Colonoscopies and Mammograms (one covered at 100% annually regardless of diagnosis when in-network), Health Education Counseling (including diabetic and smoking cessation counseling), Family Planning (including insertion/removal of birth control devices, surgical sterilization in office, birth control and therapeutic injections), Immunizations (including travel immunizations); Well-Child Care; Routine Vision or Hearing Screenings through age 19	No Charge (deductible waived)
Acupuncture, Chiropractic (Spinal Manipulation), Massage Therapy (if medically necessary), **Naprapathy and Rolfing** (combined max. benefit of 30 visits/calendar year)	$35 copay (deductible waived)
Ambulance Service: Ground and Emergency Air Transport	$25 copay (deductible waived)
Ambulance Services: Inter-facility Transport	$0 (deductible waived)
Autism Spectrum Disorder Diagnosis and Treatment of all children up to age 19 or up to age 22 if still attending school. Up to 90 visits per member per year (in & out-of- network combined) PCP copay for Applied Behavioral Analysis (ABA). Specialist includes outpatient physical therapy occupational therapy & speech therapy.	(deductible waived) PCP $25 copay Specialist $35 copay
Biofeedback (for specified medical conditions only)	$35 copay (deductible waived)
Cardiac and Pulmonary Rehabilitation (office/outpatient)	$35 copay (deductible waived)
Dental/Facial Accident, Oral Surgery & TMJ/CMJ Services	Varies by Services
Emergency Room Treatment Physician and other professional Provider Charges	$150 copay plus 20% per visit
Hearing Aids and Related Services **Age 21 & older**: Routine exams/testing not covered.	Hearing Aids: No Charge up to $500; thereafter you pay 90% coinsurance in any 36 month period
Hearing Aids and Related Services **(Under age 21**: Exam testing subject to usual cost-sharing.)	Hearing Aids: No Charge up to $2,200 per hearing impaired ear; thereafter you pay 90% coinsurance in any 36 month period
Home Health Care/Home I.V. Services Limitations	20% Unlimited
Hospice Services including respite care (limited to 10 days for each 6-month per hospice period -2 periods per lifetime) & bereavement counseling (limited to 3 sessions during the hospice benefit period	No charge (deductible waived)
Infertility: Diagnosis Only - No Treatment	Varies by Services
Lab, X-Ray, and other Basic Diagnostic Tests - non-routine (Office/Freestanding Lab or Radiology)	$25 copay or actual allowable amount, whichever is less, per day (deductible waived)
Lab, X-Ray, and other Basic Diagnostic Tests - non-routine (Outpatient Department of Hospital)	$50 copay or actual allowable amount, whichever is less, per day (deductible waived)

NMPSIA EPO Benefits There is no overall lifetime maximum benefit. However, certain services have maximum annual limits. See below.	**Member's Share of Covered Charges** (Deductible applies unless specified as "deductible waived.) Preferred Provider
High Tech Imaging: MRI, MRA, CT Scan, PET Scan	$500 copay or 20%, whichever is less per day (deductible waived)
Professional Intepretation & Reading (Lab, X-Ray, & High Tech)	No Charge
Prothrombin Time Test	$10 copay (deductible waived)
Sleep Study	20%
Inpatient Hospital facility Services (Copays are waived if you are re-admitted for the same condition within 15 days of discharge or transferred to a rehab or skilled nursing facility within 15days of discharge from acute care facility.)	
Medical/Surgical Acute Care, and Maternity-Related Room & Board, Covered Ancillaries, Related Professional charges, Skilled Nursing Facility (max. 60 days/calendar year) **Inpatient Physical Rehabilitation**	$500 facility copay per admission plus 20%
Observation Stay including Related Professional Charges	$100 facility copay plus 20%
Maternity Services	
Physicians Midwife Services (delivery, pre- and post-natal care, including lab, diagnostic testing, and pre-natal genetic testing, if medically necessary)	Office Visit Copay/Initial visit
Hospital Admission (including routine newborn nursery charges)	$500 copay per pregnancy plus 20%
Extended Stay (non-routine) Charges for covered Newborn	$500 facility copay/admission plus 20%
Home Birth	20%
Mental Health Services	
Office, Home, Outpatient Facility/Physician	$25 copay (deductible waived)
Inpatient	$500 copay plus 20%
Partial Hospitalization	$250 copay plus 20%
Facility-Based Intensive Outpatient Programs (IOP)	$125 copay plus 20%
Substance Abuse Rehabilitation (Lifetime maximum two courses of treatment for all services combined.)	
Office, Home, Outpatient Facility/Physician (max. 30 days/calendar year)	$25 copay (deductible waived)
Inpatient (**max. 30 days**/calendar year combined with Partial Hospitalization)	$500 copay plus 20%
Partial Hospitalization (**max. 30 days**/calendar year combined with Inpatient)	$250 copay plus 20%
Facility-Based Intensive Outpatient Programs (IOP)	$125 copay plus 20%
Outpatient Hospital Facility/Ambulatory Surgery Facility (including Related Professional Charges)	$150 copay plus 20%
Residential Treatment Center (RTC): (for adults age 18 & older only) LIMIT: 60 Days/calendar year and 30 days per admit.	$250 copay plus 20%
Short-Term Rehabilitation, Outpatient and Office: Occupational, Physical & Speech Therapy Services (Member pays $35 each visit up to a maximum of $350 per calendar year; thereafter plan pays 100% once met for the remaining calendar year.)	$35 copay (deductible waived) up to $350; thereafter no charge for the remaining calendar year
Smoking/Tobacco Use Cessation (includes medication, hypnotherapy ,acupuncture, related tests, and any counseling programs not eligible under Preventive)	No Charge For Prescription Drugs, see your Express Scripts Plan for details.
Supplies, Durable Medical Equipment, Prosthetics & Functional Orthotics (Support hose limited to 12 pair (or 24 hose) Mastectomy Bras up o 6 per calendar year.) Prior Authorization needed for services over $1,000	20%
Insulin Pump Supplies (Insertion sets, reservoirs)	No Charge (deductible waived)
Therapy: Chemotherapy and Radiation Therapy	No Charge (deductible waived)
Therapy: Dialysis	20%
Transplant Services Maximums apply to donor charges and travel and lodging Must be received at a facility that contracts with the plan or with a national transplant network approved by the plan.	Applicable copays based on place and type of service
Urgent Care includes all services and supplies such as xrays/labs/physician fees)	$45 copay(deductible waived)

Prescription Drugs, Insulin, Diabetic Supplies, Nutritional Products, Smoking/Tobacco Cessation Products:
Administered by Express Scripts. Cal Express Scripts Customer Service Center: 1-800-498-4904.

MEDICAL PLAN EXCLUSIONS AND LIMITATIONS
THAT ARE COMMON TO BOTH PRESBYTERIAN PLANS AND BLUE CROSS BLUE SHIELD OF NEW MEXICO PLANS

The following outlines some of the plan exclusions that are the same in the Medical Plans administered by Presbyterian and by Blue Cross Blue Shield of New Mexico. This is not a complete list of all Medical plan exclusions. For detailed information about the covered benefits and excluded benefits of the Medical plans, refer to the Medical plan documents (benefit booklets) found on the NMPSIA website at www. nmpsia.com.

- Portion of inpatient treatment provided before member's effective date
- Charges in excess of Plan limits
- Charges in Excess of Medicare Allowable Amounts from out-of-network providers
- Experimental or Investigational services/treatment
- Medically Unnecessary Services
- Work-related injuries or illnesses
- Cosmetic Surgery
- Complications related to non-covered benefits
- Contact lenses or eyeglasses; Radial Keratotomy, LASIK, and other eye refractive surgeries
- Convalescent care, or Custodial care
- Dental Services, unless related to an Accidental Injury of the Teeth
- Duplicate Expenses
- Hair Loss Treatment including wigs and hair transplants
- Infertility diagnostic testing, drugs and treatment
- Late Filed Claims; Claims with no Legal payment obligations
- Long-term Therapy Rehabilitation Services or Maintenance Therapy
- Missed appointments
- Modifications to home, vehicle or workplace to accommodate a condition
- Most Genetic Testing or Counseling
- Nutritional Supplements (unless required by law)
- Over the Counter (non-prescription) medications unless required by law
- Private-duty nursing
- Services/membership at a spa, health club or other similar facilities
- Sex-change operations and reversals
- Sexual dysfunction testing and treatment
- Thermography (a technique that photographically represents the surface temperature of the body)
- Travel and transportation expenses not covered under Ambulance Services or Transplant
- Veterans Administration facility services for service-related disability or while member is active military
- War-related injuries or illnesses.

EXPRESS SCRIPTS®

PRESCRIPTION DRUG BENEFIT SUMMARY

Administered by Express Scripts • Toll-free: **1-800-498-4904**

Effective Date of Coverage: July 1, 2018

	LOCAL PARTICIPATING RETAIL PHARMACY (including Walgreens)	MAIL-ORDER PHARMACY
Maximum day's supply per copay	**30 days**	**90 days**
Generic drugs	**$10 copay**	**$22 copay**
Preventative Products Under the Patient Protection & Affordable Care Act. *(Prescription required. To confirm products covered, contact Member Services at 1-800-498-4904.)*	**$0 copay**	**$0 copay**
Diabetic supplies, Generic & preferred-brand insulin	**$0 copay**	**$0 copay**
Generic & preferred-brand oral diabetes medications	**$10 copay**	**$22 copay**
Non-preferred diabetes medications and supplies	**70% copay**	**70% copay**
Preferred brand-name drugs	**30% of the discounted cost; minimum payment of $30 and maximum payment of $60**	**$60 copay**
Non-preferred drugs	**70% copay** **Visit www.express-scripts.com to view the current formulary, obtain copay cost estimates, and find less costly alternatives for your doctor's review.**	**70% copay** **Visit www.express-scripts.com to view the current formulary, obtain copay cost estimates, and find less costly alternatives for your doctor's review.**
Specialty drugs **These drugs must be filled via the contracted specialty pharmacy, (Accredo) at Express Scripts.** *(Call 1-800-501-7210)*	**30 day supply (if 90-day supply is approved, copay will multiply x 3):** • **Generic $55 copay** • **Preferred brand-name $80 copay** • **Non-preferred drugs $130 copay** Please Note: Any specialty medication not obtained via the Accredo Specialty Pharmacy will reject.	
Immunizations administered by certified pharmacists. *(See definitions in this Section.)*	**$0 copay** **To locate a certified pharmacist, visit https://nmpsia.com/ExpressScripts.html or Contact Member Services at 1-800-498-4904.**	**Not covered at mail order.** **Only available from local, certified pharmacist. Visit https://nmpsia.com/ExpressScripts.html or contact Member Services at 1-800-498-4904.**
Out of pocket Maximum *(specialty/non-specialty combined; $3,100/individual, $6,200/family)*	**If you choose to take a brand name drug where a generic is available, you will still pay the difference in cost between the brand and the generic even after your out-of-pocket has been met.**	

EXPRESS SCRIPTS®

DEFINITIONS

Generic prescription drug. A medication that contains the same active ingredient and is manufactured according to the same strict federal regulations as its brand-name counterpart. Generic medications may differ in color, size, or shape, but the Food and Drug Administration requires that they have the same strength, purity, and quality as their brand counterparts. A generic medication can be produced once the manufacturer of the brand medication is required to allow other manufacturers the opportunity to produce it.

