New Mexico Public Schools Insurance Authority

NMPSIA Wellness

EMPLOYEE HEALTH & WELL-BEING BENEFITS PROGRAM GUIDE

July 2022

IMPORTANT PHONE NUMBERS

Carriers & Consultants			
NEW MEXICO PUBLIC SCHOOLS INSURANCE AUTHORITY			
New Mexico Public Schools Insurance Authority	Customer Service for Administrative Issues • Claim Issues • Appeals	1-800-548-3724	https://nmpsia.com
NMPSIA ELIGIBILITY ADMINISTRATION OFFICE			
EASI Erisa Administrative Services, Inc.	**Erisa Administrative Services, Inc.** Eligibility•Enrollment•Premium Billing•COBRA Administration	1-800-233-3164	https://nmpsiaonline.nmpsia.com/
MEDICAL			
Carrier	**Group Number**	**Customer Service**	**Website Address**
BlueCross BlueShield of New Mexico	N05501 – High N05502 – Low 213895 – EPO	1.888.966.7742	https://www.bcbsnm.com/nmpsia
Video Visits: mdlive.com! NMPSIA (or visit bcbsnm.com; log in as a member to locate the link)			
Cigna	3343552	1.800.244.6224	https://connections.cigna.com/newmexico/
Video Visits: visit myCigna.com for an appointment via MDLIVE			
PRESBYTERIAN Health Plan, Inc.	A0000035	1.888.275.7737	https://www.phs.org/health-plans/employer-plans/Pages/new-mexico-public-schools-insurance-authority.aspx
Video Visits: visit phs.org and click on "Login to MyPres" to locate link			
PRESCRIPTION DRUGS			
CVS caremark	Rx BIN 04336	1.877.787.0652	https://www.caremark.com/
DENTAL			
DELTA DENTAL	8564	1.877.395.9420	https://www.deltadentalnm.com/
UNITED CONCORDIA® DENTAL Protecting More Than Just Your Smile®	812022 (refer to ID card for subgroup #)	1.888.898.0370	https://www.unitedconcordia.com/home
VISION			
VersantHealth bringing you DavisVision	7129	1.800.999.5431	https://www.davisvision.com/member
LIFE AND DISABILITY			
TheStandard	645549	1.888.609.9763 Ext. 0957	https://nmpsia.com/TheStandard.html

New Mexico Public Schools Insurance Authority

Table of Contents

New Mexico Public Schools Insurance Authority
2022-2023 Letter from NMPSIA

Greetings from NMPSIA,

The New Mexico Public Schools Insurance Authority (NMPSIA) was created by the New Mexico Legislature in 1986 to serve as a purchasing agency for public school districts, post-secondary educational entities, and charter schools. Through NMPSIA, member schools are afforded the opportunity to offer comprehensive medical, pharmacy, dental, vision, life and disability benefit coverages to approximately 39,800 employees and 75,700 total members.

NMPSIA continues to offer High and Low Option medical plans, administered through BlueCross BlueShield of New Mexico, Cigna Health, and Presbyterian Health Plan. The Low Option medical plans offer a lower monthly premium but will include a higher deductible and require higher out-of-pocket expenses for services. *This Low Option plan may work well for individuals with minimal health care needs.* The Exclusive Provider Organization (EPO) plan offered only through BlueCross BlueShield of New Mexico will continue to be offered at a lower deductible and lower out-of-pocket costs in comparison to the High and Low Option plans. *The network for the EPO plan is very limited, please be sure to review the contracted providers in your area of the state before seeking services*.

NMPSIA offers prescription drug coverage through CVS Caremark when enrolled in one of our medical plans, High and Low Option dental plans through Delta Dental and United Concordia Dental, a Premier vision plan through Davis Vision, and Life and Disability plans through The Standard.

Also offered is a robust wellness program that includes opportunities for no-cost digital health management programs and personalized nutrition coaching with a health care professional. No matter what your health goal or condition, there is a benefits and wellness program designed to meet your needs. Please visit https://nmpsia.com/wellnessWellBeing.html for detailed information.

NMPSIA encourages members to be knowledgeable on benefit options and selected plans.

> *Schedule free in-network annual preventative care such as routine physical exams, tests like colonoscopy and mammogram, health education counseling, family planning, immunizations, well-childcare, routine vision and hearing screenings. Utilize carrier-specific virtual visit sites, obtain prior authorizations for non-routine tests and procedures prior to scheduling the appointment, know your specific plan's deductible, co-pays, and co-insurance. Remember, virtual visits through your primary care (PCP) or specialist preferred provider will be billed at the office visit co-pay. Schedule annual preventative dental services and affordable eye exam with in-network providers.*
>
> *Work with your provider(s) to plan for cost-effective care, treatment and medications. Ask your provider about prior authorizations for treatment and prior approvals for certain medications. Share the quarterly medication formulary updates with providers before filling prescriptions. Ask your provider if there is a generic alternative to a brand-named drug as generics are less expensive.*

To assist you in deciding the benefits that meet your health and wellness needs, we strongly encourage you to carefully read all information in this guide and visit each carrier's website. A side-by-side medical plan comparison chart is also available at https://nmpsia.com/.

Always visit your employer's benefit office first for guidance on enrolling, disenrolling, or making changes to your coverages timely within 31 days of a life event including updating address, phone, and email information by completing a NMPSIA Change Card.

Thank you for participating in NMPSIA's benefits.

Sincerely,
NMPSIA Benefits Team

Participating Employers

NMPSIA Participating Employers	Basic Life	Medical Plan Choices	Dental	Vision	Disability Plan	Add. Life
ACADEMY FOR TECHNOLOGY AND THE CLASSICS	$25,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
ACE LEADERSHIP HIGH SCHOOL	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	60 days	YES
ACES TECHNICAL CHARTER SCHOOL	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
AFT NEW MEXICO	$10,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	N/A
ALAMOGORDO PUBLIC SCHOOLS	$25,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	90 days	YES
ALBUQUERQUE BILINGUAL ACADEMY	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
ALBUQUERQUE CHARTER ACADEMY	$10,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	N/A	YES
ALBUQUERQUE COLLEGIATE CHARTER SCHOOL	$25,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	60 days	YES
ALBUQUERQUE INSTITUTE FOR MATH & SCIENCE	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	90 days	YES
ALBUQUERQUE SCHOOL OF EXCELLENCE	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
ALBUQUERQUE SIGN LANGUAGE ACADEMY	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	60 days	YES
ALBUQUERQUE TALENT DEVELOPMENT	$25,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
ALDO LEOPOLD CHARTER SCHOOL	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	60 days	YES
ALICE KING COMMUNITY SCHOOL	$25,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
ALMA D ARTE CHARTER HIGH SCHOOL	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
ALTURA PREPARATORY SCHOOL	$25,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	60 days	YES
AMY BIEHL CHARTER HIGH SCHOOL	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	60 days	YES
ANANSI CHARTER SCHOOL	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
ANIMAS PUBLIC SCHOOLS	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
ARTESIA PUBLIC SCHOOLS	$25,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	N/A	N/A	YES
AZTEC MUNICIPAL SCHOOLS	$25,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	90 days	YES
BELEN CONSOLIDATED SCHOOLS	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	N/A	YES
BERNALILLO PUBLIC SCHOOLS	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
BLOOMFIELD MUNICIPAL SCHOOLS	$25,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	N/A	YES
CAPITAN MUNICIPAL SCHOOLS	$10,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	N/A	YES
CARLSBAD MUNICIPAL SCHOOLS	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	N/A	N/A	30 days	YES
CARRIZOZO MUNICIPAL SCHOOLS	$10,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	N/A	YES
CENTRAL CONSOLIDATED SCHOOL DISTRICT	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
CESAR CHAVEZ COMMUNITY SCHOOL	$25,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
CHAMA VALLEY INDEPENDENT SCHOOLS	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	90 days	YES
CHRISTINE DUNCAN'S HERITAGE ACADEMY	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
CIEN AGUAS INTERNATIONAL SCHOOL	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
CIMARRON MUNICIPAL SCHOOLS	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	60 days	YES
CLAYTON MUNICIPAL SCHOOLS	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
CLOUDCROFT MUNICIPAL SCHOOLS	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	N/A	YES
CLOVIS MUNICIPAL SCHOOLS	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	N/A	N/A	30 days	YES
COBRE CONSOLIDATED SCHOOLS	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
COOPERATIVE EDUCATIONAL SERVICES	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	N/A	YES
CORAL COMMUNITY CHARTER SCHOOL	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	60 days	YES
CORONA PUBLIC SCHOOLS	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	60 days	N/A
CORRALES INTERNATIONAL SCHOOL	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	60 days	YES
COTTONWOOD CLASSICAL PREPARATORY SCHOOL	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
COTTONWOOD VALLEY CHARTER SCHOOL	$25,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
CUBA INDEPENDENT SCHOOLS	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
DEMING CESAR CHAVEZ CHARTER HIGH SCHOOL	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	60 days	YES
DEMING PUBLIC SCHOOLS	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	N/A	60 days	YES
DES MOINES MUNICIPAL SCHOOLS	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	N/A	YES
DEXTER CONSOLIDATED SCHOOLS	$25,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	N/A	YES
DIGITAL ARTS AND TECHNOLOGY ACADEMY	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
DORA CONSOLIDATED SCHOOLS	$25,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	N/A	YES
DREAM DINE' CHARTER SCHOOL	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
DULCE INDEPENDENT SCHOOLS	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
DZIL DITL'OOÍ SCHOOL OF EMPOWERMENT, ACTION & PERSEVERANCE	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	90 days	YES
EAST MOUNTAIN HIGH SCHOOL	$10,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	N/A	YES
EL CAMINO REAL ACADEMY	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	60 days	YES
ELIDA MUNICIPAL SCHOOLS	$25,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	N/A	YES

Participating Employers

NMPSIA Participating Employers	Basic Life	Medical Plan Choices	Dental	Vision	Disability Plan	Add. Life
ENMU - PORTALES	$25,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	60 days	YES
ENMU - ROSWELL	$25,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	60 days	YES
ESPANOLA PUBLIC SCHOOLS	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
ESTANCIA MUNICIPAL SCHOOLS	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	N/A	YES
ESTANCIA VALLEY CLASSICAL ACADEMY	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
EUNICE MUNICIPAL SCHOOLS	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
EXPLORE ACADEMY	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
EXPLORE ACADEMY - LAS CRUCES	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
FARMINGTON MUNICIPAL SCHOOLS	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	N/A	N/A
FLOYD MUNICIPAL SCHOOLS	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
FORT SUMNER MUNICIPAL SCHOOLS	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
GADSDEN INDEPENDENT SCHOOLS	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
GALLUP-MCKINLEY COUNTY SCHOOLS	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	N/A	YES
GILBERT L. SENA CHARTER HIGH SCHOOL	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	90 days	YES
GORDON BERNELL CHARTER SCHOOL	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
GRADY MUNICIPAL SCHOOLS	$25,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	60 days	YES
GRANTS/CIBOLA COUNTY SCHOOLS	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
HAGERMAN MUNICIPAL SCHOOLS	$25,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
HATCH VALLEY PUBLIC SCHOOLS	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
HEALTH LEADERSHIP HIGH SCHOOL	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	60 days	YES
HOBBS MUNICIPAL SCHOOLS	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	N/A	YES
HONDO VALLEY PUBLIC SCHOOLS	$10,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	N/A	YES
HORIZON ACADEMY WEST	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	60 days	YES
HOUSE MUNICIPAL SCHOOLS	$25,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	N/A	YES
HÓZHÓ ACADEMY	$25,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	60 days	YES
J. PAUL TAYLOR ACADEMY	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
JAL PUBLIC SCHOOLS	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
JEFFERSON MONTESSORI ACADEMY	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
JEMEZ MOUNTAIN PUBLIC SCHOOLS	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
JEMEZ VALLEY PUBLIC SCHOOLS	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
LA ACADEMIA DE ESPERANZA	$25,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	60 days	YES
LA ACADEMIA DOLORES HUERTA	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
LA TIERRA MONTESSORI SCHOOL OF THE ARTS AND SCIENCES	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
LAKE ARTHUR MUNICIPAL SCHOOLS	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
LAS CRUCES PUBLIC SCHOOLS	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
LAS MONTANAS CHARTER HIGH SCHOOL	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
LAS VEGAS CITY SCHOOLS	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
LEA REGIONAL EDUCATIONAL # 7	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	N/A	YES
LOGAN MUNICIPAL SCHOOLS	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
LORDSBURG MUNICIPAL SCHOOLS	$25,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	N/A	YES
LOS ALAMOS PUBLIC SCHOOLS	$25,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	90 days	YES
LOS ALAMOS SCHOOLS CREDIT UNION	$10,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
LOS LUNAS SCHOOLS	$25,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	N/A	30 days	YES
LOS PUENTES CHARTER SCHOOL	$25,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
LOVING MUNICIPAL SCHOOLS	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	N/A	YES
LOVINGTON MUNICIPAL SCHOOL DISTRICT	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	60 days	YES
LUNA COMMUNITY COLLEGE	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
MAGDALENA MUNICIPAL SCHOOLS	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	90 days	YES
MARK ARMIJO ACADEMY	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	90 days	YES
MAXWELL MUNICIPAL SCHOOLS	$25,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
MCCURDY CHARTER SCHOOL	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
MEDIA ARTS COLLABORATIVE CHARTER SCHOOL	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
MELROSE MUNICIPAL SCHOOLS	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	N/A	YES
MESA VISTA CONSOLIDATED SCHOOLS	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
MESALANDS COMMUNITY COLLEGE	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
MIDDLE COLLEGE HIGH SCHOOL	$25,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	N/A	YES

Participating Employers

NMPSIA Participating Employers	Basic Life	Medical Plan Choices	Dental	Vision	Disability Plan	Add. Life
MISSION ACHIEVEMENT AND SUCCESS CHARTER SCHOOL	$25,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	60 days	YES
MONTE DEL SOL CHARTER SCHOOL	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
MONTESSORI OF THE RIO GRANDE CHARTER SCHOOL	$25,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
MORA INDEPENDENT SCHOOL DISTRICT	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	60 days	YES
MORENO VALLEY HIGH SCHOOL	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
MORIARTY-EDGEWOOD SCHOOL DISTRICT	$25,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	60 days	YES
MOSAIC ACADEMY	$25,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
MOSQUERO MUNICIPAL SCHOOLS	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
MOUNTAIN MAHOGANY COMMUNITY SCHOOL	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	90 days	YES
MOUNTAINAIR PUBLIC SCHOOLS	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	N/A	YES
NATIVE AMERICAN COMMUNITY ACADEMY	$10,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
NEA	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	60 days	YES
NEW MEXICO ASSOCIATION OF SCHOOL BUSINESS OFFICIALS	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
NEW MEXICO CONNECTIONS ACADEMY	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
NEW MEXICO INTERNATIONAL SCHOOL	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
NEW MEXICO JUNIOR COLLEGE	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	90 days	YES
NEW MEXICO SCHOOL FOR THE ARTS	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
NEW MEXICO TECH	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	90 days	YES
NEW MEXICO TECH RETIREES	N/A	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	N/A	YES
NM ACTIVITIES ASSOCIATION	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
NM COALITION OF EDUCATIONAL LEADERS	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
NM SCHOOL BOARD ASSOCIATION	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
NM SCHOOL FOR THE DEAF	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
NMPSIA	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
NORTH VALLEY ACADEMY	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	60 days	YES
NORTHERN NEW MEXICO COLLEGE	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	N/A	YES
PECOS CYBER ACADEMY	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
PECOS INDEPENDENT SCHOOL DISTRICT	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
PECOS VALLEY REC #8	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
PENASCO INDEPENDENT SCHOOL DISTRICT	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
POJOAQUE VALLEY SCHOOL DISTRICT	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
PORTALES MUNICIPAL SCHOOLS	$25,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	N/A	YES
PUBLIC ACADEMY FOR PERFORMING ARTS	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	60 days	YES
PUBLIC CHARTER SCHOOLS OF NEW MEXICO	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
QUAY SCHOOLS FEDERAL CREDIT UNION	$25,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	N/A	YES
QUEMADO INDEPENDENT SCHOOLS	$25,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	N/A	YES
QUESTA INDEPENDENT SCHOOL DISTRICT	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
RAICES DEL SABER XINACHTLI COMMUNITY SCHOOL	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	90 days	YES
RATON PUBLIC SCHOOLS	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	N/A	YES
REC #2	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
RED RIVER VALLEY CHARTER SCHOOL	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	N/A	N/A
REGIONAL EDUCATIONAL CENTER #6	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
RESERVE INDEPENDENT SCHOOLS	$25,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
RIO GALLINAS SCHOOL FOR ECOLOGY AND THE ARTS	$25,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
RIO GRANDE ACADEMY OF FINE ARTS	$25,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	60 days	YES
RIO RANCHO PUBLIC SCHOOLS	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
ROBERT F. KENNEDY CHARTER SCHOOL	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
ROOTS AND WINGS COMMUNITY SCHOOL	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
ROSWELL INDEPENDENT SCHOOL DISTRICT	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
ROY MUNICIPAL SCHOOLS	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
RUIDOSO MUNICIPAL SCHOOLS	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	N/A	YES
SAN DIEGO RIVERSIDE CHARTER SCHOOL	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
SAN JON MUNICIPAL SCHOOLS	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
SANDOVAL ACADEMY OF BILINGUAL EDUCATION	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
SANTA FE COMMUNITY COLLEGE	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	90 days	YES
SANTA FE PUBLIC SCHOOLS	$25,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES

Participating Employers

NMPSIA Participating Employers	Basic Life	Medical Plan Choices	Dental	Vision	Disability Plan	Add. Life
SANTA ROSA CONSOLIDATED SCHOOLS	$25,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
SCHOOL OF DREAMS ACADEMY	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
SIDNEY GUTIERREZ MIDDLE SCHOOL	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
SIEMBRA LEADERSHIP HIGH SCHOOL	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	60 days	YES
SILVER CONSOLIDATED SCHOOLS	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	60 days	YES
SIX DIRECTIONS INDIGENOUS SCHOOL	$25,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
SOCORRO CONSOLIDATED SCHOOLS	$25,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	N/A	YES
SOLARE COLLEGIATE CHARTER SCHOOL	$25,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	60 days	YES
SOUTH VALLEY ACADEMY	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	N/A	N/A
SOUTH VALLEY PREPARATORY SCHOOL	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
SOUTHWEST AERONAUTICS, MATHEMATICS & SCIENCE ACADEMY	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
SOUTHWEST PREPARATORY LEARNING CENTER	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
SOUTHWEST SECONDARY LEARNING CENTER	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
SPRINGER MUNICIPAL SCHOOLS	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
TAOS ACADEMY	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	60 days	YES
TAOS CHARTER SCHOOL	$10,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	N/A	N/A
TAOS INTEGRATED SCHOOL OF THE ARTS	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
TAOS INTERNATIONAL SCHOOL	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
TAOS MUNICIPAL SCHOOLS	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
TATUM MUNICIPAL SCHOOLS	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
TECHNOLOGY LEADERSHIP HIGH SCHOOL	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	60 days	YES
TEXICO MUNICIPAL SCHOOLS	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	N/A	YES
THE ASK ACADEMY	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
THE GREAT ACADEMY	$25,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
THE INTERNATIONAL SCHOOL	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
THE MASTERS PROGRAM	$25,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
THE MONTESSORI ELEMENTARY & MIDDLE SCHOOL	$10,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	N/A	YES
THE NEW AMERICA SCHOOL - LAS CRUCES	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
THE NEW AMERICA SCHOOL NEW MEXICO	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
THRIVE COMMUNITY SCHOOL	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	90 days	YES
TIERRA ADENTRO OF NEW MEXICO	$25,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
TIERRA ENCANTADA CHARTER HIGH SCHOOL	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	90 days	YES
TRUTH OR CONSEQUENCES MUNICIPAL SCHOOLS	$25,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	N/A	YES
TUCUMCARI PUBLIC SCHOOLS	$25,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
TULAROSA MUNICIPAL SCHOOL DISTRICT	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
TURQUOISE TRAIL CHARTER SCHOOLS	$25,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
TWENTY FIRST CENTURY PUBLIC ACADEMY	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	60 days	YES
VAUGHN MUNICIPAL SCHOOLS	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
VISTA GRANDE CHARTER HIGH SCHOOL	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
VOZ COLLEGIATE	$25,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	60 days	YES
WAGON MOUND PUBLIC SCHOOLS	$25,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	N/A	YES
WALATOWA HIGH CHARTER SCHOOL	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	90 days	YES
WEST LAS VEGAS SCHOOL DISTRICT	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
WESTERN NM UNIVERSITY	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
WILLIAM W. AND JOSEPHINE DORN COMMUNITY CHARTER SCHOOL	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
ZUNI PUBLIC SCHOOLS	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	90 days	YES

Enrollment and Eligibility Guidelines

This guide gives you an overview to help you understand your eligibility requirements, enrollment guidelines, and qualifying events for enrolling in benefit coverages and wellness programs.

The following pages include a summary of the benefits and wellness programs offered for medical, prescription, dental, vision, disability, and life options. Through its benefits and wellness programs, NMPSIA offers options to select health coverages with delivery systems to support your healthcare needs while managing your health, healthcare costs and stabilizing NMPSIA's self-funded claims.

Wellness programs such as annual preventative visits, video/virtual provider visits, routine screenings, health coaching, mindfulness programs, behavioral health, weight and chronic disease management programs, personal health assessments, and many other opportunities are at no-cost to enrolled members.

Benefit Enrollment Guidelines

You are Eligible for Benefits if:

- Your employer has informed you that you are eligible for benefits.
- You are active at work on the day coverage is scheduled to start.
- You work the minimum qualifying number of hours established by your employer.

NMPSIA Requirements:

- You must work 15 hours or more per week to receive basic life insurance.
- You must work 20 hours or more per week to enroll in all other lines of coverage.

  Note: If you work fewer than 20 hours per week, but at least 15 hours per week, you may be eligible to participate if your employer has adopted an annual part-time employee resolution and has been approved by the NMPSIA Board of Directors.
- You are a one-bus owner operator, designated as a *bus employee*.
- You are an international employee on a work visa in the U.S.
- You are a variable hour or seasonal employee (or substitute), as determined by your employer, eligible for medical coverage only, as stated in the Affordable Care Act guidelines.

Ineligible Employee

You are an employee of an independent contractor or fleet bus driver.

Benefits Enrollment Begin Here:

Automatic Basic Life Enrollment

Your employer will:

- Enroll you in the basic life benefit amount offered to you.
- Basic life coverage is effective the first day of the month following your hire date (first day you report to work).

Guidelines on How to Apply for Your Benefit Options:

Your employer will provide you with the benefit options available to you, or you can find this information by looking for your employer on pages 4-7.

You must provide a Social Security Number (SSN) or Individual Taxpayer Identification Number (ITIN).

- An international employee must also provide a copy of a passport or work visa.

  Note: If your SSN or ITIN has not been received by the time benefits are scheduled to start, a temporary ID number will be provided by the NMPSIA Benefits Administrator. *(Visit your benefits office for details.)*

Guidelines on How to Apply for Your Benefit Options:

You have **31 days** from your date of hire **to apply** for all other benefits offered by your employer.
You have **31 days** from the date of a qualifying event **to apply** for other benefits offered by your employer.
*(See **How to Report a Change of Status** section on page 14 for details.)*

To apply you must complete and sign all required forms and turn in the forms and any other required documents to your employer's benefits office or online on the NMPSIA online benefit system at https://nmpsiaonline.nmpsia.com if allowed by your employer).

- All other lines of coverage become effective the first day of the month following the day you apply.
- Effective date of coverage is determined by your employer based on payroll deductions authorized by you in writing.

Coverage will never be effective sooner than the first day of the month following your first day actively at work.

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

- You must wait until the annual open enrollment period in the fall to apply for Medical/Prescription Drug Coverage, Dental Coverage, Vision Coverage. Your coverage will become effective January 1st of the next year.
- You may apply for Long Term Disability Coverage (LTD) and/or Additional Life Coverage (ADL) at any time. Coverage is not guaranteed. Coverage is not offered during the annual open enrollment period.
  - You may apply for LTD or add/increase ADL coverage by providing satisfactory evidence of insurability for yourself. Coverage will become effective the first of the month following approval by the LTD and Life Carrier.

Once enrolled you may switch medical and dental carriers and/or medical and dental plans during the annual switch enrollment period in the fall, and coverage will start January 1st of the next year.

Coverage ends on the last day of the month that your employer deducts premium from your payroll check. This end date is set only by your employer and not by NMPSIA.

Active Eligible Board Member Enrollment Process:

You may qualify for benefits as a board member if you are actively serving as a *(publicly elected)* board member of a participating school district or participating college/university.

- You have **31 days** from being sworn into office **to apply** for benefits.
- You are eligible to enroll in benefit plans offered at the entity you represent (except for basic life and long-term disability coverage).
- Any additional life insurance amounts available are equal to the basic life insurance amount offered to active employees at the entity.
- You pay 100% of the premiums.
- Coverage ends on **December 31st** of the year in which your board member term expires.

Benefit Enrollment Guidelines for Eligible Dependents:

Dependents must meet one of the following definitions of eligible dependent, and you must provide all required documentation to prove your dependent's eligibility. When enrolling dependents, coverage may not be greater than that of the employee.

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 offered by the Employer)*	Notarized affidavit of domestic partnership
Child UNDER the age of 26 as follows: **Natural** Child or Stepchild.	Original official state publicly filed birth certificate from the Bureau of Vital Statistics *(hospital birth registration form is also acceptable).* For children of international employees, also provide a copy of a passport or U.S. visa.
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 who 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 documents, kinship or conservatorship documents are not acceptable).** NMPSIA Statute 6.50.1.7.P.3.e NMAC
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 **impaired and relies completely on the eligible employee** for maintenance and support, who is incapable of self-sustaining employment because of mental or physical impairment.	Evidence of impairment and dependency in the form of a physician statement indicating diagnosis and prognosis along with your request to continue this child's coverage **must be provided to your employer 31 days before the child reaches age 26** or within **31 days** from the date the child becomes impaired **while covered under the NMPSIA Group Plan.**
**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.*	*Final determination is made **by the insurance carrier. For Dental and Vison only enrollees or Cigna members the final determination is made by NMPSIA.***

Your Dependent is Ineligible for Benefits if they are:

- Ex-spouses *(Even if specified in a final divorce decree)* or terminated domestic partners.
- Common Law relationships which are not recognized by New Mexico Law.
- Dependents that are in active military service.
- Children that are age 26 or older.
- 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 an eligible dependent under the NMPSIA Rules or **Benefit Enrollment Guidelines for Eligible Dependents** on page 10.
- Domestic partners unless your employer has elected this option.

Guidelines on How to Apply for Your Dependent's Benefit Options:

You have **31 days** from your date of hire to apply for eligible dependent benefits offered by your employer.
You have **31 days** from the date of a qualifying event to apply for eligible dependent benefits offered by your employer. *(See **How to Report a Change of Status** section on page 14 for details.)*

Apply by completing, signing, and turning in the required form and any required documents to your employer's benefits office or via the NMPSIA online benefit system at https://nmpsiaonline.nmpsia.com *if allowed by your employer.*

- If you apply to enroll one eligible dependent, you **MUST enroll all eligible dependents** (NMPSIA Statute 6.50.10.8.C.8 NMAC), unless one of the following applies:
  1. The eligible dependent you are requesting to exclude from a particular line of NMPSIA coverage is covered for that particular line of coverage under another plan.
  2. Your enrollment meets the requirements of a Special Enrollment event for adding medical coverage only. *(See **Guidelines for a Special Enrollment Event** section on page 15 for details) or,*
  3. A final 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 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 coverage.)

Supportive documentation as determined by NMPSIA is required when #2 or #3 apply.

- You must provide an SSN or ITIN for **all enrolled dependents**.
  Note: For international dependents - if SSN or ITIN has not been received by the time benefits are scheduled to start, a temporary ID number will be provided by the NMPSIA Benefits Administrator. *(Visit your benefits office for details.)*
- A copy of the required dependent supportive documentation must accompany your form and be submitted to your employer's benefits office prior to coverage becoming effective.

You have **61 days** from the day your new hire coverage becomes effective to provide all required documents.
You have **61 days** from the date of a qualifying event to provide all required documents.
Coverage for your dependent(s) becomes effective the first day of the month following the day you turn in the required documents to your employer's benefits office, *(provided you have applied on time and met the **61-day** deadline for required documentation of the qualifying event).*

- Your dependent(s) benefits will never be effective any sooner than your effective date, with the exception of newborns and adopted children who are enrolled on time due to a qualifying event. *(See Effective Date Exception for Newborns and Adopted Children section on page 13 for details.)*

Guidelines on How to Apply for Your Dependent's Benefit Options: (continued)

If you miss the 31-day enrollment period to add eligible dependents, decline dependent coverage, or you did not meet the 61-day deadline to provide required dependent documents:

- You must wait until the annual open enrollment period in the fall to apply for dependent Medical/Prescription Drug Coverage, Dental Coverage, Vision Coverage. Dependent coverage will start January 1st of the next year.
- You may apply for Dependent Life coverage at any time, provided you are already covered on Additional Life. Dependent Life coverage for spouse is not guaranteed. Life Coverages are not offered during the annual open enrollment.
  - Your spouse may apply for Dependent Life coverage by providing satisfactory evidence of insurability (not required for children). Coverage will start the 1st of the month after approval by the Life Carrier.
- Your dependent's coverage ends on the last day of the month in which the eligible dependent becomes ineligible.

NMPSIA Wellness Did You Know?

NMPSIA's Wellness and Well-Being programs promote a culture of wellness, build supportive networks, and grow engagement and personal responsibility. Participation in wellness programs improves overall health, promotes well-being, prevents future diseases, and manages current conditions while balancing work and home.

Take Advantage of the No Cost Programs Listed Below

- 24/7 Nurse Advice Line & Virtual Health/Video Visits
- Behavioral Health Programs – $0 to member for in-network services
- Customized Wellness Plan
- $0 for diabetes supplies from Approved Formulary
- Health Coaching
- Incentive & Rewards Programs
- Mindfulness Based Stress Reduction Programs – online and group
- Monthly Communication & Topics
- Monthly Skill Builders
- Self-Directed Courses and Self-Help Tools
- Tobacco Cessation Programs
- Weight Management and Chronic Disease Programs
- Wellness Ambassador Program
- Health & Wellness Challenges

Effective Date Exceptions for Newborns and Adopted Children

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 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 you are enrolled in 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 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 family medical coverage, your newborn will **not** be automatically covered from date of birth.	If you are **not** enrolled in 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 newborn within **31 days from the newborn's date of birth.**	You must apply to enroll your child within **31 days from the date of adoption or date of placement** (whichever comes first).
If your newborn is enrolled timely, within 31 days from birth, **NMPSIA's newborn rule** allows your newborn's coverage to be effective on the date of birth.	If your adopted or placed child is enrolled timely, within 31 days from adoption or placement, **NMPSIA's adopted or placed child rule** allows your adopted or placed child's coverage to be effective on the date of adoption or placement.
A premium increase change will become effective the 1st of the month after the date of birth.	A premium increase change will become effective the 1st of the month after the date of adoption or date of placement
If you miss the 31 day enrollment period, your newborn will not be eligible for coverage until January 1 via application for open enrollment.	**If you miss the 31-day enrollment period, your child will not be eligible for coverage until January 1st via application for open enrollment.**

If you are **not enrolled in a NMPSIA medical plan**, the birth of your newborn, placement or adoption may qualify as a Special Enrollment event.
See **Special Enrollment Event for Medical Coverage Only** for details.

Working Well tip #1…Prevent future health risks. Schedule your no-cost in-network annual preventative care such as routine physical exams and tests, colonoscopy, and mammogram. Also available are health education counseling, family planning, immunizations, well-childcare, and routine vision, and hearing screenings. Schedule your no-cost annual preventative dental services and an affordable eye exam.

How to Report a Change of Status:

A change of status due to any qualifying event **MUST** be reported by completing, signing, and turning in a Change Card to your employer's benefits office within **31 days from the qualifying event, change of basic information or Special Enrollment event**.

You have **61 days** from the date of a qualifying event to provide your employer all required documents. Coverage becomes effective the first day of the month following the day you turn in the required documents to your employer's benefits office, ***(provided you have applied on time and met the 61-day deadline for required documentation of the qualifying event).***

While insured you may experience a Qualifying Event such as…

Birth
Marriage or Notarized Affidavit of Domestic Partnership
Adoption of a child or child placement order in anticipation of adoption
Incapacity of a child while covered under the NMPSIA Group Plan
Legal guardianship of a child
Promotion to a new job classification with a salary increase
Employment status change from a part-time to a full-time position with a salary increase.
Divorce, annulment, or termination of domestic partnership *(not a legal separation)*

- A spouse or any enrolled children cannot be canceled when a divorce is in progress.
- Immediate cancellation of an ex-spouse/partner and ineligible children is required by the last day of the month the divorce/partnership becomes final. (see INSURANCE FRAUD statement on page 16 for details.

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, dental, vision or life insurance due to:

- Reduction in hours worked
- Resignation, termination, or retirement from employment
- Divorce, annulment, or termination of domestic partnership
- No longer meet eligibility requirements for insurance
- Exhaustion of COBRA
- Death

Be advised: voluntary cancelling other coverage or non-compliance to maintain other coverage is not considered a qualifying event.

IMPORTANT: PROOF OF INVOLUNTARY LOSS REQUIRED

Verifiable proof of involuntary loss is required to be provided to your employer's benefits office. A loss of coverage letter MUST contain the following information: *(See your employer's benefits office for an example.)*

- Name and contact information of employer and/or entity who maintained the insurance coverage lost.
- Who lost coverage?
- What type of coverage was lost?
- What date coverage ended.
- Why coverage was lost.

Unacceptable forms of proof of loss of coverage include:

- Certificate of Creditable Coverage
- COBRA Qualifying Event Letter
- Divorce decree

Report Basic Information and Beneficiary Designation Changes:

- Timely report all changes of address, phone, and email.
- A name change requires valid proof in the form of a copy of Social Security card or driver's license.
- Beneficiary designations must be completed on a Schedule A-Beneficiary Assignment form signed, dated, and witnessed by your employer. Visit http://www.standard.com/eforms/17041.pdf for designation information.