Brand-name drug. A medication that is available only from its original manufacturer or from another manufacturer that has a licensing agreement to produce it. These medications are marketed under recognized brand names. A brand-name drug may have a generic equivalent once the manufacturer is required to allow other manufacturers the opportunity to produce it.

Multisource brand drug. A medication that may have a Food and Drug Administration generic equivalent substitute available.

Maintenance drug. A medication prescribed for long-term use (e.g., therapy taken daily by those with high blood pressure or diabetes).

Formulary. A list of commonly prescribed medications that have been selected based on their clinical effectiveness and opportunity for savings. An independent Pharmacy and Therapeutics Committee updates this list regularly, based on continuous evaluation of medications. You can contact Express Scripts at **1-800-498-4904** to determine if the medication you are taking is on the formulary. You can also locate this information at www.express-scripts.com. If a medication you are taking is not on the formulary, you may want to discuss alternatives with your doctor or pharmacist. Using medications on the formulary will keep your costs and NMPSIA's costs lower.

Coverage review (prior authorization). Express Scripts must review prescriptions for certain medications with your doctor before they can be filled under your plan, since more information than appears on a prescription is needed. The review uses plan rules based on FDA-approved prescribing and safety information, clinical guidelines, and uses that are considered reasonable, safe, and effective. Your doctor can request a coverage review (prior authorization) by calling Express Scripts at **1-800-753-2851**. If you need to know whether your prescription will require a coverage review (prior authorization), visit www.express-scripts.com or call Member Services at **1-800-498-4904**.

Immunizations covered if administered by a certified pharmacist include the following: DPT, MMR, Tetanus/ Diphtheria, HPV, Hepatitis A & B, Shingles, Meningococcal, Varicella (chicken pox), Influenza (Flu), Pneumonia.

Quantity management. NMPSIA sets limits on quantities of certain medications. To promote safe and effective drug therapy, certain covered medications may have quantity restrictions. These quantity restrictions are based on manufacturer or clinically approved guidelines and are subject to periodic review and change.

Request generics whenever possible. If you or your doctor selects a brand medication instead of a generic, you will be charged the brand copay, plus the difference in cost between the brand and the generic.

EXPRESS SCRIPTS®

DEFINITIONS (cont.)

Step therapy requirement. Your plan uses a coverage tool called step therapy, which requires you first to try one or more specified drugs to treat a particular condition before your plan will cover another (usually more expensive) drug that your doctor may have prescribed. Step therapy is intended to reduce costs to you and your plan by encouraging the use of medications that are less expensive but can treat your condition effectively. If your doctor believes that you should use medication that requires a review for coverage, your doctor can request such a review. Your doctor can call toll-free **1-800-753-2851**, 6:00am to 7:00pm, Mountain Standard Time, Monday through Friday. To see which medications are affected by step therapy, visit www.express- scripts.com or call Member Services at **1-800-498-4904**.

Specialty medications. Accredo, Express Scripts' specialty pharmacy, is the provider of specialty medications. Specialty medications are used to treat complex conditions, such as Cancer, Growth Hormone Deficiency, Hemophilia, Hepatitis C, Immune Deficiency, Multiple Sclerosis, and Rheumatoid Arthritis. Your plan participates in a specialty pharmacy co-pay assistance program through SaveonSP. Certain specialty pharmacy medications (Program drugs) in this program are considered Non-Essential Health Benefits under the plan and the cost of such drugs will NOT be applied toward satisfying the patient out of pocket maximum. Although the cost of the Program drugs will not be applied towards satisfying the patient out of pocket maximum, once enrolled, the cost of the Program drugs will be reimbursed by the manufacturer at no cost to the patient. To find out more about your specialty prescription drug benefit, visit www.express-scripts.com or call Accredo at **1-800-501-7210**.

Drug safety. Prescription drugs help fight off illness and can improve health. They can also be dangerous if the wrong person takes them, or if they're taken in the wrong amount. It's important they be taken only as directly and stored safely. Your plan partners with Express Scripts to identify unusual or excessive utilization patterns.

MEMBERS WITH DIABETES

Insulin and diabetes supplies are covered. To confirm copay or coverage of insulin or diabetes supplies, visit www.express-scripts.com or contact Member Services at **1-800-498-4904**.

Diabetic Supplies & Test Strips: The test strips you currently use may no longer be covered under your formulary. As the preferred brand for Express Scripts*, OneTouch® may offer you savings that are not available with non-preferred brands. Talk to your doctor about OneTouch® to avoid paying full cost for your diabetes supplies.

To order a OneTouch® System at no charge: Visit **www.OneTouch.orderpoints.com** and input order code **573EXP333** or call **1-800-668-7148** and provide order code **573EXP333**. Get started with your free kit and start saving today.

Not covered: Drugs for cosmetic purposes only. Proton Pump Inhibitors, Intranasal Steroids and Antihistamines with over-the-counter (OTC)/OTC equivalents (Prilosec®, Nexium®, Claritin®, Zyrtec®, Allegra®, Alavert®, Nasacort®, Flonase®), except certain preventative products under the Patient Protection and Affordable Care Act. Compound medications that contain certain ingredients which have a FDA approved commercially available alternative drug. Medical supplies and equipment (except syringes and needles used to administer insulin, and spacers for asthma inhalers). Medications prescribed by a physician or healthcare practitioner acting outside the scope of his or her license. Experimental, investigational, and unproven drugs. Replacement prescriptions filled due to loss or theft.

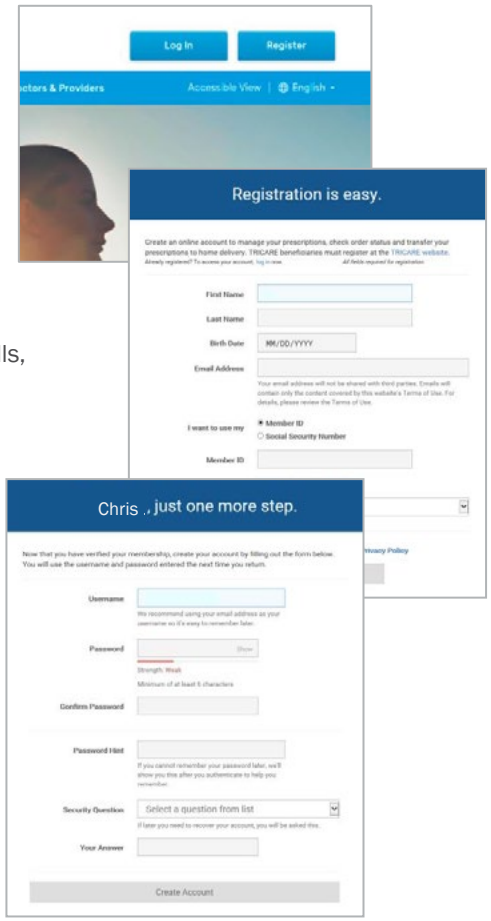
This is intended as a summary only. This summary does not supersede the provisions of the program documents, which in all cases govern program eligibility and benefits. This is a summary of material modifications to the New Mexico Public Schools Insurance Authority benefit program and should be read as an amendment to the program documents.

EXPRESS SCRIPTS

Registering with Express Scripts

Online access to savings and convenience

Manage your medicines anywhere, any time with express-scripts.com and the Express Scripts™ mobile app



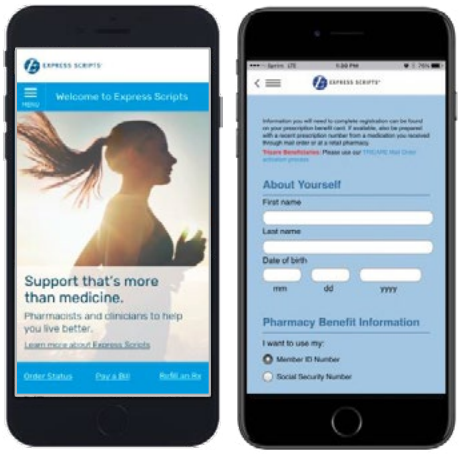
Register now so you can experience:

- **More savings.**
  Compare prices of medicines at multiple pharmacies. Get free standard shipping[1] from the Express Scripts Pharmacy℠.
- **More convenience.**
  Get up to 90-day supplies of your long-term medicine sent to your home. Order refills, check order status, and track shipments. Print forms and ID cards, if needed.
- **More confidence.**
  Talk with a pharmacist from the privacy of your home any time, from anywhere. Find the latest information on your medicine, including possible side effects and interactions.
- **More flexibility.**
  Download the Express Scripts mobile app to manage your medicines, find nearby pharmacies and get directions, and use your virtual ID card while on the go.

Get Started Today!

Registering is safe and simple. Your information is secure and confidential. Please have your member ID number or SSN available.

- Go to express-scripts.com, select **Register** or download the **Express Scripts mobile app** for free from your mobile device's app store and select **Register**
- Complete the information requested, including personal information and member ID number or Social Security Number (SSN), create your username and password, along with security information in case you ever forget your password
- Click **Register now** and you're registered
- To set preferences[2], select **Communication Preferences** from the menu under **Account**, scroll to **Communication** and **Viewing Preferences**. Click **Edit preferences**. Preferences can only be selected via the member website.



Members who have **touch ID authentication** on their mobile devices can enable it to log in to their Express Scripts account on the mobile app, if desired.

[1] Standard shipping costs are included as part of your prescription plan benefit.

[2] Preferences include the option to share your prescription information with other adult members of your household (aged 18+) covered under your prescription drug plan.

- All covered adults (aged 18+) in the household need to register separately.
- When you grant permission to share your prescription information with other registered household members, they can view your information, place orders on your behalf and more.

The Express Scripts mobile app is available for iPhone®, Android™, Windows Phone®, Amazon™, and Blackberry® mobile devices.

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UNITED CONCORDIA® DENTAL
Protecting More Than Just Your Smile®

Welcome to United Concordia!