Guidelines for a Special Enrollment Event for ADDING MEDICAL COVERAGE ONLY:

Special enrollment, mandated by state and federal law, allows eligible employees and/or eligible dependents who previously declined medical coverage, to enroll in medical coverage or switch medical plans within **31 days** from the occurrence of the following events:

1. Involuntary loss of eligibility or loss of employer contributions for other medical coverage. Some examples of loss of eligibility for other medical coverage:
   - Reduction in hours worked
   - Resignation, termination, or retirement from employment
   - Divorce, annulment, or termination of domestic partnership
   - No longer meet eligibility requirements for insurance
   - Exhaustion of COBRA
   - Death
2. Employees, spouses/domestic partners, and new dependents are allowed to enroll because of:
   - Marriage or Notarized Affidavit of Domestic Partnership
   - Birth, adoption, or placement for adoption
3. Employees or dependents suffer an involuntary loss of Medicaid or CHIP. **This event allows enrollment within 60 days of the involuntary loss of this particular coverage.** *(Proof of loss is required.)*

What Happens When You Are Late in Reporting a Change of Status?

NMPSIA requires timely reporting of enrollments, qualifying events, changes, and separation of employment along with any timely submission of required supportive documentation to your employer's benefits office. Not reporting timely may create consequences like:

- No retroactive effective or termination dates.
- Delayed effective dates.
- Delays or no access to benefit coverage.
- Waiting for the next open or switch enrollment for the following January 1st.
- Require satisfactory evidence of insurability for LTD or ADL coverage.
- Employer and/or NMPSIA will not refund premium.
- Not eligible for COBRA continuation.
- NMPSIA ineligible claim overpayments that are not eligible for collection by the insurance carrier, may be collected from the employee.

NMPSIA Wellness ***Working Well* tip #2….** Take advantage of the no-cost diabetes, blood pressure, diabetes prevention and weight management programs including digital devices and health coaching.

The NMPSIA Rules and Regulations found at https://nmpsia.com/ supersede any information contained in this summary document.

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, charter or other education entity.

If you have questions regarding NMPSIA eligibility, enrollment, or billing, contact your employer's benefits office or the NMPSIA eligibility administrative office at 1.800.233.3164.

Visit https://nmpsia.com/ to access valuable enrollment and benefits information and links to contact NMPSIA staff.

NMPSIA Wellness ***Working Well* means….**

1. Know your plan and covered benefits before scheduling your appointments and services.
2. Work with your provider(s) to plan for cost-effective care and treatment.
   a. Before procedures or filling your prescriptions, ask your provider about prior authorizations.
3. Take advantage of preventative care and no-cost health and wellness resources.
   a. Schedule your annual screenings and physicals. (No in-network copay by your medical plan.)
   b. Schedule your annual oral exams and cleanings on your dental plan. (Two cleanings allowed every calendar year and paid at 100% in-network.)
   c. Schedule your annual preventive eye examination on the vision plan. (An affordable $10 in-network copay.)

Through NMPSIA's benefits and wellness program, you will find the benefits and programs to help you…

- Lead a healthy and balanced life
- Eat well
- Be active
- Avoid unhealthy behaviors
- Embrace personal wholeness

NMPSIA Wellness ***Working Well* tip #3….** Take a mindful moment

- Take 5 Mindful Breaths, 5 Times a Day
- Wake up, take 5 breaths
- Before bed, take 5 breaths
- Add 5 breaths 3 additional times/day

Important Information for Successful Enrollment …

1. Enrollment starts with your employer's local policies defining a benefits-eligible employee.
2. Remember **31 days** to apply for employee and/or eligible dependent coverage.
   a. ***Apply means completing, signing, and turning in the required form to your employer's benefits office or via the online system at https://nmpsiaonline.nmpsia.com as allowed by your employer.***
3. Remember, **61 days** from the day your new hire coverage becomes effective and/or a change in status/qualifying event **to provide required supportive documentation.**
4. Open Enrollment to add medical, dental or vision insurance or add dependents occurs each fall for an effective date of January 1st. Open enrollment does not apply to LTD or ADL coverage.
5. Switch Enrollment **only** applies to switching medical and dental carriers and/or medical and dental plans. This enrollment occurs each fall for an effective date of January 1st.
6. Vision coverage has a two-year enrollment requirement; you may not drop the vision plan until **you and each of your enrolled dependents have been enrolled for two years.**
7. NMPSIA rules do not permit **double coverage** within the NMPSIA group plans. If you, your spouse, or your child work for a NMPSIA participating employer, you may NOT cover each other for the same lines of coverage.
8. Involuntary loss of medical, dental, vision or life coverage qualifying event **requires proof of loss** with: a) **Name and contact information** of employer and/or entity who maintained the insurance coverage lost; b) **Who** lost coverage; c) **What type** of coverage was lost; d) **What date** coverage ended; and e) **Why** coverage was lost
9. Involuntary **loss of Medicaid** is a loss of medical, dental and vision coverage. **Eligible employees have 60 days to provide proof of loss.**
10. Return to work Retiree requires enrollment in NMPSIA benefits as an active employee. Consult with NMRHCA at 1.800.233.2576 to ensure you are complying with NMRHCA rules.
11. NMPSIA enrollment while also **enrolled in Medicare**; **NMPSIA is the primary payer** and Medicare is secondary.
12. If you apply to enroll one eligible dependent, you **MUST enroll all eligible dependents**. *(See Guidelines to Apply for Your Dependents' Benefit Options section on page 11 for details.*
13. To exclude an eligible dependent from coverage, provide proof the eligible dependent you are excluding from a particular line of NMPSIA coverage **is covered** for that line of coverage **under another plan.**
14. If you have an eligible dependent that **does not live in the U.S.**, proof of other coverage is **not required**.
15. A newborn may be excluded from dental and vision enrollment.
16. If you have **ADL coverage**, a **child may be added** to child life at any time.
17. If you already have child life insurance coverage on one or more children and a new eligible dependent is added to medical, dental or vision insurance, the child will **automatically be added to child life insurance**.
18. Dropping NMPSIA coverage must be **approved by your employer** and reviewed for enrollment in an **IRS Section 125 Cafeteria Plan** and you must experience a valid IRS Qualifying Event.
19. Confirmation of enrollment will be mailed or emailed to you after a requested transaction. Review these notices carefully and **report any discrepancies to your employer's benefits office immediately**.
20. Continue NMPSIA medical, dental and vision insurance via **COBRA** if you have a reduction in hours per week worked, resign, retire, or terminate employment. Call **1.800.233.3164 for COBRA** assistance; for retirement contact **NMRHCA at 1.800.233.2576** for eligibility and enrollment information.
21. To continue life insurance: If disabled, apply for a waver of premium or convert to a private policy. If employment ends or if you retire, apply to port, or convert to a private policy. If retiring, continue any ADL with NMPSIA until age 65. If eligible, apply with NMRHCA life at 1.800.233.2576 and receive credit for any NMPSIA coverage lost if enrolling timely.
22. Contact your employer for payroll questions and when making changes to your benefit coverages.

BE A SMART CONSUMER: Cost-Effective Benefits and Access to Care

No-Cost Basic Life Insurance Coverage for the Employee

No-Cost Services Provided by all the Medical Plans

- 24/7 Nurseline: a toll-free number for covered members to access a registered nurse (RN) answering health questions or concerns to help you decide whether to make an appointment with a doctor, visit Urgent Care or Emergency Room.
- Email access to your providers by creating an online member account with your selected carrier to communicate with your care team, request medical advice, prescription renewals or schedule office or telephone visit.
- Telehealth video/online visits access available via your health plan's website for non-emergency medical and behavioral health needs.
- In-Network Provider Care for High Option, Low Option and EPO Option for:
    - 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 & therapeutic injections), Immunizations (including travel immunizations); Well-Child Care; Routine Vision or Hearing Screenings through age 17.

No-Cost Services Provided by the Prescription Drug Benefit

- Preventive Products under the Patient Protection & Affordable Care Act
- Diabetic supplies, Generic & preferred-brand insulin via retail or home delivery pharmacy
- Immunizations administered by certified pharmacists

No-Cost Services Provided by the Dental Plans

- In-Network Provider Care for High Option Routine/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)

Low-Cost Services Provided by the Vision Plan

- In-Network Provider Care
    - Eye Examination every 12 months, covered in full after a $10 copayment, Spectacle Lenses every 12 months for standard single-vision, lined bifocal, or trifocal lenses after a $15 copayment, Frames every 24 months with $0 or low-cost options, Contact Lenses in lieu of eyeglasses with $0 or low-cost options.

Accessing Wellness Resources and Opportunities

No-Cost Services Offered by all the Benefit Plans (visit https://nmpsia.com/)

- Behavioral Health and Mindfulness-Based Stress Reduction Programs
- Carrier Customized Web Portals for access to self-directed and self-help health, wellness tools and topics
- Chronic Condition Management for asthma, chronic obstructive pulmonary disease, congestive heart failure, coronary artery disease, depression, diabetes, low back pain
- Health Coaching and Consulting to create your own customized wellness plan
- Incentive and Reward Programs
- Lifestyle Management Programs for blood pressure, weight loss, diabetes, stress, asthma and more

New Mexico Public Schools Insurance Authority

Life, Accidental Death & Dismemberment

New Mexico Public Schools Insurance Authority knows that no two employees are alike. We all have different lifestyles, different family situations and different benefit needs. With this in mind, NMPSIA offers a variety of life benefit options to help you and your family achieve financial security. The advantages to you and your loved ones include:

- **Choice –** You select the coverage you need from the range of amounts and plans available
- **Savings –** Group insurance rates are typically more affordable than those for individual insurance plans, providing you with the same amount of coverage at a lower cost
- **Convenience –** Since premiums are deducted from your paycheck, you don't have to worry about remembering to mail in monthly payments
- **Peace of mind –** Take comfort and satisfaction in knowing you have done something positive for your family's future

Life and Accidental Death & Dismemberment Benefits at a Glance

For complete coverage details, visit https://nmpsia.com/TheStandard.html or call 888.609.9763, extension 0957.

Product	Coverage	Who pays the premium?
Basic Life and AD&D: Employee	Employer elects $10,000, $25,000 or $50,000	Employer pays 100%
Additional Life and AD&D: Employee[1]	1X, 2X or 3X base annual earnings to a maximum of $500,000[2]	Employee pays 100%
Dependent Life: Spouse[2]	Lesser of 50% of employee's coverage or 1X employee's base annual earnings	Employee pays 100%
Dependent Life: Child(ren)	$5,000 per eligible dependent child	Employee pays 100%
Other Provisions		
Accelerated Benefit	If you become terminally ill, you may be eligible to receive up to 75% of your combined Basic and Additional Life benefit to a maximum of $500,000. This benefit is also available for your insured spouse up to 75% of the Spouse Dependent Life amount.	
Specified Disease Benefit	Up to 25% of Basic Life benefit amount for life-threatening cancer; myocardial infarction (heart attack); coronary artery bypass procedure; renal failure; stroke; major organ transplant; acquired immune deficiency syndrome (AIDS).	

[1] See page 83 or visit https://nmpsiaonline.nmpsia.com/EROnline/PremiumCal/ViewPremiumCal

[2] Late application and employee amounts above the Guarantee Issue (up to $600,000) require satisfactory evidence of insurability and approval by The Standard.

Waiver of Premium	If you become totally disabled while insured, under age 60, and complete a waiting period of 180 days, your Life insurance may continue without premium payment provided you give us satisfactory proof that you remain totally disabled. Waiver of premium does not apply to AD&D insurance.
Conversion	If your insurance ends or reduces due to a qualifying event, you may be eligible to convert to an individual Life policy without submitting proof of good health. A benefit may be payable if death occurs within 60-days from the qualifying event during the conversion period.
Portability	If your insurance ends because your employment terminates, you may be eligible to buy portable group insurance coverage.
Suicide Exclusion	Additional and Dependent Spouse Life includes an exclusion for death resulting from suicide or other intentionally self-inflicted injury. The amount payable will exclude amounts that have not been continuously in effect for at least two years on the date of death.
Repatriation Benefit	If you die more than 150 miles from your primary residence, we will pay the expenses incurred to transport your body to a mortuary near your primary place of residence, but not to exceed $5,000 or 10% of the Life benefit, whichever is less.
Travel Assistance	Designed to help you respond to medical care situations and other emergencies you and your family may experience while traveling 100 miles or more from your home. Travel Assist provides information, referral, coordination and assistance services, including pre-trip assistance, medical assistance, emergency transportation, travel and technical assistance, legal services and medical supplies.
Life Services Toolkit	Comprehensive online tools and services can help the employee create a will, make advanced 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 for up to 12 months after the date of death.
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.
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.

AD&D Table of Losses			
Life	100%	Paraplegia	75%
One hand and one foot	100%	Hemiplegia	50%
Sight in both eyes	100%	One hand or one foot	50%
Both hands or both feet	100%	Sight in one eye	50%
One hand or one foot and sight in one eye	100%	Speech	50%
Speech and hearing in both ears	100%	Hearing in both ears	50%
Quadriplegia	100%	Thumb & index finer (same hand)	25%

Other AD&D Benefits

- Seat belt benefit
- Air bag benefit
- Exposure and disappearance benefit
- Coma benefit
- Higher education benefit (for your children)
- Career adjustment benefit (for your spouse)
- Child care benefit
- Occupational assault benefit

AD&D Exclusions

No AD&D benefit is payable if the accident or loss is caused or contributed to by any of the following:

1. War or act of war. War means declared or undeclared war, whether civil or international, and any substantial armed conflict between organized forces of a military nature.
2. Suicide or other intentionally self-inflicted Injury, while sane or insane.
3. Committing or attempting to commit an assault or felony, or actively participating in a violent disorder or riot. Actively participating does not include being at the scene of a violent disorder or riot while performing your official duties.
4. The voluntary use or consumption of any poison, chemical compound, alcohol or drug, unless used or consumed according to the directions of a physician.
5. Sickness or pregnancy existing at the time of the accident.
6. Heart attack or stroke.
7. Medical or surgical treatment for any of the above.

Long Term Disability

New Mexico Public Schools Insurance Authority knows that no two employees are alike. We all have different lifestyles, different family situations and different benefit needs. With this in mind, NMPSIA offers a Long Term Disability plan to help you and your family achieve financial security. The advantages to you and your loved ones include:

- **Choice –** You select the coverage you need from the range of amounts and plans available
- **Savings –** Group insurance rates are typically more affordable than those for individual insurance plans, providing you with the same amount of coverage at a lower cost
- **Convenience –** Since premiums are deducted from your paycheck, you don't have to worry about remembering to mail in monthly payments
- **Peace of mind –** Take comfort and satisfaction in knowing you have done something positive for your family's future

Long Term Disability Benefits at a Glance

For complete coverage details, visit **https://nmpsia.com/TheStandard.html** or call 888.609.9763, extension 0957.

LTD Benefit	Late application requires satisfactory evidence of insurability and approval by The Standard.
Benefit Waiting Period	Employer elects either: 30 days, 60 days or 90 days
Monthly Benefit	66 2/3% of the first $7,500 of your predisability earnings, reduced by deductible income
Minimum Benefit	$100
Maximum Benefit	$5,000 before reduction by deductible income
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.

Who pays the premium?

You and your employer share the cost of LTD insurance, based on your contracted base annual salary.

If you earn:	**Your employer's share is:**	**Your share is:**
$25,000 or more	60%	40%
$20,000–$25,000	65%	35%
$15,000–$20,000	70%	30%
Less than $15,000	75%	25%

See page 83 or visit https://nmpsiaonline.nmpsia.com/EROnline/PremiumCal/ViewPremiumCal

Long Term Disability, (cont'd)

Definition of Disability
For the benefit waiting period and the first 24 months for which LTD benefits are payable, being unable – as a result of physical disease, injury, pregnancy or mental disorder – to perform with reasonable continuity the material duties of *your own* occupation and suffering a loss of at least 20% of predisability 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.
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.
Other Features and Services
• 24 hour coverage, including coverage for work-related disabilities • Continuation of insurance during school breaks • Assisted living benefit • Assistance with Social Security benefits • Assistance with tax payments • Lifetime security benefit • Reasonable accommodation expense benefit • Rehabilitation plan provision • Return to work incentive • Return to work responsibility • Survivors benefit • Temporary recovery provision • Waiver of premium while LTD benefits are payable • 24-month lifetime limited pay periods for mental disorders, substance abuse and other limited conditions

This information is only a summary of the benefits. The controlling provisions will be in the group policy issued by The Standard. The group policy contains a detailed description of the limitations, reductions in benefits, exclusions and when The Standard and NMPSIA may increase the cost of coverage, amend or cancel the policy. A group certificate of insurance that describes the terms and conditions of the group policy is available for those insured according to its terms. For complete details of coverage, call 888.609.9763, extension 0957 or visit **https://nmpsia.com/TheStandard.html**.

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 referral.
- 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.
- You'll have access to our nationwide network of providers.

When choosing the Blue Preferred EPO

- Features a wide range of benefits to help control your costs 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.
- The Blue Preferred EPO network includes more than 25,000 quality healthcare providers such as Lovelace Hospitals and Medical Group, and UNM Hospitals and Physicians.

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.

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.

The Value of Blue– Meeting your Health Care Needs

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.
- Fitness Program The Fitness Program gives you unlimited access to a nationwide network of more than 10,000 fitness locations.
- Blue Points Members can earn points for completing healthy activities like taking a Health Assessment, enrolling in a self-management program, joining the Fitness Program or using a fitness tracker. They can then redeem those points for merchandise.

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 explanation 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
- Back pain
- Dizziness or severe headaches
- A baby's nonstop crying
- Sore throat
- And much more

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**.

*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.

**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.

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.

Powered by MDLIVE®

Virtual Visits: Get 24/7 Care, Anywhere

Call your doctor's office first. They also may offer telehealth consultations by phone or online video.

With Virtual Visits, the doctor is always in. Get 24/7 non-emergency care from a board-certified doctor by phone, online video or mobile app from the privacy and comfort of your own home.

Don't risk crowded waiting rooms, expensive urgent care or ER bills, or waiting weeks or more to see a doctor, when you can speak with a Virtual Visits doctor within minutes.

Virtual Visits, provided by **Blue Cross and Blue Shield of New Mexico** and powered by MDLIVE®, are a convenient alternative for treatment of more than 80 health conditions, including:

- Allergies
- Cold/Flu
- Fever
- Headaches
- Nausea
- Sinus infections

Virtual Visits with licensed behavioral health therapists are available by appointment. Get virtual care for:

- Anxiety
- Depression
- Stress management
- And more

Virtual Visit doctors can even send an e-prescription to your local pharmacy.

Activate your MDLIVE account today:

- Call MDLIVE at 888-676-4204
- Go to MDLIVE.com/bcbsnm
- Text BCBSIL to 635-483
- Download the MDLIVE app

Virtual Visits may not be available on all plans. Non-emergency medical service in Montana and New Mexico is limited to interactive online video. Non-emergency medical service in Arkansas and Idaho is limited to interactive online video for initial consultation.

Retrain Your Brain

learntolive

See how much better life can feel with digital mental health programs from Learn to Live.[1]

More than half of people will struggle with a mental health concern at some point in their lives.[2] But you can learn new skills to break old patterns that may be holding you back. Digital mental health programs from Learn to Live can help you get your mental health on track so you can feel better and enjoy life more.

Find out where you may need support

An online assessment helps pinpoint the right programs for you, such as:

- Stress, anxiety and worry
- Depression
- Insomnia
- Social anxiety
- Substance use

Get a mental health tune-up — online

Learn to adjust unhelpful thoughts and control your moods

Explore quick and easy lessons whenever it fits your schedule. A little homework between sessions helps you keep up your progress. Activities are based on therapy techniques with a track record of helping people get better.

An expert coach can guide you

If you need one-on-one support to reach your goals, connect with a coach by phone, text or email. They'll lift you up, cheer you on and help you master your new skills.

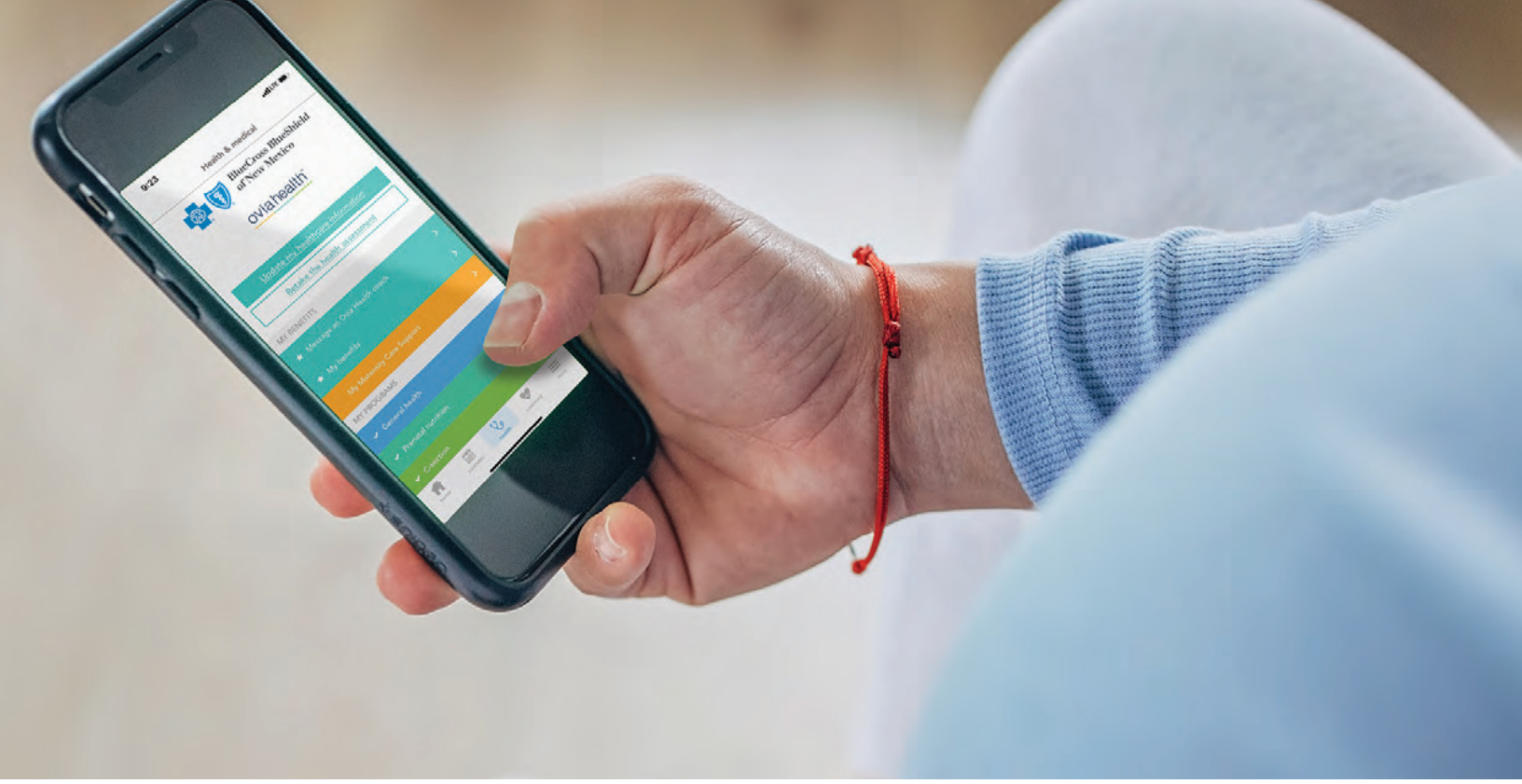
Your personal details are private

Just like with face-to-face therapy, your personal results, program progress and messages with your coach will not be shared with your employer.

Check out the programs included at no added cost through your Blue Cross and Blue Shield of New Mexico plan:

1. Log in at **bcbsnm.com**.
2. Click **Wellness**.
3. Choose **Digital Mental Health**.

1. Learn to Live provides educational behavioral health programs; members considering further medical treatment should consult with a physician.
2. https://www.cdc.gov/mentalhealth/learn/index.htm



Prepare for Your Life-Changing Journey

Women's and Family Health Pregnancy and Parenting Support

Whether you are pregnant or planning to get pregnant, you should prepare as much as you can. Blue Cross and Blue Shield of New Mexico has tools to help you – at no extra cost to you.

- **Ovia Health**™† apps are for tracking your cycle, pregnancy and baby's growth. The apps are available in English and Spanish*, and provide videos, tips, coaching and more.
  - **Ovia Fertility:** Track your cycle and predict when you are more likely to get pregnant.
  - **Ovia Pregnancy:** Monitor your pregnancy and baby's growth week by week leading up to your baby's due date.
  - **Ovia Parenting:** Keep up with your child's growth and milestones from birth through three years old.
- **Well onTarget**® has self-guided courses about pregnancy that you can take online, covering topics such as healthy foods, body changes and labor.

Plus, if your pregnancy is high-risk, BCBSNM will provide support from maternity specialists to help you care for yourself and your baby. Having a baby changes everything, so use these tools to help you get ready.

Download any of the Ovia Health apps from the Apple App Store or Google Play. During sign-up, make sure to choose "I have Ovia Health as a benefit." Then select BCBSNM as your health plan and enter your employer name. Also, visit **wellontarget.com** to explore our online courses.

Please call **888-421-7781** if you have questions or want to learn more.

†Ovia Health is an independent company that provides maternity and family benefits solutions for Blue Cross and Blue Shield of Illinois.
*To access the Spanish version of the Ovia Fertility, Ovia Pregnancy and Ovia Parenting apps, you must select "Español" as the language preference in your mobile phone or device settings.

Well onTarget®

Experience Wellness Your Way

Well onTarget gives you the tools and resources to create your personal journey — no matter where you may be on your path to wellness.

Well onTarget can give you the support you need to make healthy choices — while rewarding you for your hard work.

Member Wellness Portal

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 inviting programs and tools.

- **Health Assessment (HA)[2]:** The HA poses questions to learn more about you. After you take the HA, you will get a personal wellness report. This confidential report offers you tips for living your healthiest life. Your answers will help tailor the Well onTarget portal with the programs that may help you reach your goals. You can share this report with your health care provider.

- **Self-Management Programs:** These programs let you work at your own pace to reach your health goals. Learn more about nutrition, fitness, losing weight, quitting smoking, managing stress and more. Track your progress as you make your way through each lesson. Reach your milestones and earn Blue Points℠.[1]

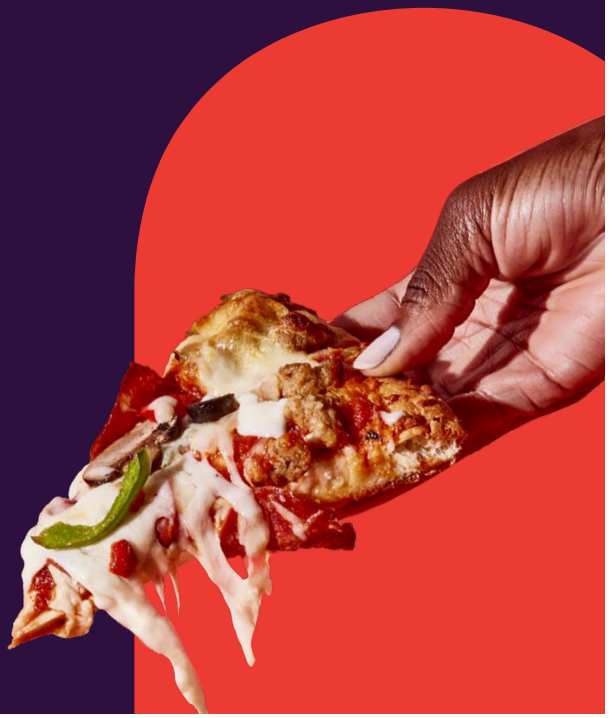
Start experiencing the wellness portal today. Go to **wellontarget.com**.

1 Blue Points Program Rules are subject to change without prior notice. See the Program Rules on the Well onTarget Member Wellness Portal at wellontarget.com for further information.
2 Well onTarget is a voluntary wellness program. Completion of the Health Assessment is not required for participation in the program.

Clinically-proven weight loss without counting calories

Now you can lose weight, gain energy, sleep better, and improve your mind and body—all while eating your favorite foods. NMPSIA has partnered with Wondr Health™ to help you improve your health at no cost to you.*

Go to wondrhealth.com/NMPSIA



What is Wondr?

No points, plans, or counting calories. Forget eating kale salads 24/7; Wondr is a skills-based digital weight loss program that teaches you how to enjoy the foods you love to improve your overall health. Our behavioral science-based program was created by a team of doctors and clinicians (which is why we left out the "e" in Won**dr**) and is clinically-proven for lasting results.

*Eligibility info can be found at wondrhealth.com/NMPSIA

Questions? Visit support.wondrhealth.com

LET'S TALK RESULTS

In as little as 10 weeks:

84% LOST WEIGHT

62% FEEL MORE CONFIDENT

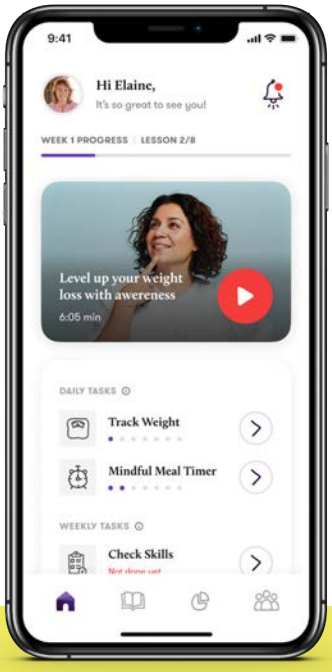
61% HAVE MORE ENERGY

85% FEEL MORE IN CONTROL OF THEIR WEIGHT

68% ARE MORE PHYSICALLY ACTIVE

57% FEEL THEIR MOOD HAS IMPROVED

*Based on Wondr Health Book of Business



"I love the whole idea of the psychology of things. I like to look in the why's and how it works. You can eat whatever you want. You just need to retrain your brain into thinking about how you need to eat your food."

—Brad M.
WONDR PARTICIPANT

LOST 70 lbs | **GAINED Confidence**

GET IT ON Google Play

Download on the App Store

wondr FORMERLY NATURALLY SLIM

Make Your Fitness Program Membership Work for You!

The Fitness Program gives you flexible options to help you live a healthy lifestyle.

Since you are a BCBSNM member, the Fitness Program is available exclusively to you and your covered dependents (age 16 and older).* The program gives you access to a nationwide network of fitness locations. Choose one location close to home and one near work, or visit locations while traveling.

Other program perks include:

- **Flexible Gym Network:** A choice of gym networks to fit your budget and preferences.**

Options	Base	Core	Power	Elite
Monthly Fee	$19	$29	$39	$99
Gym Facility Network Size†	3,000	7,500	12,000	12,400
$19 Initiation Fee				

- **Studio Class Network:** Boutique-style classes and specialty gyms with pay-as-you-go option and 30% off every 10th class.
- **Family Friendly:** Expands gym network access to your covered dependents at a bundled price discount.
- **Convenient Payment:** Monthly fees are paid via automatic credit card or bank account withdrawals.

Features

- **Mobile App:** Allows members to access location search, studio class registration, location check-in and activity history.
- **Real-time Data:** Provided to the mobile app and Well onTarget portals.
- **Complementary and Alternative Medicine (CAM) Discounts Through the Whole Health Living Choices Program:** Save money through a nationwide network of 40,000 health and well-being providers, such as acupuncturists, massage therapists and personal trainers. To take advantage of these discounts, register at **whlchoices.com**.
- **Blue Points:** Get 2,500 points for joining the Fitness Program. Earn additional points for weekly visits. You can redeem points for apparel, books, electronics, health and personal care items, music and sporting goods.***
- **Web Resources:** You can go online to find fitness locations and track your visits.

Are You Ready for Fitness?

It's easy to sign up:

1. Go to **bcbsnm.com** and log in to Blue Access for Members.
2. Under "**Quick Links**," choose "**Fitness Program**." On this page, you can enroll, search for nearby fitness locations and learn more about the program.
3. Click "**Enroll Now**." Then search and select the fitness location that is best for you. Remember, you can visit any participating fitness location in your plan after you sign up.
4. Verify your personal information and method of payment. Print or download your Fitness Program membership ID card. You may also request to receive the ID card in the mail.
5. Visit a fitness location today!

Prefer to sign up by phone or have questions about the Fitness Program? Just call the toll-free number **888-762-BLUE (2583)** Monday through Friday, between 7 a.m. and 7 p.m., CT (6 a.m. and 6 p.m., MT).

WholeHealth Living Choices program is administered by Tivity Health ™ Services, LLC.This is NOT insurance. Some of the services offered through this program may be covered by a health plan. The relationship between this vendor and BCBSNM is that of independent contractors.

† Represents possible network locations. Check local listings for exact network options as some locations may not participate. Network locations are subject to change without notice.

*Individuals must be 18 years old to purchase a membership. Dependents, 16-17 years old, can join but must be accompanied to the location by a parent/guardian who is also a Fitness Program member. Check your preferred location to see their membership age policy. Underage dependents can login and join through the primary member's account as an "additional member."

**Taxes may apply. Individuals must be at least 18 years old to purchase a membership.

***Member agrees to comply with all applicable federal, state and local laws, including making all disclosures and paying all taxes with respect to their receipt of any reward.

2023 Plan Year

We at Cigna are thrilled to be an ongoing Medical Plan partner with NMPSIA!
Thanks for all you do every day to support the students and staff of New Mexico's schools.