At United Concordia, we know oral health is more than just your smile—it affects your entire body. That's why everything we do is focused on connecting you to a life of better overall health. You can count on our more than 40 years of dental experience, strong dental network and personal service. We proudly serve the dental health needs of NMPSIA, as well as the needs of more than six million Americans worldwide.

With your United Concordia dental plan, you will experience:

- Access to quality dentists through our **Alliance** network with more than 1,500 access points in New Mexico
- Online and personal service
  - Access your benefit information when you need it, where you need it through **UnitedConcordia.com** and our mobile app—scan the code now to get started
  - Create a **My Dental Benefits** account for fast, secure access to claim details, payment information, procedure history, printable ID cards and more
  - Speak to a knowledgeable, US-based representative by calling **1-888-898-0370** who can resolve problems and give on-the-spot solutions

Why use a United Concordia network dentist?

Network dentists agree to accept our discounted fees as payment in full for covered services. Non-network dentists can charge you more. This means you'll lower your out-of-pocket expense using a network dentist. Using a network dentist maximizes your dental benefits because they:

- **Save money**—a network dentist saves you the difference between our negotiated fees and the dentist's regular charges; putting more money in your pocket
- **Save time**—a network dentist files your claims for you, saving you time and the hassle of paperwork
- **Save worry**—every network dentist is carefully screened, so you know you're getting high-quality care

You can still receive care from any licensed dentist, but your benefits may differ and your out-of-pocket costs could be higher with a non-network dentist. Find a dentist by visiting **UnitedConcordia.com** and click **Find a Dentist** on our homepage; select **Alliance** network.

Your plan includes Smile for Health®–Wellness

If you or your dependents have a chronic medical condition,* you are eligible for improved dental benefits to care for gum disease. With Smile for Health®–Wellness, you get 100% coverage for periodontal services. Here's how to sign up:

- Visit **UnitedConcordia.com**
- Sign in to **My Dental Benefits** (Or, create an account)
- Click **My Oral Health**
- Add your medical condition

Enhanced Benefits with Smile for Health®–Wellness

Service	Coverage*
Periodontal Maintenance—**one additional** to your plan's standard limit per year	100%
Scaling & Root Planing	
Periodontal Surgery—four procedures**	

* Conditions include diabetes, heart disease, lupus, oral cancer, organ transplant, rheumatoid arthritis, stroke

** Four procedures related to gingival flap or osseous surgeries. Must have selected High Option to have Periodontal Surgeries covered.

UNITED CONCORDIA® DENTAL
Protecting More Than Just Your Smile®

HIGH OPTION

Concordia Preferred Comprehensive Plan

Benefit Category	Alliance Network		Non-Network	
	Plan Pays[1]	You Pay[1]	Plan Pays[4]	You Pay
Diagnostic & Preventive Services ■ Routine Oral Exams (twice every 12 months) ■ Routine Cleanings (twice every 12 months) ■ Periodontal Cleanings (twice every 12 months) ■ X-rays—complete mouth (once every 5 years); bitewings (twice every 12 months through age 13, once every 12 months thereafter) ■ Sealants (through age 15): permanent first and second molars only ■ Emergency Treatment for Relief of Pain ■ Fluoride Treatment (twice every 12 months through age 19)	100%	0% (No Deductible)	100% (of Allowed Amount)	0% (of Allowed Amount) + Any charges in excess of the allowed amount (No Deductible)
Basic Services ■ Basic Restorative (amalgam and posterior composites) ■ Simple Extractions ■ Endodontics ■ Repair of Denture and Bridgework ■ General Anesthesia & IV Sedation (covered only in conjunction with dental surgery) ■ Complex Oral Surgery ■ Surgical Periodontics ■ Nonsurgical Periodontics	80%	20% (Deductible Applies)	55% (of Allowed Amount)	45% (of Allowed Amount) + Any charges in excess of the allowed amount (Deductible Applies)
Major Services ■ Removable Partial or Complete Dentures and Fixed Bridges (to replace teeth lost while insured under this contract) ■ Inlays, Onlays & Crowns (when teeth cannot be restored to normal form and function with amalgam, composite resin or plastic fillings) ■ Implant Coverage	50%	50% (Deductible Applies)	35% (of Allowed Amount)	65% (of Allowed Amount) + Any charges in excess of the allowed amount (Deductible Applies)
Orthodontic Services ■ Diagnostic, Active, Retention Treatment Adult and Child	50%	50% (No Deductible)	50% (of Allowed Amount)	50% (of Allowed Amount) + any charges in excess of the allowed amount (No Deductible)
Included Plan Features ■ Pregnancy Benefit	■ Covers 1 additional cleaning during pregnancy ■ Covers 1 additional periodontal maintenance			
■ Smile for Health®–Wellness[2] (Provides periodontal care for people with certain chronic medical conditions: diabetes, heart disease, lupus, oral cancer, organ transplant, rheumatoid arthritis and stroke)	■ Covers 1 additional periodontal maintenance per year and all are covered at 100% ■ Scaling and root planing are covered at 100% ■ 4 periodontal surgery procedures are covered at 100%			
Calendar Year Deductible (per person/per family)	$50/$150		$50/$150	
Calendar Year Maximum (per person) [3]	$1,500		$1,000	
Lifetime Orthodontic Maximum (per person)	$1,500		$500	

1. Network providers agree to accept United Concordia's maximum allowable charge as payment-in-full.
2. Members (subscribers or covered dependents) with certain medical conditions must sign up for this program through My Dental Benefits on UnitedConcordia.com.
3. Network and non-network maximums cannot be combined.
4. Non-network reimbursed at the 80th percentile.

This Benefit Summary highlights some of the benefits available under your plan. A complete description regarding the terms of coverage and exclusions and limitations will be provided in your summary plan description, available online at www.nmpsia.state.nm.us.

UNITED CONCORDIA® DENTAL
Protecting More Than Just Your Smile®

LOW OPTION

Concordia Preferred Basic Plan

Benefit Category	Alliance Network		Non-Network	
	Plan Pays[1]	You Pay[1]	Plan Pays[4]	You Pay
Diagnostic & Preventive Services ■ Routine Oral Exams (twice every 12 months) ■ Routine Cleanings (twice every 12 months) ■ Periodontal Cleanings (twice every 12 months) ■ X-rays—complete mouth (once every 5 years); bitewings (twice every 12 months through age 13, once every 12 months thereafter) ■ Sealants (through age 15), permanent first and second molars only ■ Emergency Treatment for Relief of Pain ■ Fluoride Treatment (twice every 12 months through age 19)	100%	0% (No Deductible)	25% (of Allowed Amount)	75% (of Allowed Amount) + Any charges in excess of the allowed amount (No Deductible)
Basic Services ■ Basic Restorative (amalgam and posterior composites) ■ Simple Extractions ■ Endodontics (root canal therapy only) ■ Repair of Denture and Bridgework ■ Nonsurgical Periodontics	80%	20% (Deductible Applies)	25% (of Allowed Amount)	75% (of Allowed Amount) + Any charges in excess of the allowed amount (Deductible Applies)
Major Services ■ Complex Oral Surgery ■ Surgical Periodontics (including endodontic surgery) ■ Removable Partial or Complete Dentures and Fixed Bridges ■ Inlays, Onlays & Crowns (when teeth cannot be restored to normal form and function with amalgam, composite resin or plastic fillings)	Not Covered			
Orthodontic Services ■ Diagnostic, Active, Retention Treatment	Not Covered			
Included Plan Features ■ Pregnancy Benefit	■ Covers 1 additional cleaning during pregnancy ■ Covers 1 additional periodontal maintenance			
■ Smile for Health®–Wellness[2] (Provides periodontal care for people with certain chronic medical conditions: diabetes, heart disease, lupus, oral cancer, organ transplant, rheumatoid arthritis and stroke)	■ Covers 1 additional periodontal maintenance per year and all are covered at 100% ■ Scaling and root planing are covered at 100%			
Calendar Year Deductible (per person/per family)	$50/$150			
Calendar Year Maximum (per person) [3]	$1,500			
Lifetime Orthodontic Maximum (per person)	Not Covered			

1. Network providers agree to accept United Concordia's maximum allowable charge as payment-in-full.
2. Members (subscribers or covered dependents) with certain medical conditions must sign up for this program through My Dental Benefits on UnitedConcordia.com.
3. Network and non-network maximums cannot be combined.
4. Non-network reimbursed at the 80th percentile.

This Benefit Summary highlights some of the benefits available under your plan. A complete description regarding the terms of coverage and exclusions and limitations will be provided in your summary plan description, available online at www.nmpsia.state.nm.us.

UNITED CONCORDIA® DENTAL
Protecting More Than Just Your Smile®

Frequently Asked Questions

Q. Do I have to complete a claim form for each dental visit?

A. If you receive care from a network dentist, he or she will file your claim for you. If you receive care from a non-network dentist, you may have to complete and submit your own claims. You can receive a claim form by visiting unitedconcordia.com/dental-insurance/member/forms.

Q. How will orthodontic benefits be paid if I am currently undergoing orthodontic treatment?

A. An orthodontic treatment plan must be submitted by the treating provider to determine the remaining benefit that you may be entitled.

Q. How do I know what my out-of-pocket costs will be for a procedure?

A. For services beyond routine diagnostic and preventive, most dentists will give you a pre-treatment estimate at the time they schedule your next appointment. This will give you an estimate of what the dentist expects to receive from your insurance per procedure. You may also ask your dentist to provide a list of procedures to be performed and their corresponding fees. Then check your dental coverage at My Dental Benefits or, create an online account, to find out how much your plan will cover for these procedures. You may also ask your dentist for a predetermination of benefits.

Q. Does United Concordia require predetermination of benefits?

A. Predeterminations are not required, although you should consider requesting that your dentist provide a predetermination before you begin treatment for services like crowns or dentures. That way you'll know whether or not a service is covered and an estimate of what you can expect to pay out-of-pocket.

Q. Are there frequency limitations for certain services?

A. Yes. For example, you can receive 2 routine cleanings in a 12 month period. This is not calendar year; it is a rolling 12 month period.

1st Cleaning	
Date	Covered?
10/04/15	Yes

2nd Cleaning	
Date	Covered?
05/01/16	Yes

3rd Cleaning			
Date	Covered?	Date	Covered?
09/25/16	No	10/07/16	Yes

In addition there are frequency limitations for other services, like x-rays. Please refer to your Certificate of Insurance for a complete listing of Plan Limitations and Exclusions.

Q. When should I take my child to the their first dental appointment?

A. ADA recommends the first dental visit six months after the first tooth appears, but no later than the child's first birthday.