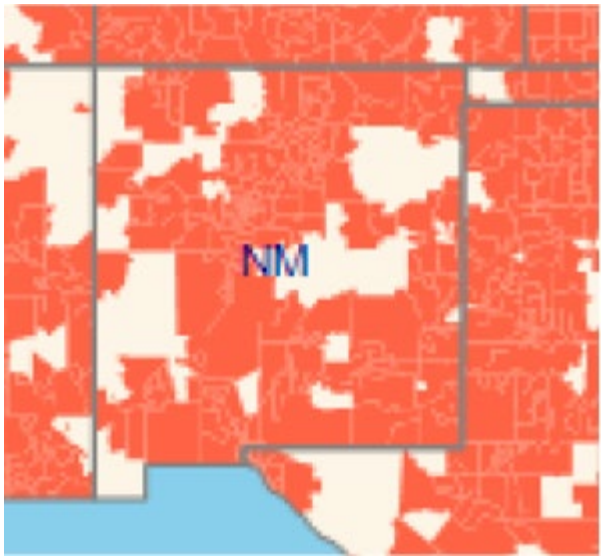
Benefits Guide Table of Contents:

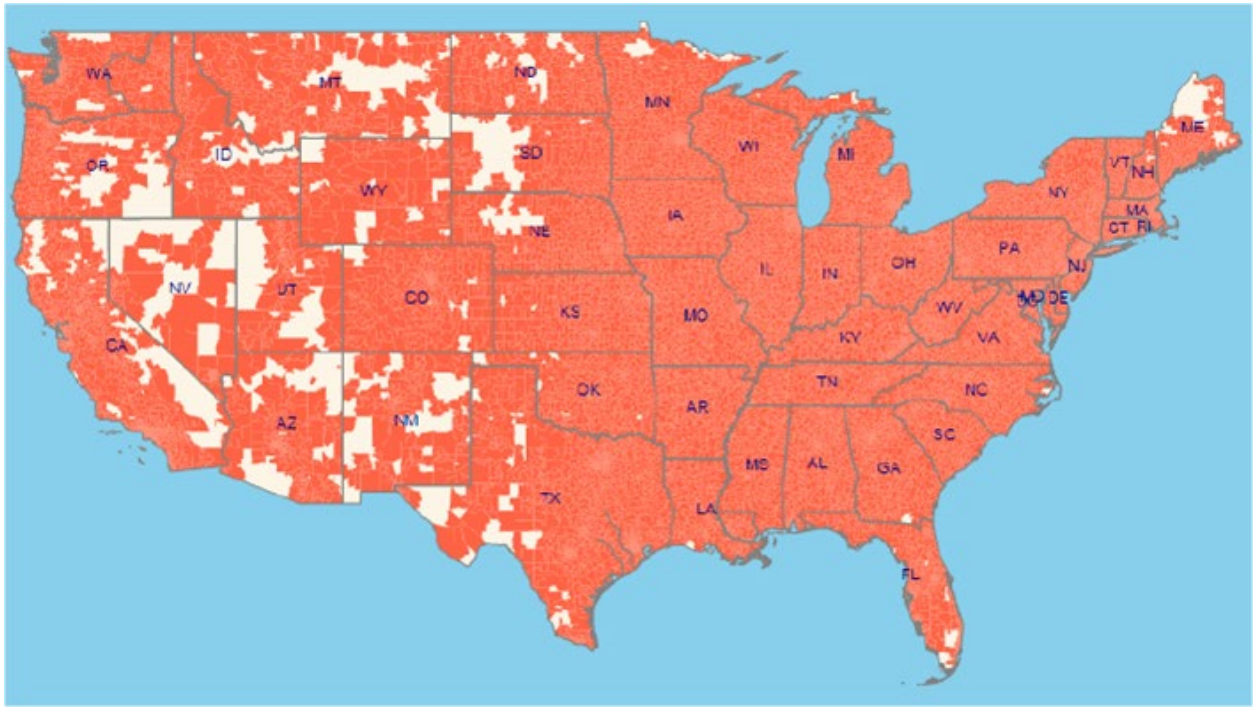
Here's to a great year of health – in partnership with Cigna!

Cigna **Open Access Plus** network reminders:

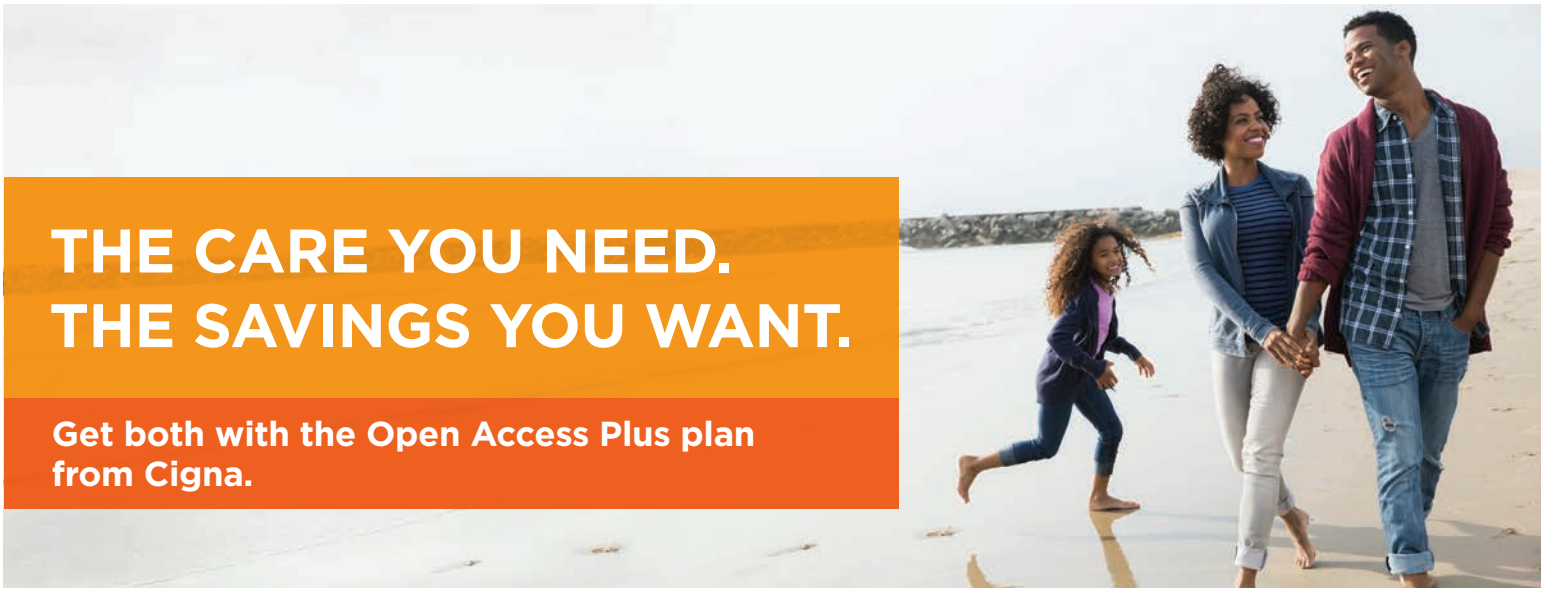
1. All across the state with both systems (aligned with Presbyterian in Albuquerque)
2. All across the country for seamless out-of-state care options
3. Go to myCigna or call the number on the back of your Cigna card for more info

Cigna Network Analysis – service area in orange:





2022 Quest Analytics, LLC



THE CARE YOU NEED. THE SAVINGS YOU WANT.

Get both with the Open Access Plus plan from Cigna.

Offering flexible access to thousands of providers – plus programs and services to support your whole health needs – the Open Access Plus (OAP) plan is designed to make it easier for you to get the quality care you need and the savings you want.

Here's how it works.

- **In-network savings**
  You have the freedom to use any provider or facility of your choice, whether they are in the Cigna OAP network or out of the network. Just know that staying in-network will help keep your costs down and avoid any additional paperwork.
- **No-referral specialist care**
  A primary care provider (PCP) is recommended, but not required. If you need to see a specialist for any reason, you don't need a referral to see an in-network health care provider. If you choose an out-of-network specialist, your care will be covered at the out-of-network level and you may be responsible for any preauthorizations needed.
- **Care coordination**
  Our robust medical management program provides you and your family a valuable resource for one-on-one support and guidance to the right programs and services.
- **Hospital stays**
  In an emergency, you have coverage. However, requests for nonemergency hospital stays (other than maternity stays) and some types of outpatient care must have prior authorization or be preauthorized. This lets Cigna determine if the services are covered by your plan.

  If your provider is in the Cigna OAP network, he or she will arrange for prior authorization. If you use an out-of-network provider, you must make the arrangements.
- **Out-of-pocket costs**
  Depending on your plan, you may have to pay an annual amount (deductible) before your plan begins to pay for covered health care costs. You may also need to pay a copay and/or coinsurance (a portion of the covered charge) for covered services. Then, your plan pays the rest. Once you reach an annual limit on your payments (out-of-pocket maximum), the health plan pays your covered health care costs at 100% for the rest of your plan year.

  If you receive out-of-network care, your costs will be higher. Out-of-network providers and facilities may also bill you for charges that are not covered by the plan. Charges not covered by the plan do not contribute to your deductible or out-of-pocket limits.

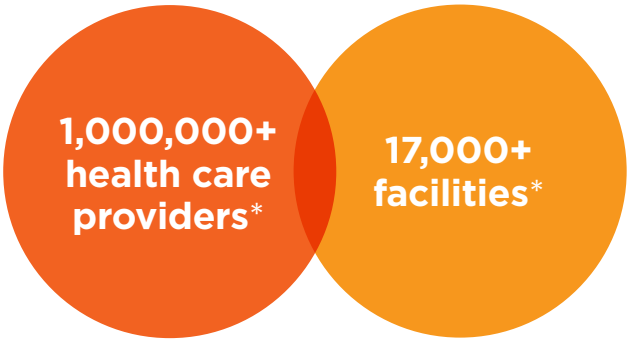
Together, all the way.®

Cigna®

Offered by Cigna Health and Life Insurance Company.

939715 10/20

Great care anywhere. Where you live, work or travel



Added convenience and support

- **Virtual Care**
  Connect 24/7 with board-certified providers and pediatricians for minor medical conditions. You can also schedule online appointments for licensed counselors or psychiatrists for behavioral or mental health conditions. You and your covered family members can get care from anywhere via video or phone.**
- **Cigna Health Information Line**
  With the Cigna Health Information Line, clinicians are just a phone call away – 24/7, and at no extra cost. They can help you understand health issues you might be experiencing, and help you to make informed decisions – whether it's reviewing home treatment options, following up on a provider's appointment, or choosing and finding the right care in the right setting.
- **Live, 24/7/365 customer service**
  Customer service representatives are here for you where and when you need us – over the phone, via chat at **myCigna.com** or on the myCigna® App.
- **The myCigna website and app**
  On **myCigna.com** and the myCigna App, you have easy access to personalized tools to help you take control of your health and your health care spending. From your computer or mobile device, you can:
  - Manage and track claims
  - See cost estimates for medical procedures
  - Compare quality information for providers and hospitals
  - Track your account balances and deductibles
  - Use the easy health and wellness tools
  - Print a temporary ID card

Want to check if your provider is in the Cigna OAP network before you enroll?

Just go to Cigna.com and click on "Find a Provider, Dentist or Facility" and then click on "Plans through your employer or school" to search the provider directory.

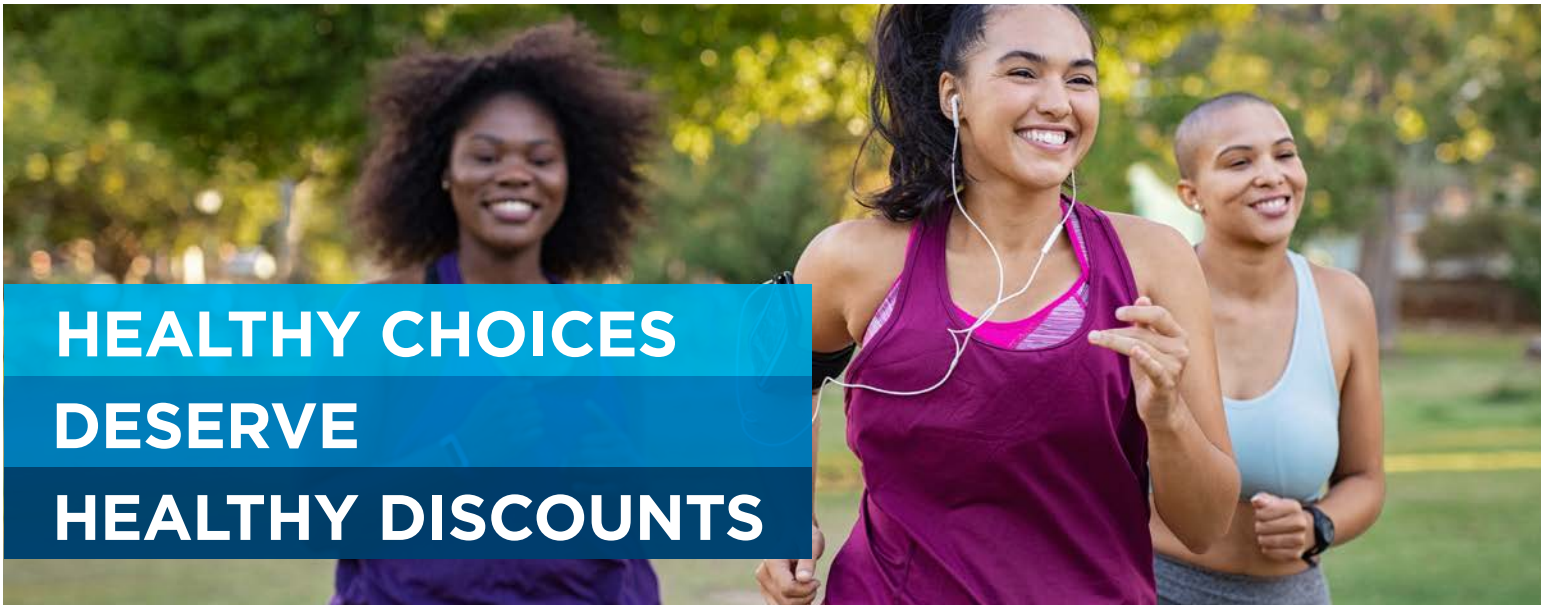
Cigna®

* Based on Cigna internal provider data for OAP service area as of 2/2020. Subject to change.

** Not all plans include coverage for behavioral services. Check your plan documents for details. Cigna provides access to virtual care through national telehealth providers as part of your plan. Providers are solely responsible for any treatment provided to their patients. Video chat may not be available in all areas or with all providers. This service is separate from your health plan's network and may not be available in all areas. A primary care provider referral is not required for this service. In general, to be covered by your plan, services must be medically necessary and used for the diagnosis or treatment of a covered condition. Not all prescription drugs are covered. Product availability may vary by location and plan type and is subject to change. All group health insurance policies and health benefit plans contain exclusions and limitations. See your plan materials for costs and details of coverage, including other telehealth/telemedicine benefits that may be available under your specific health plan.

Product availability may vary by location and plan type and is subject to change. All group health insurance policies and health benefit plans contain exclusions and limitations. For costs and details of coverage, review your plan documents.

All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including Cigna Health and Life Insurance Company (CHLIC), Cigna Behavioral Health, Inc. and Cigna Health Management, Inc. In Texas, Open Access Plus plans are considered Preferred Provider plans with certain managed care features. Policy forms: OK - HP-APP-1 et al., OR - HP-POL38 02-13, TN - HP-POL43/HC-CER1V1 et al. (CHLIC). The Cigna name, logo, and other Cigna marks are owned by Cigna Intellectual Property, Inc.



HEALTHY CHOICES DESERVE HEALTHY DISCOUNTS

Start saving today with Cigna Healthy Rewards®*

Just use your Cigna ID wallet card when you pay and let the savings begin.

Get discounts on the health products and programs you use every day for:

- Nutritional Meal Delivery Service
- Fitness Memberships and Devices**
- Vision Care, Lasik Surgery, Hearing Aids
- Alternative medicine
- Yoga Products and Virtual Workouts**

Real brands. Real discounts. Real easy.

Log into **myCigna.com** and navigate to Healthy Rewards Discount Program or call **800.870.3470**.

For Cigna customers who don't have access to **myCigna.com** and want an Active&Fit Direct™ gym membership:

- Call **800.870.3470**; and
- Press 3 to be transferred to a customer service agent.

* Healthy Rewards is a discount program. Some Healthy Rewards programs are not available in all states and programs may be discontinued at any time. If your health plan includes coverage for any of these services, this program is in addition to, not instead of, your plan benefits. Healthy Rewards programs are separate from your your plan benefi ts. **A discount program is NOT insurance, and you must pay the entire discounted charge.** All goods, services and discounts offered through Healthy Rewards are provided by third parties who are solely responsible for their products, services and discounts.

** Fitness Membership and Devices along with Yoga Products and Virtual Workouts can only be accessed by login into **myCigna.com** and navigating to Healthy Rewards Discount Program.

Together, all the way.®

Cigna®

Offered by: Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company or their affiliates.

Cigna®

Interested in LASIK Eye Surgery?

You can access savings on LASIK just for being a Cigna member!

Through Healthy Rewards™, Cigna members receive up to **$1,000 off LASIK***, with the "all laser" Wavelight Laser, at Lasik*Plus*, TLC Laser Eye Centers and The LASIK Vision Institute.

Members have access to more than **600 provider locations** nationwide. Cigna members and their eligible dependents are entitled to significant and exclusive savings with credentialed providers.

Find a credentialed LASIK provider and schedule your FREE LASIK exam today. LASIK helps correct nearsightedness, farsightedness and astigmatism.

Call1-855-665-2020 or visit myCigna.com click Wellness and then Prevention.

LasikPlus® | The LASIK Vision INSTITUTE® | TLC Laser Eye Centers®

Healthy Rewards programs are NOT insurance. Rather, these programs give a discount on the cost of certain goods and services The customer must pay the entire discounted cost Some Healthy Rewards programs are not available in all states and programs may be discontinued at any time. Participating providers are solely responsible for their goods and services. *Must mention this promotion and be treated by December 31, 2022 to qualify. $1,000 discount applies to standard Wavelight price when treating both eyes, $500 discount for one eye.

YOU'VE GOT A GOAL. AND YOU'VE GOT WHAT IT TAKES TO REACH IT.