Q. Can I receive care from a dentist that is not in United Concordia's network?

A. Yes, you may receive care from any licensed dentist. If you choose to see a non-network dentist, you will be responsible for higher coinsurance amounts; subject to lower plan maximums and billed for any charges over and above United Concordia's allowed amount for covered services.

Q. How much will I pay if go out of network?

A. Depends on the plan, type of procedure and the dentist location. The following chart shows an example of the difference in costs if you have the high plan and receive a crown:

Dental Care from IN-NETWORK DENTIST	Example Dentist Charge	Plan Allowance	Plan Pays 50%	Member Owes the Network Dentist
1 Crown	$1,200	$690	$690 minus $50 deductible = $640 $640 x .50 = $320	**$370** **($690–320 = $370)**

Dental Care from NON-NETWORK DENTIST	Example Dentist Charge	Plan Allowance	Plan Pays 35%	Member Owes the Non-Network Dentist
1 Crown	$1,200	$690	$690 minus $50 deductible = $640 $640 x .35 = $224	**$976** **($1,200–224 = $976)**

Actual cost will vary depending on geographic area and actual dentist charge. You can request a predetermination to help determine your out-of-pocket cost. A predetermination lets you know what procedures will or won't be covered prior to receiving services. It calculates the total amount you owe and what your plan will cover based on your coinsurance amounts. A predetermination is not a guarantee of payment—it is an estimate of what you can expect to owe.

DAVIS VISION EYECARE REFRAMED™ MEMBER | SAVINGS

Davis Vision members save up to 60% off of retail on brand name hearing aids from major manufacturers through the EPIC Hearing Service Plan.

- Phonak
- Unitron
- Hansaton
- Resound
- Starkey
- Signia
- Widex
- Oticon

Level Of Hearing Aid Technology	Typical Retail Price	EPIC HSP Pricing	AVERAGE MEMBER SAVINGS
Basic	$1,400-$1,600	$495	$1,005
Standard	$1,601-$2,300	$849-$1,499	$776
Advanced	$2,301-$3,000	$1,500-$2,099	$851
Premium	$3,001-$4,000	$2,100-$2,500	$1,200

WELLNESS REWARDS | PROGRAM

ListenHear • LiveWell

Participants who complete the four fun, educational hearing health related activities in the Listen Hear, Live Well hearing wellness program receive *Wellness Reward Coupons* for additional savings on their hearing purchase! Go to **www.listenhearlivewell.com** on your desktop computer or mobile device to participate.

- **$200 off** Premium Level Devices*
- **$100 off** Advanced Level Devices*
- **$50 off** Standard Level Devices*

Wellness Reward Coupons are applied to each device that is purchased!

*applies to all Standard, Advanced, and Premium level hearing aid makes/models; cannot be combined with any other offers or promotions

Call EPIC today to start the process to better hearing.

1 844.246.0544

www.epichearing.com/davisvision

EPIC HEARING HEALTHCARE

Hear Better • *Live Well*

Welcome

Davis Vision members now have access to the largest hearing care provider network in the country and substantial savings on top-tier manufacturer brand devices and related professional services through the **EPIC Hearing Service Plan**.

Provider Network

The EPIC network is comprised of professional Audiologists and ENT physicians and represents the largest accredited network of its kind in the nation, with provider locations in all 50 states.

Hearing Aid Technology

The EPIC Hearing Service Plan gives you access to all name brand hearing aid technology by the top-tier hearing aid manufacturers at reduced prices, 30%-60% below MSRP; maximizing your value and savings.

How it Works

Contact an EPIC hearing counselor today. The hearing counselor can answer any questions you may have about the plan and coordinate your referral to a nearby participating provider. If the provider recommends you obtain hearing aids, an EPIC counselor will contact you to coordinate your coverage and payment. You will receive a 45 day trial period with a complimentary extended 3-year product warranty and one year supply of batteries*.

Warranty & Batteries

All hearing aids, with the exclusion of the Basic Level, come with the EPIC guaranteed warranty which covers repair, damage, and one time loss for three years. (Basic level is one-year). Each hearing aid purchase includes a one year supply of hearing aid batteries at no additional cost (48 cells per aid)*. *excludes Basic Level Products

Introducing HearTEK LEASING

A new and unique program to lease brand name hearing aid technology at an affordable monthly payment-- with option to purchase or upgrade to a new device, every 18 months! Almost all applicants are approved. Contact EPIC or go to www.hearTEKleasing.com for more information.

ALL HEARING CARE SERVICES AND PRODUCTS DESCRIBED ARE PROVIDED BY EPIC HEARING HEALTHCARE AS A VALUE-ADDED SERVICE TO DAVIS VISION MEMBERS. EPIC HEARING IS AN INDEPENDENT COMPANY THAT PROVIDES HEARING CARE SERVICES. DISCOUNTS AND PRICING ARE SUBJECT TO CHANGE.

EPICHSPIDV616

DAVIS VISION
EYECARE REFRAMED℠

NEW MEXICO PUBLIC SCHOOLS INSURANCE AUTHORITY

Premier Vision Plan

New Mexico Public Schools Insurance Authority is pleased to provide this information about your vision care plan, administered by Davis Vision, Inc., a leading national administrator of vision care programs. Healthy eyes and clear vision are an important part of your overall health and quality of life. With the rising cost of eyewear you can't afford not to be covered through a managed vision care plan. Your vision plan helps you care for your eyes while saving you money by offering:

Paid-in-full eye examinations, eyeglasses and contacts!

Frame Collection: Your plan includes a selection of designer, name brand frames that are completely covered in full.[1]

Contact Lens Collection: Select from the most popular contact lenses on the market today with Davis Vision's Contact Lens Collection.[1]

One-year eyeglass breakage warranty included on plan eyewear at no additional cost!

How to locate a Network Provider...

Just log on to the Open Enrollment section of our Member site at davisvision.com and enter Client Code 7129 to locate a provider near you including:

Visionworks

Eligibility for vision care benefits is determined by the same rules that apply to your other health care benefits. A description of coverage is listed to the right. Keep in mind that this information is a summary only. Please Refer to the plan's official Summary Plan Description for full details, including all limitations and exclusions. Once enrolled just log on to our Member site at www.davisvision.com or call us at 1.800.999.5431 for more information.

IN-NETWORK BENEFITS	
Eye Examination	Every 12 months, **Covered in full** after $10 copayment
Eyeglasses	
Spectacle Lenses	Every 12 months, **Covered in full** For standard single-vision, lined bifocal, or trifocal lenses after $15 copayment
Frames	Every 24 months, **Covered in full** Any Fashion, Designer or Premier frame from Davis Vision's Collection[1] (value up to $190) OR $40 wholesale allowance toward any other frame from provider OR $130 retail allowance to go toward any frame from a Visionworks family of store locations.[5]
Contact Lenses (in lieu of eyeglasses)	
Contact Lens Evaluation, Fitting & Follow Up Care	Every 12 months, Collection Contacts: **Covered in full** OR Non Collection Contacts: 15% discount[3]
Contact Lenses	Every 12 months, **Covered in full** Any contact lenses from Davis Vision's Contact Lens Collection[1] OR $110 retail allowance toward provider supplied contact lenses, plus 15% off balance[3] OR Visually required contacts covered in full with prior approval

ADDITIONAL DISCOUNTED LENS OPTIONS & COATINGS		
MOST POPULAR OPTIONS Savings based on in-network usage and average retail values.	Without Davis Vision	With Davis Vision
Scratch-Resistant Coating	$45	$0
Polycarbonate Lenses	$64	$0[2]-$30
Standard Anti-Reflective (AR) Coating	$62	$35
Standard Progressives (no-line bifocal)	$154	$50
Plastic Photosensitive (Transitions®[4])	$123	$65

Lower costs and more benefits! *See the savings!*

Service	Without Davis Vision	With Davis Vision
Eye Examination	$100	$10
Lenses		
Bifocals	$80	$15
Scratch-Resistant Coating	$45	$0
Transitions®[4]	$123	$65
Frame	$100	$0
Total	$448	$90

Savings up to:
$358

[1] The Davis Vision Collection is available at most participating independent provider locations. Collection is subject to change. Collection is inclusive of select toric and multifocal contacts.
[2] For dependent children, monocular patients and patients with prescriptions of 6.00 diopters or greater.
[3] Additional discounts not applicable at Walmart or Sam's Club locations.
[4] Transitions® is a registered trademark of Transitions Optical Inc.
[5] Enhanced frame allowance available at all Visionworks Locations nationwide.

Davis Vision has made every effort to correctly summarize your vision plan features. In the event of a conflict between this information and your organization's contract with Davis Vision, the terms of the contract or insurance policy will prevail.

Davis Vision plans offer...

Value for our Members

A comprehensive benefit ensuring low out-of-pocket cost to members and their families. Our goal is 100% member satisfaction.

Convenient Network Locations

A national network of credentialed preferred providers throughout the 50 states.

Freedom of Choice

Access to care through either our network of independent, private practice doctors (optometrists and ophthalmologists) or select retail partners.

Value-Added Features:

- Mail Order Contact Lenses Replacement contacts (after initial benefit) through DavisVisionContacts.com mail-order service ensures easy, convenient, purchasing online and quick, direct shipping to your door. Log on to our member Web site for details.
- Laser Vision Correction discounts of up to 25% off the provider's Usual & Customary fees, or 5% off advertised specials, whichever is lower.

Contact Info

For more details about the plan prior to enrolling, just log on to the Open Enrollment section of our Member site at davisvision.com or call 1.877.923.2847 and enter Client Code 7129.

ADDITIONAL LENS OPTIONS	WITHOUT DAVIS VISION	WITH DAVIS VISION
All Ranges of Prescriptions and Sizes	**$90**	**$0**
Plastic Lenses	**$33**	**$0**
Oversized Lenses	**$20**	**$0**
Tinting of Plastic Lenses	**$20**	**$0**
Scratch-Resistant Coating	**$45**	**$0**
Polycarbonate Lenses	$64	$0[1/] or $30
Ultraviolet Coating	$28	$12
Standard Anti-Reflective (AR) Coating	$62	$35
Premium AR Coating	$80	$48
Ultra AR Coating	$113	$60
Intermediate-Vision Lenses	$150	$30
Standard Progressive Addition Lenses	$154	$50
Select Progressive Addition Lenses	$248	$70
Premium Progressive Addition Lenses	$248	$90
Ultra Progressive Addition Lenses	$462	$140
High-Index Lenses	$120	$55
Plastic Photosensitive Lenses	$123	$65
Scratch Protection Plan (Single vision | Multifocal lenses)		$20 | $40

[1/] Polycarbonate lenses are covered in full for dependent children, monocular patients and patients with prescriptions 6.00 diopters or greater.