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

Weight Management

Reach your goal of maintaining a healthy weight – all without the fad diets. Create a personal healthy-living plan that will help you build your confidence, be more active and eat healthier. And, you'll get the support you need to stick with it.

Tobacco Cessation

Get the help you need to finally quit tobacco. Create a personal quit plan with a realistic quit date. And, get the support you need to kick the habit for good. You'll even get free over-the-counter nicotine replacement therapy (patch or gum).

Stress Management

Get help lowering your stress levels and raising your happiness levels. Learn what causes you stress in your life and develop a personal stress management plan. And, get the support you need to help you cope with stressful situations – both on and off the job.

Take the first step.

Call 1-800-244-6224 or visit myCigna.com

Over the phone*

- One-on-one wellness coaching
- Convenient evening and weekend hours
- Program workbook and toolkit

Online

- Convenient support
- Self-paced program
- Educational materials, interactive tools and resources

Together, all the way.®

Cigna®

*Telephone support may not be available under your employer's specific program.

Active&Fit DIRECT®

Cigna

Gym or Home?

We'll keep you active either way.

11,000+ STANDARD FITNESS CENTERS
Access 11,000+ fitness center options with the ability to change at any time, for just $25 a month.

5,000+ *NEW* PREMIUM EXERCISE STUDIOS AND FITNESS CENTERS
Choose from 5,000+ premium options, with substantial discounts on most. Fees will vary and apply to each option chosen.

4,000+ DIGITAL WORKOUT VIDEOS
Try 200 videos for free today!

***NEW* ENROLL YOUR SPOUSE**
*or domestic partner.***

NO LONG-TERM CONTRACTS

FITNESS PROGRAM MEMBERSHIP
AS LOW AS
$25/mo*
16,000+ FITNESS CENTERS
4,000+ WORKOUT VIDEOS
Active&Fit® DIRECT
TM

Learn More: Visit the wellness offers on mycigna.com.

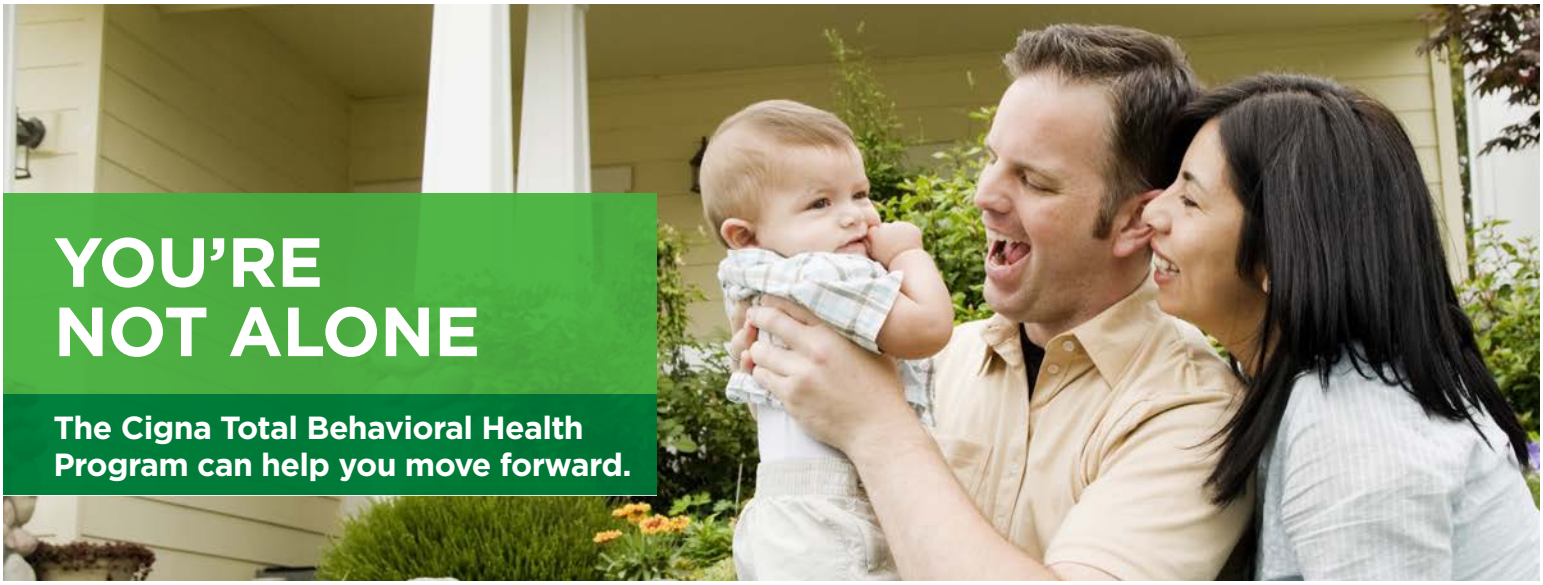
11,000+ Standard Fitness Centers, including:

Gold's Gym · Anytime Fitness · Crunch Fitness · Curves · Snap Fitness 24/7 · Chuze Fitness · blink Fitness · 24 Hour Workout Anytime · LA Fitness

5,000+ NEW Premium Exercise Studios & Fitness Centers, including:

pure barre · acac · YogaSix · CycleBar · Row House · Club Pilates · campGladiator · STRIDE · Stretch Lab

*Plus an enrollment fee and applicable taxes. Fees will vary based on fitness center selection.
**Add a spouse/domestic partner to a primary membership for additional monthly fees. Spouses/domestic partners must be 18 years or older. Fees will vary based on fitness center selection.



YOU'RE NOT ALONE

The Cigna Total Behavioral Health Program can help you move forward.

Studies show that behavioral problems, such as depression, can contribute to heart disease.[1] Many physical conditions can worsen with stress, substance use and other behavioral health issues. Our Cigna Total Behavioral Health® program can help.

Our whole-person approach

If you or a loved one has been diagnosed with a behavioral health condition, Cigna is here for you. Our comprehensive program provides help with life events, dedicated support, lifestyle coaching, and online tools. We help you take control of your health – mind and body.

Services to help manage life events – At no additional charge to you, you can receive face-to-face sessions[2] with a licensed mental health professional in Cigna's Employee Assistance Program network. You also get online, on-demand seminars, as well as community resources and referrals on a range of topics, including:

- Child care
- Adoption
- Senior care
- Pet care
- Identity theft support
- Summer camps
- Parenting
- Convenience services
- Legal and financial consultation services[3]

Virtual behavioral care – You can talk to a licensed psychiatrist or counselor by phone or video with MDLIVE or Cigna Behavioral Health network. With MDLIVE you can schedule phone and video appointments online. With Cigna Behavioral Health network, you can find a provider and start video counseling by going to MyCigna.com, Find Care & Costs.

You can also access online therapy through Talkspace, via private messaging or live video session. Refer to your plan documents for costs and details of coverage.

iPrevail

On-demand coaching and personalized learning with iPrevail offered through Cigna[4] – Learn how to boost your mood and improve mental health with on-demand coaching 24/7. After completing a brief assessment, you receive a program tailored to your needs that includes interactive lessons and tools. You get access to a peer coach who is matched based on your symptoms. You can also join support communities focused on stress, anxiety, depression and more.

happify™

Science-based activities and games for stress and worries, with Happify offered through Cigna[4] – Everyday stressors can impact your relationships, work, health and emotional well-being. But you can change your outlook – and the way you see the world – with Happify. Happify's activities and games are designed to help you overcome life's challenges and can be accessed at any time.

Together, all the way.®

Cigna®

You can call us anytime, any day. We're here 24/7 to assist you with your routine and urgent needs. We can also help you with appointment scheduling too.

Behavioral Specialty Coaching & Support Services – Our coaches provide dedicated support for a broad range of conditions including:

- Autism spectrum disorder
- Eating disorders
- Intensive behavioral case management
- Opioid and pain management
- Substance use

We also provide coaching and support for parents and families, which empowers individuals to be effective advocates for their family member or their own mental health needs. Our team can help for as long as needed. (You must stay covered under your plan to continue service.) They can help you:

- Understand a behavioral diagnosis.
- Learn about treatment choices and how your choices can affect what you'll pay out of pocket.
- Identify and manage triggers that affect your condition.
- Find a health care professional or facility in Cigna's network geared to your needs. Our network includes Centers of Excellence for Mental Health and Substance Use facilities that provide quality, cost-effective care.
- Find community resources and programs near you.
- Get referrals to other Cigna wellness and lifestyle programs available to you.

Take control of your health with extra support.

Lifestyle management programs – Get help to reach your goals like losing weight, quitting tobacco or lowering your stress level. Each program offers support with phone and online coaching.

Behavioral awareness webinars – Cigna offers free monthly seminars on autism, eating disorders, substance use and behavioral health awareness for children and families. The seminars are taught by industry experts and offer tips, tools and helpful information.

Enhanced online tools – Visit **myCigna.com** or use the myCigna® app to access on-demand support, including:

- Information about your benefits, in-network providers and treatment options
- Health and well-being articles
- Self-assessments, stress management and mindfulness podcasts and tools

Additional resources can be found on **Cigna.com**.

99% of program participants were very satisfied with the service their case manager provided.[5]

To learn more or access services:

To access services to help manage life events, visit **myCigna.com**, Coverage, Employee Assistance Program. You can call **877.231.1492** for referrals or go online, search the provider directory and obtain an authorization.

For links to iPrevail and Happify, visit the Wellness page – Emotional Health on **myCigna.com**.

You can also call the toll-free number on your Cigna ID card.

1. American Psychological Association, Mind/Body Health: Heart Disease, 2018.
2. Three face-to-face visits per issue per year. Some restrictions apply, please check with your employer to confirm services included in your plan.
3. Legal consultations related to employment matters are not available under this program.
4. iPrevail and Happify program services are provided by independent companies/entities and not by Cigna. Programs and services are subject to all applicable program terms and conditions. Program availability is subject to change. These programs do not provide medical advice and are not a substitute for proper medical care provided by a physician. Information provided should not be used for self-diagnosis. Always consult with your physician for appropriate medical advice.
5. Cigna satisfaction survey, 2019.

ANSWERING THE CALL FOR BETTER HEALTH

Why is Cigna calling me?

You're being offered Cigna programs to help you get healthy and live well. We're excited to get to know you, so we call you to talk about ways we can work together to help you manage your health.

Why do I get so many phone calls?

You may be offered different Cigna health programs, so you may receive calls from different Cigna specialists. They are all equally important, and designed to help in different ways.

Why should I answer the call?

Cigna's here to help you manage your health in many ways, but if you want the most personalized support be sure to answer our call. When we call, we want to start a conversation so we can learn what's important to you – whether that's a chronic condition, making healthy choices or filling a prescription. If you participate, you may be eligible for incentives, depending on your plan.

If you aren't able to answer the call right away, feel free to call when you have time. Our coaching programs are open for coaching appointments during the day and evenings.

If you have urgent or immediate concerns we are here to help you 24/7 to answer any questions you have about your health and well-being. *Every phone call is private and confidential*. We always talk in easy-to-understand terms. And we're not trying to sell you anything – we're just calling to help you live a healthier life. This service is included as part of your medical plan and at no extra cost to you.

What happens on the call?

When you answer, you'll be connected with a health advocate who will tell you their name and why they're calling. They will help you determine the best way Cigna can assist you. If you decide you want to join the program, you'll set up an appointment for your first coaching call. One-on-one coaching begins during the first coaching session.

Sometimes, we use an automated calling system to reach out to you. This is not a telemarketing service. We'll connect you with a live health advocate so you can make a coaching appointment and get started working on your health goals.

Health advocates are a cross functional team of clinical experts – all supported by doctors and pharmacists.

Is it private?

Yes. Every call is private and confidential.

Why do you use an automated phone system?

To make a quick connection with you – like getting you in touch with a health advocate or reminding you about an appointment.

Do I have to wait for you to call me?

No! We're happy you want to get started taking steps on the path to better health right away. You can call us anytime, day or night, by dialing the number on the back of your ID card. We're available 24/7 to serve you, and hold coaching calls during convenient hours. If you call late at night or early in the morning, we'll help you schedule a call during a time your health advocate is available.

What if I don't want to get any more phone calls?

Ask the Cigna caller to remove you from the contact list, or call the number on the back of your ID card and ask for customer service.

Together, all the way.®

Cigna®

848226 e 05/20

What programs might you call me about?

Below is a list of programs we might call you about. These programs have been chosen to help you take steps toward a healthier life, and you may be eligible for an incentive when you participate. We do our best to suggest programs you might be interested in by listening to you and looking at information such as your health assessment answers and claim information.

STRESS MANAGEMENT, WEIGHT MANAGEMENT AND TOBACCO CESSATION

You' ll be connected with a health advocate who will work with you to identify your health care priorities and set smart goals to quit smoking, maintain a healthier weight or manage stress.

HEALTH CARE THAT'S THERE FOR YOU WHEN AND WHERE YOU NEED IT

Head-to-toe virtual care[1] from MDLIVE.®

It's not always easy to find time for the health care you need. After all, doctors' appointments traditionally involve time and travel. That can lead to putting off care until problems become more serious, and potentially more expensive.

That's why Cigna has partnered with MDLIVE to offer a comprehensive suite of convenient virtual care options — available by phone or video whenever it works for you. MDLIVE board-certified doctors, dermatologists, psychiatrists and licensed therapists have an average of over 10 years of experience, and provide personalized care for hundreds of medical and behavioral health needs.

Now you don't have to wait — or travel — for the care you need.

Connect with video or phone, whenever it's convenient for you. Best of all, virtual care from MDLIVE board-certified doctors is available to you and your eligible dependents as part of your health benefits.

MDLIVE®

Primary Care

Preventive care, routine care, and specialist referrals

- Preventive care checkups/wellness screenings available at no additional cost[2] to identify conditions early
- Routine care visits allow you to build a relationship with the same primary care provider (PCP) to help manage conditions
- Prescriptions available through home delivery or at local pharmacies, if appropriate
- Receive orders for biometrics, blood work and screenings at local facilities[3]

Urgent Care

On-demand care for minor medical conditions

- On-demand 24/7/365, including holidays
- Care for hundreds of minor medical conditions
- A convenient and affordable alternative to urgent care centers and the emergency room
- Prescriptions available, if appropriate

Behavioral Care

Talk therapy and psychiatry from the privacy of home

- Access to psychiatrists and therapists
- Schedule an appointment that works for you
- Option to select the same provider for every session
- Care for issues such as anxiety, stress, life changes, grief and depression

Dermatology[4]

Fast, customized care for skin, hair and nail conditions — no appointment required

- Board-certified dermatologists review pictures and symptoms; prescriptions available, if appropriate
- Care for common skin, hair and nail conditions including acne, eczema, psoriasis, rosacea, suspicious spots and more
- Diagnosis and customized treatment plan, usually within 24 hours

Cigna®

961333 11/21

Offered by: Cigna Health and Life Insurance Company or its affiliates.

3 easy steps to connect to care

Virtual care visits are convenient and easy.
To schedule an appointment:

Access MDLIVE by logging into myCigna.com and clicking on "Talk to a doctor." You can also call MDLIVE at 888.726.3171. (No phone calls for virtual dermatology.)

Select the type of care you need: medical care or counseling; cost will be displayed on both myCigna.com and MDLIVE

Follow the prompts for an on-demand urgent care visit, to make an appointment for primary or behavioral care, or to upload photos for dermatology care

Appointments are available via video or phone, whenever it's most convenient for you. Virtual dermatology does not require an appointment.

Visit myCigna.com to make an appointment for virtual care today.

Together, all the way.®

Cigna®

1. Cigna provides access to virtual care through national telehealth providers as part of your plan. This service is separate from your health plan's network and may not be available in all areas or under all plans. Referrals are not required. Video may not be available in all areas or with all providers. Refer to plan documents for complete description of virtual care services and costs. Virtual primary care through MDLIVE is only available for Cigna medical members aged 18 and older.
2. For customers who have a non-zero preventive care benefit, MDLIVE virtual wellness screenings will not cost $0 and will follow their preventive benefit.
3. Limited to labs contracted with MDLIVE for virtual wellness screenings.
4. Virtual dermatological visits through MDLIVE are completed via asynchronous messaging. Diagnoses requiring testing cannot be confirmed. Customers will be referred to seek in-person care. Treatment plans will be completed within a maximum of 3 business days, but usually within 24 hours.

Valuable Resources Available to You

PRESBYTERIAN Health Plan, Inc.

Dedicated Member Service Team

You now have access to a highly trained, dedicated customer service team that can help:

- Navigate you to the most cost-effective level of medical care, whether it's a virtual visit, outpatient options, or urgent or emergency care.
- Find in-network primary care providers (PCPs) and specialists and schedule appointments.
- Answer questions about your benefits and help coordinate benefits for your personalized needs.
- Assist with follow-up care and claims resolution.

Contact us at (505) 923-5600 or 1-888-ASK-PRES (1-888-275-7737), TTY 711, Monday through Friday from 7 a.m. to 6 p.m.

Assist America

You have the protection of Assist America's global emergency travel assistance services 24 hours a day, 365 days a year. This unique program immediately connects you to services when experiencing a medical emergency while traveling 100 miles or more away from a permanent residence or in another country.

First, download the *free* Assist America Mobile App, then log in with reference number 01-AAPXI-10071.

For questions, contact Assist America's Operations Center at **1-800-872-1414** (or +1-609-986-1234 outside of the USA).

Wellness at Work

Through this online tool you can access all your wellness programming and create a personalized health improvement plan. It features a powerful Personal Health Assessment (PHA) tool to help identify personal health risks and provide recommendations for improving those risks. To participate, visit **www.phs.org** and register or login to myPRES.

Community Health Worker Program

Our community health workers work and live in the same communities as you and are specially trained to help you get what you need to stay as healthy as possible. They can help you find housing, food, utility assistance, transportation and translation services, and they will help you schedule a visit with a healthcare provider. They can also help you better manage other health conditions such as pregnancy, asthma, diabetes, high blood pressure, behavioral health, and substance use problems.

This service is confidential and provided at no additional cost to you. For more information, call **(505) 923-8567**.

Disease Management Programs

As a member, you have access to several comprehensive disease management programs at no additional cost to you.

If you have diabetes, asthma, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), or coronary artery disease (CAD), our licensed nurses will work collaboratively with your healthcare provider to provide you with coaching and self-management tools. To enroll in one or more of these Healthy Solutions programs, call **1-800-841-9705** or email **healthysolutions@phs.org**.

Our care coordinators also provide support for managing cancer or low back pain/musculoskeletal conditions. To enroll in one or more of the care coordination programs, call **1-866-672-1242** or email **phpreferral@phs.org**.

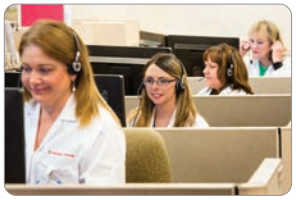
Estimate Your Cost of Care

Now you can better evaluate the cost of certain tests and procedures with our new treatment cost estimator. This tool will provide estimates for many of your covered services and help you find more convenient lower cost locations to obtain care. Your provider or Presbyterian's Customer Service Center can also refer you to lower cost locations for certain care needs. Call the number on the back of your Member ID card for guidance.

No-Cost Member Benefits

PRESBYTERIAN Health Plan, Inc.

PresRN Nurse Advice Line



Speak with a registered Presbyterian nurse for medical advice at no cost 24 hours a day, every day, including holidays. Call (505) 923-5570 or 1-866-221-9679.

For details, visit **www.phs.org** and search for "PresRN."

MyChart

Members with a Presbyterian Medical Group provider can send electronic messages and communicate with their care team, request prescription renewals and schedule office or telephone visits. You can also view medical records, lab and radiology reports, procedures and test results.

For details, visit **www.phs.org/mychart**.

myPRES

Get the information you want when you need it. Presbyterian's web-based services offer fast and convenient service any day of the year. To sign in or register, visit **www.phs.org/myPRES**.

- Look up benefit information securely, view claims status and track deductibles.
- Access your personal health assessment and other health education tools.
- View or request a replacement member ID card.

Talkspace

talkspace

No-cost messaging therapy offers members age 14 and older behavioral health coaching with licensed behavioral therapists via text, video or audio messaging at a time and place that is convenient for them.

Go to **www.talkspace.com/php** to access the program.

Clickotine

Clickotine®

Clickotine is a no-cost, innovative program that uses clinically driven app technology to help you create and stick to a quit plan and overcome nicotine cravings.

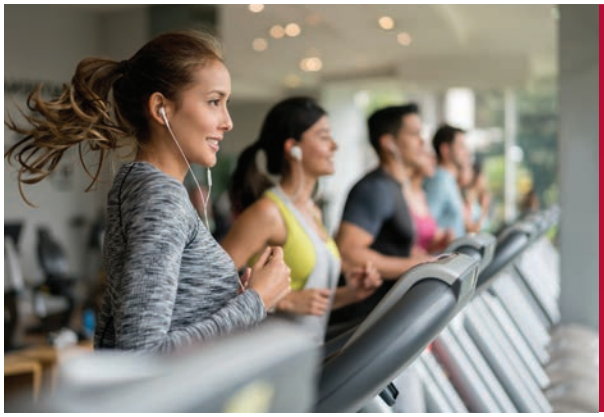
Go to **www.clktx.com/join** and enter Client ID code: LNV20C.

On to Better Health

Magellan HEALTHCARE

This interactive software offers an alternative to traditional mental health and substance abuse care by providing access to tools and resources that are easy to use, confidential and available 24/7 at no cost.

Go to **www.ontobetterhealth.com/php**.



Keep moving with a Fitness Pass membership.

Only $12.50 per eligible member per month.
Enrollment is open year-round.

PRESBYTERIAN Health Plan, Inc.

As a Presbyterian Health Plan member, you and your dependents have access to more than 10,000 fitness, recreation and community centers, including:

- Defined Fitness locations in Albuquerque, Rio Rancho, Farmington and Santa Fe
- Prime Fitness network (nationwide)
- A discount on Sports & Wellness gym fees

DEFINED FITNESS
www.defined.com

Defined Fitness is one of New Mexico's premier health clubs, offering a wide variety of group exercise classes, supervised child care and state-of-the-art strength training and cardiovascular equipment. All locations feature an aquatic complex with an indoor pool, hot tub, dry sauna and steam room.

prime
www.primemember.com

The Prime Fitness network provides group exercise classes and amenities such as pools, sport courts, tracks and more. You can visit participating locations nationwide as often as you like, including select CHUZE, YMCAs, Snap Fitness, Curves® and more. When you use Prime Fitness, your fitness travels with you.

SPORTS & WELLNESS
www.sportsandwellness.com

Sports & Wellness is where Albuquerque has gone to find fun, friends and fitness for 25+ years. Enjoy a special Presbyterian Health Plan member rate and experience five-star service and first-rate amenities at five New Mexico locations.

Fitness Pass program enrollment is easy. How to start:

For quick access and to learn more about Fitness Pass, go to **www.phs.org/wellness**.

Or, from **www.phs.org** you can:

Log in or register for MyPRES	Select MyHealthPlan	Select Wellness Information	Select Fitness Pass

MyHealthPlan

Fitness Pass

Enrollment must be completed by the health plan subscriber.

- All enrolled health plan members aged 18 and older are eligible to enroll. Employees must enroll in the program for dependents to be eligible for the program.
- Once enrolled, Presbyterian will automatically debit your account or credit card each month.
- Your enrollment will last through the current calendar year, and you must reenroll each year.

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

Keep Moving with a Fitness Pass Membership

PRESBYTERIAN Health Plan, Inc.

Your journey to a healthier you is as easy as a few clicks!

1. Visit **www.phs.org**.
2. Sign in using your myPRES credentials. Need a myPRES account? Sign up at **www.phs.org/myPRES**.
3. Select the eligible family members that would like to enroll. Remember, only enrolled members aged 18 and older are eligible for the Fitness Pass.
4. Fill out the banking information. Presbyterian accepts debit accounts and most major credit cards.
5. Print/save a copy of your confirmation page. If you have any questions, please call our customer service center using the number on the back of your Member ID card and reference the confirmation number.
6. We will send your eligibility information beginning the first of the following month.
7. Visit the gym of your choice. At Defined Fitness and Sports & Wellness, you will be issued an ID card directly by the gym after you present your Presbyterian Member ID card. If you want to use Prime Fitness, visit **www.primemember.com** to obtain a Prime ID Card before visiting a gym in that network.

Some things to keep in mind about your Fitness Pass membership

- You can use as many gyms simultaneously as you would like; there is no limit to the number of gyms you can utilize.
- Upon enrollment, your fitness pass eligibility will start on the first of the following month.
- Initial enrollment is open all year, although if you enroll you are committed through the calendar year.
- Eligible dependents must be at least 18 years of age to participate.
- Dependents living outside of New Mexico can still participate and have access to the nationwide Prime Fitness Network.
- You must be active on your Presbyterian Health Plan policy to remain eligible for the Fitness Pass.
- Fitness Pass accounts cannot be changed or cancelled voluntarily.
- If your account is cancelled for non-payment, you cannot re-enroll until the following year.
- All gym memberships through the Fitness Pass are basic memberships; upgrades may be purchased directly through the fitness center.

Wherever You Go, We'll Be There

PRESBYTERIAN
Health Plan, Inc.

Care in New Mexico

With access to more than 24,000 providers statewide and in bordering communities, Presbyterian gives you more freedom to manage your own healthcare. To find the most current list of providers and create your very own personal Provider Directory based on criteria you choose, visit **www.phs.org/directory**.

Care Outside New Mexico

In addition to our robust provider network, members also receive in-network benefits outside of New Mexico with nearly 900,000 providers through our partnership with a national network. Visit **www.multiplan.com/presbyterian**.

Investing in Growing Communities

Presbyterian has served the communities of northern New Mexico for more than 60 years. In 2015, we opened our first Santa Fe facility on St. Michael's Drive, and in 2018, we opened the Presbyterian Health Park in Santa Fe, featuring a medical center with 30+ patient beds, specialty medical services, surgery suites and an urgent care and emergency department.

(505) 923-5600, 1-888-ASK-PRES (1-888-275-7737)

www.phs.org/nmpsia

Investing in Growing Communities

PRESBYTERIAN

PRESNow 24/7 Urgent and Emergency Care is Albuquerque's only 24/7 urgent care and emergency care under one roof. The first location in the Northeast Heights opened in June 2019. Two other locations have recently opened in Albuquerque at 4515 Coors Blvd. NW and at 3436 Isleta Blvd. SW.

Presbyterian Medical Group opened a new clinic at 3630 Las Estancias Dr. SW, expanding our current services on Albuquerque's south side to include a community room, a demonstration kitchen and other valuable resources for area residents.

In partnership with Lincoln County, Presbyterian built a new 70,000 square foot hospital with 25 private rooms to better meet the needs of Ruidoso residents and surrounding areas. Presbyterian has managed Lincoln County Medical Center since 1972.

The recent expansion of our Physician Office Building at Rust Medical Center in Rio Rancho allows us to provide many specialty services in one convenient location, including an outpatient surgical center and screening, diagnosis, treatment and ongoing care for breast disease in our Presbyterian Breast Care location.

(505) 923-5600, 1-888-ASK-PRES (1-888-275-7737)

www.phs.org/nmpsia

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 01/01/2022.
This plan is available under BlueCross BlueShield of New Mexico, Cigna Health and Presbyterian Health Plan.
The Summary Plan Description supersede any information outlined in this summary.

NMPSIA High Option Health Plan 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 (Includes copayments, coinsurance, and deductibles) Individual Family	 $4,100 $8,200	 $9,500 $19,000
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 visit access. *Cost varies dependent on specific plan details - see your health plan for more information.)	Office Visit Copay *(deductible waived)* $25 $50 $0*	 40% 40% Not Covered
Office Surgery (Including casts, splints, and dressings)	20%	40%
Allergy injections (only), Extract Preparation	No Charge *(deductible waived)*	40%
Therapeutic injections: Allergy Testing	$25	40%
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	No Charge *(deductible waived)*	40% *(deductible waived)*
Acupuncture, Chiropractic (Spinal Manipulation), Massage Therapy (If medically necessary. Combined max. benefit of 30 visits/calendar year) **Naprapathy and Rolfing** (combined max. benefit of 30 visits/calendar year)	$50 copay *(deductible waived)*	40% Naprapathy and Rolfing Not Covered
Ambulance Service: Ground and Emergency Air Transport	$50 copay *(deductible waived)*	
Ambulance Services: Inter-facility Transport	$0 *(deductible waived)*	
Autism Spectrum Disorder Applied Behavioral Analysis (ABA). Specialist includes outpatient physical therapy, occupational therapy & speech therapy.	No Charge	40%
Biofeedback (For specified medical conditions only)	$50 copay *(deductible waived)*	40%
Cardiac and Pulmonary Rehabilitation (Office/Outpatient)	$50 copay *(deductible waived)*	40%
Dental/Facial Accident, Oral Surgery & TMJ/CMJ Services	Varies by Services	40%
Emergency Room Treatment Physician and other professional provider charges	$450 copay *(deductible waived)*	
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	40% 120 visits per 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)*	40%
Infertility: Diagnosis Only - No Treatment	Varies by services	40%
Lab, X-Ray, and other Basic Diagnostic Tests - non-routine (Office/Freestanding Lab or Radiology Facility)	$30 copay or actual allowable amount, whichever is less per day *(deductible waived)*	40%
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)*	40%

NMPSIA High Option Health Plan 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)*	40%
Professional Interpretation & Reading (Lab, X-Ray, & High Tech)	No Charge	40%
Prothrombin Time Test	$10 copay *(deductible waived)*	40%
Sleep Study	20%	40%
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**	20% coinsurance after deductible	40% coinsurance after deductible
Observation Stay including Related Professional Charges	$100 facility copay plus 20%	40%
Maternity Services		
Physicians Midwife Services (Delivery, pre- and post-natal care, including lab, diagnostic testing, and pre-natal genetic testing, if medically necessary)	$25 Office Visit Copay/Initial Visit	40%
Hospital Admission (Including routine newborn nursery charges)	20% coinsurance after deductible	40%
Extended Stay (non-routine) Charges for covered Newborn	20% coinsurance after deductible	40%
Home Birth	20%	40%
Mental Health Services		
Office, Home, Outpatient Facility/Physician	No Charge	40%
Inpatient	No Charge	40%
Partial Hospitalization	No Charge	40%
Facility-Based Intensive Outpatient Programs (IOP)	No Charge	40%
Substance Abuse Rehabilitation (Lifetime-no limit on number of courses of treatment for all services combined)		
Office, Home, Outpatient Facility/Physician (No limit on number of days/calendar year)	No Charge	40%
Inpatient (No limit on number of days/calendar year)	No Charge	40%
Partial Hospitalization (No limit on number of days/calendar year combined with Inpatient)	No Charge	40%
Facility-Based Intensive Outpatient Programs (IOP)	No Charge	40%
Residential Treatment Center		
Residential Treatment Center (RTC): (For adults age 18 & older only) (No limit on number of days/calendar year and no limit on days/admit)	No Charge	40%
Outpatient Hospital/Facility/Ambulatory Surgery Facility (Including Related Professional Charges)	20% coinsurance after deductible	40%
Short-Term Rehabilitation, Outpatient and Office: Occupational, Physical & Speech Therapy Services	$25 copay up to $250 *(deductible waived);* thereafter no charge for the remaining calendar year	40%
Smoking/Tobacco Use Cessation (Includes medication, hypnotherapy, acupuncture, related tests, and any counseling programs not eligible under Routine/Preventive Services)	No Charge For Prescription Drugs, see your Express Scripts Plan for details	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%	40%
Insulin Pump Supplies (Insertion sets, reservoirs)	No Charge *(deductible waived)*	40%
Therapy: Chemotherapy and Radiation Therapy	No Charge *(deductible waived)*	40%
Therapy: Dialysis	20%	40%
Transplant Services Maximums apply to donor charges, travel, and lodging. Services 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)	$50 copay *(deductible waived)*	40%
Prescription Drugs, Insulin, Diabetic Supplies, Nutritional Products, Smoking/Tobacco Cessation Products: Administered by CVS Caremark. Call CVS Customer Service Center: 1-877-787-0652		

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 01/01/2022.
This plan is available under BlueCross BlueShield of New Mexico, Cigna Health and Presbyterian Health Plan.
The Summary Plan Description supersede any information outlined in this summary.

NMPSIA Low Option Health Plan 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 (Includes copayments, coinsurance, and deductibles) Individual Family	 $4,100 $8,200	 $9,500 $19,000
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 visit access. *Cost varies dependent on specific plan details - see your health plan for more information.)	Office Visit Copay *(deductible waived)* $30 $60 $0*	 50% 50% Not Covered
Office Surgery (Including casts, splints, and dressings)	25%	50%
Allergy injections (only), Extract Preparation	25%	50%
Therapeutic injections: 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	No Charge *(deductible waived)*	50% *(deductible waived for routine testing only)*
Acupuncture, Chiropractic (Spinal Manipulation), Massage Therapy (If medically necessary. Combined max. benefit of 30 visits/calendar year) **Naprapathy and Rolfing** (combined max. benefit of 30 visits/calendar year)	25% $50 copay (Limit $500 per year) *(deductible waived)*	50% Naprapathy and Rolfing Not Covered
Ambulance Service: Ground and Emergency Air Transport	25% coinsurance after deductible	
Ambulance Services: Inter-facility Transport	$0 *(deductible waived)*	
Autism Spectrum Disorder Applied Behavioral Analysis (ABA). Specialist includes outpatient physical therapy, occupational therapy & speech therapy.	No Charge	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	$450 copay after deductible	
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	25% Unlimited	50% 120 visits per 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)	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 Facility)	$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 Health Plan 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 Tech)	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		
Physicians Midwife Services (Delivery, pre- and post-natal care, including lab, diagnostic testing, and pre-natal genetic testing, if medically necessary)	25%	50%
Hospital Admission (Including routine newborn nursery charges)	25%	50%
Extended Stay (non-routine) Charges for covered Newborn	25%	50%
Home Birth	25%	50%
Mental Health Services		
Office, Home, Outpatient Facility/Physician	No Charge	50%
Inpatient	No Charge	50%
Partial Hospitalization	No Charge	50%
Facility-Based Intensive Outpatient Programs (IOP)	No Charge	50%
Substance Abuse Rehabilitation (Lifetime-no limit on number of courses of treatment for all services combined)		
Office, Home, Outpatient Facility/Physician (No limit on number of days/calendar year)	No Charge	50%
Inpatient (No limit on number of days/calendar year)	No Charge	50%
Partial Hospitalization (No limit on number of days/calendar year combined with Inpatient)	No Charge	50%
Facility-Based Intensive Outpatient Programs (IOP)	No Charge	50%
Residential Treatment Center		
Residential Treatment Center (RTC): (For adults age 18 & older only) (No limit on number of days/calendar year and no limit on days/admit)	No Charge	50%
Outpatient Hospital/Facility/Ambulatory Surgery Facility (Including Related Professional Charges)	25%	50%
Short-Term Rehabilitation, Outpatient and Office: Occupational, Physical & Speech Therapy Services	$30 *(deductible waived)*	50%
Smoking/Tobacco Use Cessation (Includes medication, hypnotherapy, acupuncture, related tests, and any counseling programs not eligible under Routine/Preventive Services)	No Charge For Prescription Drugs, see your Express Scripts Plan for details	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, travel, and lodging. Services 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 CVS Caremark. Call CVS Customer Service Center: 1-877-787-0652		

EPO OPTION - SUMMARY OF BENEFITS

This is only a summary that lists the member cost-sharing amounts and provides a brief description of NMPSIA Exclusive Provider Organization(EPO) Plan benefits effective 01/01/2022. This plan is ONLY available under BlueCross BlueShield of New Mexico (BCBSNM).