Out-of-Network Benefits

You may receive services from an out-of-network provider, although you will receive the greatest value and maximize your benefit dollars if you select a provider who participates in the network. If you choose an out-of-network provider, you must pay the provider directly for all charges and then submit a claim for reimbursement to:

Vision Care Processing Unit
P.O. Box 1525
Latham, NY 12110

OUT-OF-NETWORK REIMBURSEMENT SCHEDULE
Eye Examination up to $35 | Frame up to $35 Spectacle Lenses (per pair) up to: Single Vision $25, Bifocal $40, Trifocal $55, Lenticular $80 Elective Contacts up to $110, Visually Required Contacts up to $210

MONTHLY PREMIUM ALLOCATION INFORMATION EFFECTIVE 10/01/2018

If you earn $25,000 or more, monthly payroll deductions are:			
	Single	Two Party	Family
Blue Cross Blue Shield NM - High Option	$272.86	$518.94	$693.10
Blue Cross Blue Shield NM - Low Option	$212.02	$403.22	$538.58
Blue Cross Blue Shield NM - EPO	$245.58	$467.02	$623.78
Presbyterian - High Option	$220.66	$463.34	$617.84
Presbyterian - Low Option	$171.48	$360.04	$480.08
Dental - High Option	$10.90	$20.74	$32.60
Dental - Low Option	$5.46	$10.38	$16.30
Vision	$2.50	$4.18	$5.66

If you earn $20,000 but less than $25,000, monthly payroll deductions are:			
	Single	Two Party	Family
Blue Cross Blue Shield NM - High Option	$238.76	$454.06	$606.46
Blue Cross Blue Shield NM - Low Option	$185.50	$352.82	$471.26
Blue Cross Blue Shield NM - EPO	$214.88	$408.64	$545.80
Presbyterian - High Option	$193.08	$405.42	$540.62
Presbyterian - Low Option	$150.04	$315.04	$420.06
Dental - High Option	$9.54	$18.16	$28.52
Dental - Low Option	$4.78	$9.08	$14.26
Vision	$2.20	$3.68	$4.94

If you earn $15,000 but less than $20,000, monthly payroll deductions are:			
	Single	Two Party	Family
Blue Cross Blue Shield NM - High Option	$204.64	$389.20	$519.82
Blue Cross Blue Shield NM - Low Option	$159.00	$302.42	$403.94
Blue Cross Blue Shield NM - EPO	$184.18	$350.26	$467.82
Presbyterian - High Option	$165.50	$347.50	$463.38
Presbyterian - Low Option	$128.60	$270.04	$360.06
Dental - High Option	$8.18	$15.56	$24.44
Dental - Low Option	$4.10	$7.78	$12.22
Vision	$1.88	$3.14	$4.24

If you earn less than $15,000, monthly payroll deductions are:			
	Single	Two Party	Family
Blue Cross Blue Shield - High Option	$170.54	$324.34	$433.18
Blue Cross Blue Shield - Low Option	$132.50	$252.02	$336.60
Blue Cross Blue Shield NM - EPO	$153.48	$291.90	$389.86
Presbyterian - High Option	$137.90	$289.58	$386.16
Presbyterian - Low Option	$107.18	$225.02	$300.04
Dental - High Option	$6.82	$12.96	$20.38
Dental - Low Option	$3.42	$6.50	$10.18
Vision	$1.58	$2.64	$3.54

FOR ADDITIONAL LIFE INSURANCE AND LONG TERM DISABILITY DEDUCTIONS, PLEASE SEE NEXT PAGE.

The contribution rates are effective **October 1, 2018** and reflect the maximum employee contribution percentages listed in NM State Statute. Rates are subject to change. Payroll deductions are made in advance of coverage (For example, September deductions pay for October coverage). Your deductions above represent about 1/3 of the total cost; your employer pays the rest. Your employer may have a customized payroll deduction table, so please verify your actual premiums with your Benefits/Human Resource Office.

MONTHLY DEDUCTION WORKSHEET

"Calculate LTD and ADL Monthly Premiums" at nmpsia.com

THE STANDARD ADDITIONAL (VOLUNTARY) LIFE *(pages 19-21)*

Age of Adult	Under 30	30-39	40-44	45-49	50-54	55-59	60-64	65-69	70 +	Child(ren)
Rate per $1,000	$.04	$.06	$.08	$.12	$.22	$.34	$.52	$.78	$1.02	$.24/mo.

EMPLOYEE PAYS 100% OF THE PREMIUM.

To calculate your Additional Life monthly payroll deduction, follow these steps, or go to nmpsia.com and find the online calculator under the "Members" tab.

		Example: Employee Age 46 earning $34,666 choosing 3x for Employee Life Insurance and enrolling Spouse Age 36 and Children
Enter Annual Contracted Salary, rounded to next higher $1,000		*$35,000*
Multiply by your selection (1x, 2x, or 3x) (Maximum amount $500,000 without medical underwriting; $600,000 if approved by medical underwriting)		*3 x $35,000 = $105,000*
Divide by 1,000 (for # of units of $1,000)		*$105,000 / $1,000 = 105*
Multiply by the rate for Employee's age group to get the Employee Life Insurance deduction		*Rate for ages 45-49 is $.12 105 x $.12 = $12.60*
If insuring Spouse, enter the lesser of: (a) 50% of your Additional Life Insurance or (b) 1x your Annual Contracted Salary, rounded to the next higher $1,000		*Spouse amount limited to $35,000 in this example because spouse amount may not exceed 1x Employee's Salary rounded to the next higher $1,000*
Divide by 1,000 (for # of units of $1,000)		*$35,000 / 1,000 = 35*
Multiply by the rate for Spouse's age group to get the deduction for Spouse Life		*Rate for ages 30-39 is $.06 35 x $.06 = $2.10*
If insuring Child(ren) for the Children's Additional Life Coverage of $5,000, add $.24		*$.24*
Add amounts in shaded rows for your total deduction for Additional Life		*$12.60 for $105,000 on Employee* *$ 2.10 for $35,000 on Spouse* *$ .24 for $5,000 on Children* *$14.94 per month*

THE STANDARD LONG TERM DISABILITY PLAN *(pages 22-23)*

Benefit Waiting Period *(as selected by your employer)*	Monthly Premium
30 Day Wait	$.58 per $100 payroll
60 Day Wait	$.34 per $100 payroll
90 Day Wait	$.28 per $100 payroll

EMPLOYER MATCHES PREMIUM.

To calculate your LTD monthly payroll deduction, follow these steps:

		Example: $40,000 Salary, 30 Day Benefit Waiting Period
Enter Contracted Annual Salary but not more than $90,000		*$40,000*
Divide by Salary by 1200		*$40,000 / 1200 = $33.34*
Multiply by plan rate from table. This is the total monthly cost, which is shared between you and your employer.		*$33.34 x $.58 = $19.34*
Your share is: 40% if you earn $25,000 or more 35% if you earn between $20,000 and $25,000 30% if you earn between $15,000 and $20,000 25% if you earn less than $15,000		*40% of $19.34 = $7.74* *Sample monthly deduction at $40,000 Salary*

New Mexico Public Schools Insurance Authority (NMPSIA)
Important Employee Benefit Program Notices

Updated July, 2018

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 entiende la información de este documento, póngase en contacto con la oficina de beneficios o recursos humanos de su empleador.

MID-YEAR CHANGES TO YOUR HEALTH CARE BENEFIT ELECTIONS

IMPORTANT: After this open enrollment period is completed, 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 Change in Status 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 your employer stops contributing toward your or your dependents' other coverage). However, you **must request enrollment within 31 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 request enrollment within 31 days** after the marriage, birth, adoption, or placement for adoption.

  Medicaid/CHIP Event: You and your 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 request enrollment within **60 days** after the Medicaid or CHIP coverage ends.
  - become eligible for a premium assistance program through Medicaid or CHIP. However, you must request enrollment 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 ERISA Administrative Services at 800-233-3164 or your school's benefits office.

- ***Mid-Year Permitted Election Change in Status Event:***

  When your employer pre-taxes your benefits, NMPSIA is 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 events **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).
- Change in number or status of dependents (e.g. birth, adoption, death).
- 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 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 rights and FMLA leaves.

You must notify the plan in writing within **31 days** of the mid-year change in status event by contacting ERISA Administrative Services at 800-233-3164 or your school's benefits office.

The Plan will determine if your change request is permitted and if so, changes become effective prospectively, on the first day of the month, following the approved change in status event (except for newborn and adopted children, who are covered back to the date of birth, adoption, or placement for adoption).

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.

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 contact ERISA Administrative Services at 800-233-3164 or your school's benefits office.

MEDICARE NOTICE OF CREDITABLE COVERAGE REMINDER

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

To find out whether the prescription drug coverage under the medical plan options offered by NMPSIA is or is not creditable you should review the Plan's Medicare Part D Notice of Creditable Coverage available at the back of this document or from www.nmpsia.com and select the most current Program Guide.

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. A copy of the Notice is provided at the back of this document and you can get another copy of this Notice from the New Mexico Public Schools Insurance Authority (NMPSIA) at 800-548-3724.

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

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

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

These benefits will be provided subject to the same deductibles, copayment and coinsurance applicable to other medical and surgical benefits provided under the various medical plans offered by NMPSIA. For more information on WHCRA benefits, contact NM Blue Cross Blue Shield at 888-966-7742 or Presbyterian Health Plan at 888-275-7737.

AVAILABILITY OF SUMMARY HEALTH INFORMATION: THE SUMMARY OF BENEFIT AND COVERAGE (SBC) DOCUMENT(S)

The health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

As required by law, across the US, insurance companies and group health plans like ours are providing plan participants with a consumer-friendly **Summary of Benefits and Coverage (SBC)** as a way to help understand and compare medical plan benefits. Choosing a health coverage option is an important decision. To help you make an informed choice, the SBC, summarizes and compares important information in a standard format.

Each SBC contains concise medical plan information, in plain language, about benefits and coverage, including, what is covered, what you need to pay for various benefits, what is not covered and where to go for more information or to get answers to questions. SBC documents are updated when there is a change to the benefits information displayed on an SBC.

Government regulations are very specific about the information that can and cannot be included in each SBC. Plans are not allowed to customize very much of the SBC documents. There are detailed instructions the Plan had to follow about how the SBCs look, how many pages long the SBC should be, the font size, the colors used when printing the SBC and even which words were to be bold and underlined.

A Uniform Glossary that defines many of the terms used in the SBC is available at https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/sbc-uniform-glossary-of-coverage-and-medical-terms-final.pdf.

The SBC for each medical plan option is available at the NMPSIA website: www.nmpsia.com, or for a paper copy of contact the New Mexico Public Schools Insurance Authority (NMPSIA) at 800-548-3724 or your school benefits office.

CAUTION: IF YOU DECLINE MEDICAL PLAN COVERAGE OFFERED THROUGH NMPSIA

The medical plan options offered by NMPSIA 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 NMPSIA's medical plan options, remember that 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.

Americans without medical plan coverage could have to pay a penalty when they file their personal income taxes. Visit the Health Insurance Marketplace for detailed information on individual shared responsibility payment penalty at https://www.healthcare.gov/fees-exemptions/fee-for-not-being-covered/.

In December 2017 Congress passed a new law (the Tax Cuts and Jobs Act) that reduces the Individual Mandate penalty to zero starting in 2019. This means that for 2018, you still need to maintain minimum essential coverage (medical plan coverage) for yourself and your family members in order to avoid having to pay a penalty (the Individual Mandate penalty) when you file your personal income taxes for the 2018 tax year.

If you choose to not be covered by a medical plan sponsored by NMPSIA at this time, your next opportunity to enroll for NMPSIA's 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 plan year.

PATIENT PROTECTION RIGHTS OF THE AFFORDABLE CARE ACT

The medical plans offered by NMPSIA do not require the selection or designation of a primary care provider (PCP). You have the ability to visit any network or non-network health care provider; however, payment by the Plan may be less for the use of a non-network provider.

You also do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a 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 NM Blue Cross Blue Shield at 888-966-7742 or Presbyterian Health Plan at 888-275-7737.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT NOTICE

Hospital Length of Stay for Childbirth: Under federal law, group health plans, like this Plan, 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 NM Blue Cross Blue Shield at 888-966-7742 or Presbyterian Health Plan at 888-275-7737 to precertify the extended stay. If you have questions about this Notice, contact NM Blue Cross Blue Shield at 888-966-7742 or Presbyterian Health Plan at 888-275-7737.

NOTICE TO ENROLLEES IN THE NMPSIA MEDICAL PLANS (A SELF-FUNDED NONFEDERAL GOVERNMENTAL GROUP HEALTH PLAN)

Group health plans sponsored by State and local governmental employers must generally comply with Federal law requirements in title XXVII of the Public Health Service Act. However, these employers are permitted to elect to exempt a plan from the requirements listed below for any part of the plan that is "self-funded" by the employer, rather than provided through a health insurance policy.

NMPSIA has elected to exempt the New Mexico Public Schools Insurance Authority (NMPSIA) Medical Plans from the following requirements:

- **Protections against having benefits for mental health and substance use disorders be subject to more restrictions than apply to medical and surgical benefits covered by the plan.**

The exemption from these Federal requirements will be effective for the 2018/2019 NMPSIA plan year beginning on July 1, 2018 through June 30, 2019. The election may be renewed for subsequent plan years.

For the 2018/2019 plan year NMPSIA is going to continue to provide the same mental health and substance abuse benefits we offered in the 2017/2018 plan year. These benefits are described in the current NMPSIA Program Guide, in the Summary of Benefits charts, in the Mental Health and Substance Abuse Rehabilitation rows (the guide is located on the website: www.nmpsia.com). This means that you will still have access to inpatient admissions and outpatient mental health and substance abuse services, but certain requirements of the Mental Health Parity regulations, such as unlimited days of stay in a residential treatment program, will not have to be met by the NMPSIA Medical plans.

NMPSIA reserves the right to amend the NMPSIA Medical Plans during the plan year and you will be notified of any plan amendments.

If you have any questions regarding this exemption, please contact the NMPSIA Deputy Director - Benefits at 800-548-3724.

KEEP THE PLAN NOTIFIED OF CHANGES IN ELIGIBILITY FOR BENEFITS

IMPORTANT NOTICE

You or your Dependents must promptly furnish to ERISA Administrative Services at 800-233-3164 information regarding change of name, address, marriage, divorce or legal separation, death of any covered family member, birth and change in status of a Dependent Child, Medicare enrollment or disenrollment, an individual no longer meeting the eligibility provisions of the Plan, or the existence of other coverage. Proof of legal documentation will be required for certain changes. Proof of legal documentation will be required for certain changes.

Notify the Plan of any of these changes within 31 days. Note that for certain events like divorce or a child reaching the limiting age for coverage, if you do not notify the Plan within 60 days of that change, the opportunity to elect COBRA will not apply.

Failure to give ERISA Administrative Services at 800-233-3164 **a timely notice of the above noted events may:**

a. cause you, your Spouse and/or Dependent Child(ren) to lose the right to obtain COBRA Continuation Coverage,
b. cause the coverage of a Dependent Child to end when it otherwise might continue because of a disability,
c. cause claims to not be considered for payment until eligibility issues have been resolved,
d. result in your liability to repay the Plan if any benefits are paid on behalf of, or to, 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 and self-payments 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 benefits, contact the New Mexico Public Schools Insurance Authority (NMPSIA) at 800-548-3724 or your school benefits office.

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 coverage 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 in writing of that event no later than 60 days after that event occurs**. That notice must be sent to ERISA Administrative Services, PO Box 9054, Santa Fe, NM 97504 or your school benefits office via first class mail 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).

If you have questions about COBRA contact ERISA Administrative Services at 800-233-3164.

GENERAL STATEMENT OF NONDISCRIMINATION: (DISCRIMINATION IS AGAINST THE LAW)

New Mexico Public Schools Insurance Authority (NMPSIA) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. NMPSIA does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. NMPSIA:

a) Provides free aids and services to people with disabilities to communicate effectively with us, such as:
   - Qualified sign language interpreters
   - Written information in other formats (large print, audio, accessible electronic formats, other formats)

b) Provides free language services to people whose primary language is not English, such as:
   - Qualified interpreters
   - Information written in other languages

If you need these services, contact the NMPSIA Civil Rights Coordinator.

If you believe that NMPSIA has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Ernestine Chavez, NMPSIA Civil Rights Coordinator
410 Old Taos Highway
Santa Fe, NM 87501

Telephone number: 800-548-3724

Fax: 505-983-8670

Email: ernestine.chavez@state.nm.us

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the NMPSIA Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-868-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/filing-with-ocr/index.html.

Free Language Assistance: The following chart displays the top 15 languages spoken by individuals with limited English proficiency in the state of New Mexico.

ATTENTION: FREE LANGUAGE ASSISTANCE This chart displays, in various languages, the phone number to call for free language assistance services for individuals with limited English proficiency.	
Language	**Message About Language Assistance**
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-548-3724.
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-548-3724.
French	ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-548-3724.
Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-548-3724.
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-548-3724.
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-548-3724.
Persian	**توجه**: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-548-3724 تماس بگیرید.
Hindi	ध्यान द: यद आप हदी बोलते ह तो आपके लिए मुफ्त म भाषा सहायता सेवाएं उपलब्ध ह। 1-800-548-3724 पर कॉल कर।
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-548-3724.
Navajo	D77 baa ak0 n7n7zin: D77 saad bee y1n7[ti'go **Diné Bizaad**, saad bee 1k1'1n7da'1wo'd66', t'11 jiik'eh, 47 n1 h0l=, koj8' h0d77lnih 1-800-548-3724.
Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-548-3724
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-548-3724번으로 전화해 주십시오.
Thai	เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-548-3724.
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-548-3724 (телетайп: 1-800-548-3724).
Japanese	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-548-3724 まで、お電話にてご連絡ください。

IMPORTANT NOTICES ATTACHED

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

- Reminder about the Employer Notice About the Health Insurance Marketplace
- Medicare Part D Notice
- HIPAA Privacy Notice
- Notice about Premium Assistance with Medicaid and CHIP

EMPLOYER NOTICE ABOUT THE HEALTH INSURANCE MARKETPLACE

Your employer should distribute a notice to new employees when they are first hired. The notice is at least two pages long. To help you recognize the notice, here is a snapshot of a portion of the first page of the Notice:

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 5-31-2020)

PART A: General Information

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

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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

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

Important Notice from NMPSIA about Prescription Drug Coverage for People with Medicare

This notice is for people with Medicare.
Please read this notice carefully and keep it where you can find it.

This Notice has information about your current prescription drug coverage with the New Mexico Public Schools Insurance Authority (NMPSIA) 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.**

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.

NMPSIA has determined that the prescription drug coverage IS "CREDITABLE" under the following medical plan options:

- **Presbyterian Low Option Plan, Presbyterian High Option Plan**
- **Blue Cross Blue Shield of New Mexico Low Option Plan and Blue Cross Blue Shield of New Mexico High Option Plan**
- **Blue Cross Blue Shield of New Mexico Preferred 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 option 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 Presbyterian Low Option Plan, Presbyterian High Option Plan, Blue Cross Blue Shield of New Mexico Low Option Plan, Blue Cross Blue Shield of New Mexico High Option Plan or Blue Cross Blue Shield of New Mexico Preferred EPO Plan 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 medical and prescription drug coverage** with the Presbyterian Low Option Plan, Presbyterian High Option Plan, Blue Cross Blue Shield of New Mexico Low Option Plan, Blue Cross Blue Shield of New Mexico High Option Plan or Blue Cross Blue Shield of New Mexico Preferred EPO plan **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 Presbyterian Low Option Plan, Presbyterian High Option Plan, Blue Cross Blue Shield of New Mexico Low Option Plan, Blue Cross Blue Shield of New Mexico High Option Plan or Blue Cross Blue Shield of New Mexico Preferred EPO 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 medical and prescription drug coverage** with the Presbyterian Low Option Plan, Presbyterian High Option Plan, Blue Cross Blue Shield of New Mexico Low Option Plan, Blue Cross Blue Shield of New Mexico High Option Plan or Blue Cross Blue Shield of New Mexico Preferred EPO plan **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 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 health 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 the medical plan in which you are enrolled. 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 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:

NMPSIA
410 Old Taos Highway
Santa Fe, NM 87501
Phone Number: 1-800-548-3724

As in all cases, NMPSIA reserves the right to modify benefits at any time, in accordance with applicable law. This document (dated July 2018) is intended to serve as your Medicare Notice of Creditable Coverage, as required by law.

NEW MEXICO PUBLIC SCHOOLS INSURANCE AUTHORITY

NOTICE OF 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 THIS NOTICE CAREFULLY.

The New Mexico Public Schools Insurance Authority (NMPSIA) self-funded group health plan (hereafter referred to as the "Plan") is required by law to take reasonable steps to maintain the privacy of your health information (called **Protected Health Information** or **PHI**) and to provide you with notice of its legal duties and privacy practices with respect to your Protected Health Information including:

1. The Plan's uses and disclosures of PHI,
2. Your rights to privacy with respect to your PHI,
3. The Plan's duties with respect to your PHI,
4. Your right to file a complaint with the Plan and with the Secretary of the U.S. Department of Health and Human Services (HHS), and
5. The person or office you should contact for further information about the Plan's privacy practices,
6. To notify affected individuals following a breach of unsecured Protected Health Information.

PHI use and disclosure by the Plan is regulated by the Federal law Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the health Information Technology for Economic and Clinical Health Act (HITECH). You may find these rules in 45 *Code of Federal Regulations* Parts 160 and 164. This Notice attempts to summarize key points in the regulation. The regulations will supersede this Notice if there is any discrepancy between the information in this Notice and the regulations. The Plan will abide by the terms of the Notice currently in effect. The Plan reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all PHI it maintains.

You may also receive a Privacy Notice from companies who offer Plan participants insured health care services, such as the Vision plan benefits. Each of these notices will describe your rights as it pertains to that plan and in compliance with the Federal regulation, HIPAA. This Privacy Notice however, pertains to your protected health information related to the NMPSIA self-funded medical plan options and COBRA Administration, (the "Plan") and outside companies contracted to help administer Plan benefits, also called "business associates."

Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

If you have questions about any part of this Notice or if you want more information about the privacy practices at NMPSIA, please contact NMPSIA's Administrative Office located at 410 Old Taos Highway, Santa Fe, NM 87501, or by telephone at 1-(800) 548-3724.

Your Protected Health Information

The term **"Protected Health Information" (PHI)** includes all information related to your past, present or future health condition(s) that individually identifies you or could reasonably be used to identify you and is transferred to another entity or maintained by the Plan in oral, written, electronic or any other form.

PHI does not include health information contained in employment records held by your employer in its role as an employer, including but not limited to health information on disability, work-related illness/injury, sick leave, Family or Medical Leave (FMLA), life insurance, dependent care flexible spending account, drug testing, etc.

The Plan's Duties

The Plan is required by law to:

- Maintain the privacy of your protected health information (PHI) ;
- Inform you promptly if a breach occurs that may have compromised the privacy or security of your information;
- Provide you with certain rights with respect to your protected health information;
- Provide you and your eligible dependents with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information;
- Follow the terms of the Notice that is currently in effect; and
- Not use or share your information other than as described here unless you tell us in writing that we can. If you tell us we can share information, you may change your mind at any time and advise us in writing of such change.

Notice Distribution: The Notice will be provided to each person when they initially enroll for benefits in the Plan (the Notice is provided in the Plan's Enrollment/Program Guide). The Notice is also available on the Plan's website: www.nmpsia.com. The Notice will also be provided upon request. Once every three years the Plan will notify the individuals then covered by the Plan where to obtain a copy of the Notice. This Plan will satisfy the requirements of the HIPAA regulation by providing the Notice to the named insured (covered employee) of the Plan; however, you are encouraged to share this Notice with other family members covered under the Plan.

Notice Revisions: If a privacy practice of this Plan is changed affecting this Notice, a revised version of this Notice will be provided to you and all participants covered by the Plan at the time of the change. Any revised version of the Notice will be distributed within 60 days of the effective date of a material change to the uses and disclosures of PHI, your individual rights, the duties of the Plan or other privacy practices stated in this Notice.

Material changes are changes to the uses and disclosures of PHI, an individual's rights, the duties of the Plan or other privacy practices stated in the Privacy Notice. Because our health plan posts its Notice on its web site, we will prominently post the revised Notice on that web site by the effective date of the material change to the Notice. We will also provide the revised notice, or information about the material change and how to obtain the revised Notice, in our next annual mailing to individuals covered by the Plan.

When the Plan May Use or Disclose Your Health Information

Under the law, the Plan may use and disclose your health information without your written authorization in the following cases:

- ***At your request.*** If you request it, the Plan is required to give you access to your PHI in order to inspect it and copy it.
- ***As required by an agency of the government.*** The Secretary of the Department of Health and Human Services may require the disclosure of your PHI to investigate or determine the Plan's compliance with the privacy regulations.
- ***For treatment, payment or health care operations.*** The Plan and its Business Associates will use your PHI (except psychotherapy notes in certain instances as described below) without your consent, authorization or opportunity to agree or object in order to carry out treatment, payment, or health care operations.

1. **For Treatment.** We may use or disclose your protected health information to facilitate medical treatment or services by providers. **For example**, we may disclose providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you to your treating specialist to enable your providers to confer regarding a treatment plan.
2. **For Payment.** We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. **For example**, we may tell your health care provider about you to determine whether the Plan will cover the treatment recommended by your provider. We may also share your protected health information with a utilization review or pre-certification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.
3. **Health Care Operations.** We may use and disclose health information about you to carry out necessary insurance-related activities. Such activities may include underwriting, enrollment, premium rating and other activities relating to plan coverage; conducting quality assessment and improvement activities; patient safety activities; submitting claims for stop-loss coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; and business planning, management and general administration. If use or disclosure of protected health information is made for underwriting purposes, any such protected health information that is genetic information of an individual is prohibited from being used or disclosed. **For example**, we may use information about your medical claims to project future benefit costs.

The Plan Sponsor has **amended its Plan documents** to protect your PHI as required by Federal law. The Plan may disclose PHI to the Plan Sponsor for purposes of treatment, payment, and health care operations in accordance with the Plan amendment. The Plan may disclose PHI to the Plan Sponsor for review of your appeal of a benefit or for other reasons related to the administration of the Plan.

Use or Disclosure of Your PHI Where Consent, Authorization or Opportunity to Object Is Not Required

In general, the Plan does not need your written authorization to release your PHI if required by law or for public health and safety purposes. The Plan and its Business Associates are allowed to use and disclose your PHI **without** your written authorization (in compliance with section 164.512) under the following circumstances:

1. **Required by Law.** As required by law, we may use and disclose your health information. For example, we may disclose medical information when required by a court order in a litigation proceeding such as a malpractice action.
2. **Public Health.** As authorized by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure.
3. **Proof of Immunization.** We may disclose information about you limited to proof of immunization to a school about an individual who is a student or prospective student of the school.
4. **Health Oversight Activities.** We may disclose your health information to health agencies during the course of audits, investigations, inspections, licensure and other proceedings related to oversight of the health care system.
5. **Judicial and Administrative Proceedings.** We may disclose your health information in the course of any administrative or judicial proceeding.

6. **Law Enforcement.** We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena and other law enforcement purposes.
7. **Coroners, Medical Examiners and Funeral Directors.** We may disclose your health information to coroners, medical examiners and funeral directors. For example, this may be necessary to identify a deceased person or determine the cause of death.
8. **Information of Decedent Related to Organ and Tissue Donation.** We may disclose your health information after you have died to organizations involved in procuring, banking or transplanting organs and tissues, as necessary.
9. **Public Safety.** We may disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.
10. **National Security.** We may disclose your health information for military, national security, prisoner and government benefits purposes.
11. **Military and Veterans.** If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority if required.
12. **Worker's Compensation.** We may disclose your health information as necessary to comply with worker's compensation or similar laws.
13. **Research.** We may disclose your health information to researchers when:
    - The individual identifiers have been removed; or
    - When an institutional review board or privacy board (a) has reviewed the research proposal; and (b) established protocols to ensure the privacy of the requested information, and approves the research.
14. **Disclosures to Plan Sponsors.** We may discuss your health information to the sponsor of your group health plan, for purposes of administering benefits under the plan. We share the minimum information necessary to accomplish these purposes.
15. **Business Associates.** We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, use and/or disclose your protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims or to provide support services, such as utilization management, pharmacy benefit management or subrogation, but only after the Business Associate enters into a Business Associate Agreement with us.

Any other Plan uses and disclosures not described in this Notice will be made only if you provide the Plan with written authorization, subject to your right to revoke your authorization, and information used and disclosed will be made in compliance with the minimum necessary standards of the regulation.

Disclosing Only the Minimum Necessary Protected Health Information

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations. However, the minimum necessary standard will not apply in the following situations:

- Disclosures to or requests by a health care provider for treatment,

- **Disclosures to You.** When you request, we are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your protected health information where the disclosure was for reasons other than for treatment, payment, or health care operations, and where the protected health information was disclosed in accordance with your individual authorization.
- **Government Audits.** We are required to disclose your health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.
- Uses of disclosures required by law, and
- Uses of disclosures required for the Plan's compliance with the HIPAA privacy regulations.

This Notice does not apply to information that has been de-identified. **De-identified information** is information that does not identify you and there is no reasonable basis to believe that the information can be used to identify you.

As described in the amended Plan document, the Plan may share PHI with the Plan Sponsor for limited administrative purposes, such as determining claims and appeals, performing quality assurance functions and auditing and monitoring the Plan. The Plan shares the minimum information necessary to accomplish these purposes.

In addition, the Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids or modifying, amending or terminating the group health Plan. Summary health information means information that summarizes claims history, claims expenses or type of claims experienced by individuals for whom the Plan Sponsor has provided health benefits under a group health plan. Identifying information will be deleted from summary health information, in accordance with HIPAA.

When the Disclosure of Your PHI Requires Your Written Authorization

Generally, the Plan will require that you sign a valid authorization form in order to use or disclose your PHI **other than**:

- When you request your own PHI
- A government agency requires it, or
- The Plan uses it for treatment, payment or health care operation.

You have the right to revoke an authorization.

Although the Plan does not routinely obtain psychotherapy notes, generally, an authorization will be required by the Plan before the Plan will use or disclose psychotherapy notes about you. Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment. However, the Plan may use and disclose such notes when needed by the Plan to defend itself against litigation filed by you.

The Plan generally will require an authorization form for uses and disclosure of your PHI for marketing purposes (meaning a communication that encourages you to purchase or use a product or service) if the Plan receives direct or indirect financial remuneration (payment) from the entity whose product or service is being marketed. The Plan generally will require an authorization form for the sale of protected health information if the Plan receives direct or indirect financial remuneration (payment) from the entity to whom the PHI is sold. The Plan does not intend to engage in fundraising activities.

Marketing. We generally will require an authorization form for uses and disclosure of your PHI for marketing purposes (meaning a communication that encourages you to purchase or use a product or service) if the Plan receives direct or indirect financial remuneration (payment) from the entity whose product or service is being

marketed. We generally will require an authorization form for the sale of Protected Health Information if we receive direct or indirect financial remuneration (payment) from the entity to which the PHI is sold.

Use or Disclosure of Your PHI Where You Will Be Given an Opportunity to Agree or Disagree Before the Use or Release

Disclosure of your PHI to family members, other relatives and your close personal friends without your written consent or authorization is allowed if:

- The information is directly relevant to the family or friend's involvement with your care or payment for that care, and
- You have either agreed to the disclosure or have been given an opportunity to object and have not objected.

Under this Plan your PHI will automatically be disclosed to your employer's benefits office as outlined below. If you disagree with this automatic disclosure by the Plan you may contact the Privacy Officer to request that such disclosure not occur without your written authorization:

- In the event of your death while you are covered by this Plan, when the Plan is notified it will automatically communicate this information to your employer's benefits office.
- In the event the Plan is notified of a work-related illness or injury, the Plan will automatically communicate this information to your employer's benefits office to allow the processing of appropriate paperwork.

Note that PHI obtained by the Plan Sponsor's employees through Plan administration activities will NOT be used for employment related decisions.

Your Personal Representatives

You may exercise your rights to your Protected Health Information (PHI) by designating a person to act as your Personal Representative. Your Personal Representative will generally be required to produce evidence (proof) of the authority to act on your behalf **before** the Personal Representative will be given access to your PHI or be allowed to take any action for you.

Under this Plan, proof of such authority will include (1) a completed, signed and approved Appoint a Personal Representative form; (2) a notarized power of attorney for health care purposes; (3) a court-appointed conservator or guardian; or, (4) for a Spouse under this Plan, the absence of a Revoke a Personal Representative form on file with the Privacy Officer. Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:

(1) You have been, or may be, subjected to domestic violence, abuse or neglect by such person;
(2) Treating such person as your personal representative could endanger you; or
(3) In the exercise of professional judgment, we believe it is not in your best interest to treat the person as your personal representative.

This Plan WILL AUTOMATICALLY recognize your legal Spouse as your Personal Representative and vice versa, without you having to complete a form to Appoint a Personal Representative. However, you may request that the Plan not automatically honor your legal Spouse as your Personal Representative by completing a form to Revoke a Personal Representative (copy attached to this notice or also available from the Privacy Officer).

If you wish to revoke your Spouse as your Personal Representative, please complete the Revoke a Personal Representative form (attached or available from the Privacy Officer) and return it to the Privacy Officer and this will mean that this Plan will NOT automatically recognize your Spouse as your Personal Representative and vice versa.

Because HIPAA regulations give adults certain rights and generally children age 18 and older are adults, if you have dependent children age 18 and older covered under the Plan, and the child wants you, as the parent(s), to be able to access their Protected Health Information (PHI), that child will need to complete a form to Appoint a Personal Representative to designate you (the employee/retiree) and/or your Spouse as their Personal Representatives.

The Plan will consider a parent, guardian, or other person acting *in loco parentis* as the Personal Representative of an unemancipated minor (a child generally under age 18) unless the applicable law requires otherwise. *In loco parentis* may be further defined by State law, but in general it refers to a person who has been treated as a parent by the child and who has formed a meaningful parental relationship with the child for a substantial period of time. Spouses and unemancipated minors may, however, request that the Plan restrict PHI that goes to family members as described above under the section titled "Your Individual Privacy Rights."

Statement of Your Individual Privacy Rights

1. **Right to Request Restrictions.** You have the right to request restrictions on certain uses and disclosures of your protected health information. The Plan is not required to agree to the restrictions that you request. If you would like to make a request for restrictions, you must submit your request in writing to NMPSIA's Administrative Office, 410 Old Taos Highway, Santa Fe, NM 87501.

2. **Right to Request Confidential Communications.** You have the right to receive your protected health information through a reasonable alternative means or at an alternative location. (such as mailing PHI to a different address or allowing you to personally pick up the PHI that would otherwise be mailed), if you provide a written request to the Plan that the disclosure of PHI to your usual location could endanger you. To request confidential communications, you must submit your request in writing to NMPSIA's Administrative Office, 410 Old Taos Highway, Santa Fe, NM 87501. We are not required to agree to your request.

3. **Right to Inspect and Copy.** You have the right to inspect and obtain a copy (in hard copy or electronic form) of your protected health information (except psychotherapy notes and information compiled in reasonable contemplation of an administrative action or proceeding) contained in a "designated record set," for as long as the Plan maintains the PHI. You may request your hard copy or electronic information in a format that is convenient for you, and the Plan will honor that request to the extent possible. You may also request a summary of your PHI.

   A **Designated Record Set** includes your medical records and billing records that are maintained by or for a covered health care provider. Records include enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan or other information used in whole or in part by or for the covered entity to make decisions about you. Information used for quality control or peer review analyses and not used to make decisions about you is not included in the designated record set.

   The Plan must provide the requested information within 30 days of its receipt of the request, if the information is maintained onsite or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline and notifies you in writing in advance of the reasons for the delay and the date by which the Plan will provide the requested information.

   To inspect and copy such information, you or your personal representative must submit your request in writing to NMPSIA's Administrative Office, 410 Old Taos Highway, Santa Fe, NM 87501. If you request a copy of the information, we may charge you a reasonable cost-based fee. You may request your hard copy or electronic information in a format that is convenient for you, and we will honor that request to the extent possible. You may also request a summary of your PHI.

4. **Right to Request Amendment.** You or your personal representative have a right to request that the Plan amend your health information that you believe is incorrect or incomplete. We are not required to change your health information and if your request is denied, we will provide you with information about our denial and how you can disagree with the denial. To request an amendment, you must make your request in writing to NMPSIA's Administrative Office, 410 Old Taos Highway, Santa Fe, NM 87501. You must also provide a reason for your request.

5. **Right to Accounting of Disclosures.** You have the right to receive a list or "accounting of disclosures" of your health information made by us, except that we do not have to account for disclosures made for purposes of

payment functions or health care operations, or made to you. To request this accounting of disclosures, you must submit your request in writing to NMPSIA's Administrative Office, 410 Old Taos Highway, Santa Fe, NM 87501. Your request should specify a time period of up to six years and may not include dates before April 14, 2003. The Plan has 60 days after its receipt of your request to provide the accounting. The Plan is allowed an additional 30 days if the Plan gives you a written statement of the reasons for the delay and the date by which the accounting will be provided. The Plan will provide one list per 12 month period free of charge; we may charge you for additional lists.

6. **Right to Paper or Electronic Copy.** You have a right to receive a paper or electronic copy of this Notice of Privacy Practices at any time. To obtain a paper copy of this Notice, send your written request to NMPSIA's Administrative Office, 410 Old Taos Highway, Santa Fe, NM 87501. This right applies even if you have agreed to receive the Notice electronically.

7. **Right to be Notified of a Breach.** You have the right to receive notification in the event that we (or a Business Associate) discover a breach of unsecured protected health information. Notice of a breach will be provided to you within 60 days of the breach being identified.

8. **Right to Choose Someone to Act for You.** You have the right to appoint a personal representative to act on your behalf with respect to your protected health information, such as if you have given someone medical power of attorney or if someone is your legal guardian.

   To appoint a personal representative to act on your behalf, you must make your request in writing to NMPSIA's Administrative Office, 410 Old Taos Highway, Santa Fe, NM 87501. Your request must specify who the individual is that you are appointing, that individual's contact information, and in which matters the appointed individual may act on your behalf.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact NMPSIA's Administrative Office, 410 Old Taos Highway, Santa Fe, NM 87501, or by telephone at 1-(800) 548-3724.

Changes to this Notice of Privacy Practices

The Plan reserves the right to amend this Notice of Privacy Practices at any time in the future and to make the new Notice provisions effective for all health information that it maintains. We will promptly revise our Notice and distribute it to you whenever we make material changes to the Notice. Until such time, the Plan is required by law to comply with the current version of this Notice.

Your Right to File a Complaint

If you believe that your privacy rights have been violated, you may file a complaint with the Plan in care of the Plan's Privacy Officer, at the address listed on the first page of this Notice. Neither your employer nor the Plan will retaliate against you for filing a complaint.

Complaints about this Notice of Privacy Practices or about how we handle your health information should be directed to NMPSIA's Administrative Office, 410 Old Taos Highway, Santa Fe, NM 87501. Neither NMPSIA nor the Plan will retaliate against you in any way for filing a complaint. All complaints to NMPSIA must be submitted in writing.

You may also file a complaint (within 180 days of the date you know or should have known about an act or omission) with the Secretary of the U.S. Department of Health and Human Services by contacting their nearest office as listed in your telephone directory or at this website (http://www.hhs.gov/ocr/office/about/rgn-hqaddresses.html) or this website: http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html.

Privacy Officer

NMPSIA has designated a Privacy Officer to oversee the administration of privacy by the Plan and to receive complaints. The Privacy Officer may be contacted at:

Privacy Officer
NMPSIA Administrative Office
410 Old Taos Highway
Santa Fe, NM 87501

Effective Date of This Notice: July 1, 2018.

Attached (form to Revoke a Personal Representative)

NEW MEXICO PUBLIC SCHOOLS INSURANCE AUTHORITY (NMPSIA)

Form to Revoke a Personal Representative

Complete the following chart to indicate the name of the Personal Representative to be revoked:

	Plan Participant	Person to be Revoked as my Personal Representative
Name (print):		
Address (*City, State, Zip*):		
Phone:	( )	( )

I, _____ (*Name of Participant or Beneficiary)* hereby revoke the authority of _____ (*Name of Personal Representative)*

□ to act on my behalf,

□ to act on behalf of my dependent child(ren), named:

_____,

in receiving any protected health information (PHI) that is (or would be) provided to a personal representative, including any individual rights regarding PHI under HIPAA, effective _____, 20____.

I understand that PHI has or may already have been disclosed to the above named Personal Representative prior to the effective date of this form.

_____ _____

Participant or Beneficiary's Signature Date

Once completed, please return this form to the:
Privacy Officer for New Mexico Public School Insurance Authority (NMPSIA)
410 Old Taos Highway Santa Fe, NM 87501
Phone: 1-800-548-3724

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, 2018. Contact your State for more information on eligibility –

ALABAMA - Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	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: http://www.indianamedicaid.com Phone 1-800-403-0864

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	IOWA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/ime/members/medicaid-a-to- z/hipp Phone: 1-888-346-9562
KANSAS – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: https://www.dhhs.nh.gov/ombp/nhhpp/ Phone: 603-271-5218 Hotline: NH Medicaid Service Center at 1-888-901- 4999
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	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
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshe alth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://mn.gov/dhs/people-we- serve/seniors/health-care/health-care- programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: https://www.dss.mo.gov/mhd/participants/pages/hipp. htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075

MONTANA – Medicaid	PENNSYLVANIA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HI PP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.ht m Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: https://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS - Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH - Medicaid	**WISCONSIN – Medicaid**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT - Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	**WYOMING – Medicaid**
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since **January 31, 2018**, 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)
2323, Menu Option 4, Ext. 61565

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
Error! Hyperlink reference not valid.1-877-267-

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 12/31/2019)

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New Mexico Public Schools Insurance Authority

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