The Summary Plan Description supersede any information outlined in this summary.

NMPSIA EPO Option Health Plan Benefits There is no overall lifetime maximum benefit. However, certain services have maximum annual limits. See below:	Member's Share of Covered Charges EPO Benefits Preferred BCBSNM Provider Network
Calendar Year Deductible Individual Family	 $500 $1,000
Annual Out-Of-Pocket Limit (Includes copayments, coinsurance, and deductibles) 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.) **Primary Preferred Provider Office/Home Visit** **Specialist/Office/Home Visit** **Telehealth** (Virtual video visit access. *Cost varies dependent on specific plan details - see your health plan for more information.)	Office Visit Copay *(deductible waived)* $25 $35 $0*
Office Surgery (Including casts, splints, and dressings)	20%
Allergy injections (only), Extract Preparation	No Charge *(deductible waived)*
Therapeutic injections: 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	No Charge *(deductible waived)*
Acupuncture, Chiropractic (Spinal Manipulation), Massage Therapy (If medically necessary. Combined max. benefit of 30 visits/calendar year) **Naprapathy and Rolfing** (combined max. benefit of 30 visits/calendar year)	$35 copay *(deductible waived*
Ambulance Service: Ground and Emergency Air Transport	$25 *(deductible waived)*
Ambulance Services: Inter-facility Transport	$0 *(deductible waived)*
Autism Spectrum Disorder Applied Behavioral Analysis (ABA). Specialist includes outpatient physical therapy, occupational therapy & speech therapy.	No Charge
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% coinsurance after deductible
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 Facility)	$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 Option Health Plan Benefits There is no overall lifetime maximum benefit. However, certain services have maximum annual limits. See below:	Member's Share of Covered Charges EPO Benefits Preferred BCBSNM Provider Network
High Tech Imaging: **MRI, MRA, CT Scan, PET Scan**	$500 copay or 20%, whichever is less per day *(deductible waived)*
Professional Interpretation & Reading (Lab, X-Ray, & High Tech)	No Charge
Prothrombin Time Test	$10 copay *(deductible waived)*
Sleep Study	20%
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**	$500 facility copay/admission plus 20% (EPO 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 an acute care facility.)
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)	$25 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	No Charge
Inpatient	No Charge
Partial Hospitalization	No Charge
Facility-Based Intensive Outpatient Programs (IOP)	No Charge
Substance Abuse Rehabilitation (Lifetime-no limit on number of courses of treatment for all services combined)	
Office, Home, Outpatient Facility/Physician (No limit on number of days/calendar year)	No Charge
Inpatient (No limit on number of days/calendar year)	No Charge
Partial Hospitalization (No limit on number of days/calendar year combined with Inpatient)	No Charge
Facility-Based Intensive Outpatient Programs (IOP)	No Charge
Residential Treatment Center	
Residential Treatment Center (RTC): (For adults age 18 & older only) (No limit on number of days/calendar year and no limit on days/admit)	No Charge
Outpatient Hospital/Facility/Ambulatory Surgery Facility (Including Related Professional Charges)	$150 copay plus 20%
Short-Term Rehabilitation, Outpatient and Office: Occupational, Physical & Speech Therapy Services	$25 copay up to $250 *(deductible waived)* ; 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 Routine/Preventive Services)	No Charge For Prescription Drugs, see your CVS 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%
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, travel, and lodging. Services 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 x-ray/labs/ physician fees)	$45 copay *(deductible waived)*
Prescription Drugs, Insulin, Diabetic Supplies, Nutritional Products, Smoking/Tobacco Cessation Products: Administered by CVS Caremark. Call CVS Customer Service Center: 1-877-787-0652	

Medical Plan Exclusions and Limitations that are Common to BlueCross BlueShield of New Mexico, Cigna Health, and Presbyterian Health Plans

The information below is a summary of the plan exclusions that are similar in the Medical Plans administered by BlueCross BlueShield of NM, Cigna Health and Presbyterian Health Plan. Refer to the Medical Plan documents (benefit booklets) located at www.nmpsia.com for a complete list and detailed information about covered and excluded benefits of the medical plans.

- 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 eyer 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

Here's an overview of your CVS Caremark benefits.

New Mexico Public Schools Insurance Authority

BCBS High & Low Plan, Cigna High & Low Plan, Presbyterian High & Low Plan – Effective July 1, 2022

Here's what you need to know about how and where to fill prescriptions to ensure they are covered under your plan starting July 1, 2022. Visit **Caremark.com** for more up-to-date, personalized information about your plan.

	Fill at any pharmacy in your plan's network		**Fill at CVS Caremark Mail Service Pharmacy**
	Cost for up to a 30 day supply	Cost for a 31-90 day supply	Cost for up to a 90 day supply
Generic Medications Best option to help you save money	**$10** for one 30 day supply	**$22** for a 31-90 day supply	**$22** for one 90-day supply
Preferred Brand-Name Medications Best option when a generic isn't available	**30% ($30 min / $60 max)** for one 30 day supply	**$60** for a 31-90 day supply	**$60** for one 90-day supply
Non-Preferred Brand-Name Medications Highest cost option	**70%** for one 30 day supply	**70%** for a 31-90 day supply	**70%** for one 90-day supply
Diabetic Supplies & Medications	Generic & Preferred Diabetic Supplies, Insulin and Injectable Diabetic medications are covered at **$0** copay. Log into Caremark.com or call us at 1-877-787-0652 for more details.		
Specialty Medications*	Per 30 day supply of specialty medicines through CVS Specialty pharmacy: Generic $55 Preferred Brand $80 Non-Preferred Brand $130		
Maximum Out-of-Pocket	$3,000 individual / $6,000 family (prescription only)		

Please Note: When a generic is available, but the pharmacy dispenses the brand-name medication for any reason, you will pay the difference between the brand-name medication and the generic plus the brand copayment.

* Your plan includes the PrudentRx program for certain eligible specialty medications exclusively dispensed by CVS Specialty. For these medications, 30% coinsurance will apply. If you are enrolled in PrudentRx, your final out of pocket cost will be $0. If you opt out of PrudentRx, you will be responsible for the 30% coinsurance. Note: only the amount you pay out of pocket will be reflected in your annual deductible and/or maximum out-of-pocket.

Copayment, copay or coinsurance means the amount a plan participant is required to pay for a prescription in accordance with a Plan, which may be a deductible, a percentage of the prescription price, a fixed amount or other charge, with the balance, if any, paid by a Plan.

Your privacy is important to us. Our employees are trained regarding the appropriate way to handle your private health information.

NUBAAG

22AS-SML-2021_SUM_RETAIL90_3COLUMN_MOOP_SP-0522
22AS-SML-2020_SUM_NON-MCHOICE_SHELL-1020
106-53123B 102320

CVS caremark®

00001

Here's an overview of your CVS Caremark benefits.

New Mexico Public Schools Insurance Authority

BCBS EPO Plan – Effective July 1, 2022

Here's what you need to know about how and where to fill prescriptions to ensure they are covered under your plan starting July 1, 2022. Visit **Caremark.com** for more up-to-date, personalized information about your plan.

	Fill at any pharmacy in your plan's network		**Fill at CVS Caremark Mail Service Pharmacy**
	Cost for up to a 30 day supply	Cost for a 31-90 day supply	Cost for up to a 90 day supply
Generic Medications Best option to help you save money	**$10** for one 30 day supply	**$22** for a 31-90 day supply	**$22** for one 90-day supply
Preferred Brand-Name Medications Best option when a generic isn't available	**30% ($30 min / $60 max)** for one 30 day supply	**$60** for a 31-90 day supply	**$60** for one 90-day supply
Non-Preferred Brand-Name Medications Highest cost option	**70%** for one 30 day supply	**70%** for a 31-90 day supply	**70%** for one 90-day supply
Diabetic Supplies & Medications	Generic & Preferred Diabetic Supplies, Insulin and Injectable Diabetic medications are covered at **$0** copay. Log into Caremark.com or call us at 1-877-787-0652 for more details.		
Specialty Medications*	Per 30 day supply of specialty medicines through CVS Specialty pharmacy: Generic $55 Preferred Brand $80 Non-Preferred Brand $130		
Maximum Out-of-Pocket	$3,100 individual/$6,200 family (prescription only)		

Please Note: When a generic is available, but the pharmacy dispenses the brand-name medication for any reason, you will pay the difference between the brand-name medication and the generic plus the brand copayment.

***** Your plan includes the PrudentRx program for certain eligible specialty medications exclusively dispensed by CVS Specialty. For these medications, 30% coinsurance will apply. If you are enrolled in PrudentRx, your final out of pocket cost will be $0. If you opt out of PrudentRx, you will be responsible for the 30% coinsurance. Note: only the amount you pay out of pocket will be reflected in your annual deductible and/or maximum out-of-pocket.

22AS-SML-2021_SUM_RETAIL90_EPO_MOOP_SP-0522
22AS-SML-2020_SUM_NON-MCHOICE_SHELL-1020
106-53123B 102320

Copayment, copay or coinsurance means the amount a plan participant is required to pay for a prescription in accordance with a Plan, which may be a deductible, a percentage of the prescription price, a fixed amount or other charge, with the balance, if any, paid by a Plan.

Your privacy is important to us. Our employees are trained regarding the appropriate way to handle your private health information.

NUBAAG

CVS caremark®

00001

Use this Plan to Fill Your Long-Term Medications

And make the most of your new benefits

This plan offers you choice and savings when it comes to filling long-term prescriptions (medications you take regularly such as asthma or high blood pressure medications). Simply make a few changes to enjoy these savings.

CVS Caremark® Mail Service Pharmacy:

- Enjoy convenient home delivery
- Receive your medications in private, tamper-resistant and (when needed) temperature-controlled packaging
- Talk to a pharmacist by phone

We'll make the transition easier by transferring any prescription you're currently filling by mail to CVS Caremark Mail Service Pharmacy as long as you have refills left.

We'll send your medications to your location of choice.

- When you receive your member ID card, register at **Caremark.com** and follow the instructions to request a new 90-day prescription or refill an existing prescription if one is available to you.
- Note: Prescriptions for some medications, including controlled substances and compound medications, cannot be transferred. If you're not sure if you are taking this type of medication, please talk to your doctor.

To sign up for mail service for the first time, you'll need to transfer your prescriptions.

Don't worry, we make it easy.

- For pickup at CVS Pharmacy®, visit **Caremark.com/MoveMyMeds**
- For delivery by mail, visit **Caremark.com/RxDelivery**

CVS Pharmacy:

- Pick up your medication at a time that is convenient for you
- Enjoy same-day prescription availability
- Talk with a pharmacist face-to-face

To pick up at CVS Pharmacy, choose the option that works best for you. After July 1, 2022, you can:

- Register or log into **Caremark.com** to select a CVS Pharmacy location for pick up
- Visit your local CVS Pharmacy and talk to the pharmacist
- Call us using the number on your member ID card, and we'll handle the rest

For personalized support, visit Caremark.com or call CVS Customer Care at 1-877-787-0652.

CVS caremark®

CVS caremark™

Generic medication

Same quality, better price.

We offer many generic options to help keep your medication as affordable as possible.

Generic medications work just like brand-name equals.

A generic has the same active ingredients, strength and dosage as its brand-name equal. It provides the same quality and performance. Generics don't have high development costs.[1] That's why they cost you less.

Generics are safe.

The U.S. Food and Drug Administration (FDA) requires generics to be as safe and effective as brand-name equals. Both types of medication must meet the same FDA standards.[1]

Here's how to save with generics.

Current prescriptions: Ask your provider or pharmacist if you can replace your brand-name medication with a generic.

New prescriptions: Ask your provider if there's a generic option.

Nearly 9 out of 10 CVS Caremark® prescriptions are for generics[2]

For savings opportunities and personalized support, visit Caremark.com (after your benefits begin).

[1] https://www.fda.gov/drugs/buying-using-medicine-safely/generic-drugs.
[2] CVS Health Book of Business, Funded Clients, January – June 2019. Provided by Enterprise Analytics, November 2019.
Your privacy is important to us. Our employees are trained regarding the appropriate way to handle your private health information.

Better diabetes management with no-cost meters

Regular blood glucose testing is an essential part of successful diabetes management. The Diabetic Meter Program makes monitoring blood glucose levels easier by offering no-cost* meters to eligible plan members.

The Diabetic Meter Program

This value-added program is offered as part of your prescription benefit plan and provides eligible members with a blood glucose meter at no out-of-pocket cost.

Eligibility

To take advantage of this offer, members must:

- Be enrolled in the prescription benefit plan
- Have diabetes
- Have a valid prescription for blood glucose test strips. Members who don't already have a prescription can request one at Caremark.com/managingdiabetes.

Additional requirements or limitations may apply. Meters will be shipped to members within 7 to 10 days of order.

Diabetic Meter Program

For more information about offering the Diabetic Meter Program to your members, **visit caremark.com/managingdiabetes and choose "*request a meter*".**

*Blood glucose meters are funded by the manufacturer. Choice of meters is subject to change. Additional requirements or limitations may apply.

Image Source: Getty Images 2018.

CVS caremark™

CVS Specialty®

More than medication.

CVS Specialty provides specialized care and support along with your medication for complex conditions (such as rheumatoid arthritis, multiple sclerosis, HIV and cancer).

A team of pharmacists and nurses specially trained in your condition.

We give you a CVS Specialty CareTeam led by pharmacists and nurses to support you 365 days a year. We'll show you how to take your medication correctly, help you manage side effects and stay on track. We also provide helpful resources at **CVSspecialty.com/EducationCenter**.

A choice of pick up at CVS Pharmacy® or home delivery at no extra cost.

We make it as easy as possible to get the medication you need, where you need it. You can have your medication delivered anywhere nationwide, even if you're on vacation. Or you can pick it up at any CVS Pharmacy location.*

Digital tools let you manage your prescriptions on your own time.

We make it easy to manage your medications and stay on track at **CVSspecialty.com/go** or with our mobile app.

What's a specialty pharmacy?

It's a pharmacy that provides specialized medication for complex conditions or medication requiring injections or infusions.

*Where allowed by law. In-store pick up is currently not available in Oklahoma. Puerto Rico requires first-fill prescriptions to be transmitted directly to the dispensing specialty pharmacy. Products are dispensed by CVS Specialty and certain services are only accessed by calling CVS Specialty directly. Certain specialty medication may not qualify. Services are also available at Long's Drugs locations. Your privacy is important to us. Our employees are trained regarding the appropriate way to handle your private health information.

CVS caremark™

Digital tools

Save time and money.

Our digital tools help you find ways to save on medication and manage your prescriptions on your own time.

Our digital tools make it easy to manage your health whenever – and wherever – you like. You can look for saving opportunities, stay on top of your prescriptions and more. Here's how our digital tools can help you every day.

Stay in the loop.
Sign up to get email or text messages about your prescriptions, ways to save, status updates and more.

Refill fast.
Request refills quickly and keep track of prescriptions for your family in one convenient place. See how close you are to meeting your deductible and out-of-pocket cost maximum anytime.

Explore Rx savings options.
Find out if your Rx is covered or if you could pay less for it. And see if options like Rx delivery by mail or changing to a generic medication can save you money.

Have the Wallet app on an Apple device?
Save your ID card to Wallet and view it anytime.

For savings opportunities and personalized support, visit Caremark.com (after your benefits begin).

CVS caremark™

Mobile app

Manage your Rx on your own time.

We make it easy to keep track of your Rx, check for savings and more from your mobile device.

Our mobile app gives you a secure, simple way to manage your prescription benefits and member information. You'll find easy-to-use tools that help you save time, get organized and stay on your path to better health. Find a nearby pharmacy no matter where you are. Learn about your medication and get information you can trust day or night. Do all this – and much more – at your convenience.

Keep an eye on drug costs and check for lower-cost alternatives that may save you money.

Order and track refills – even get timely refill reminders – so you never miss a dose.

Stay on top of order status so you know when to pick up your medication or watch for delivery by mail.

Access your Rx list, member ID cards and Rx history at your doctor's office or anytime you need them.

For savings opportunities and personalized support, visit Caremark.com (after your benefits begin).

Your privacy is important to us. Our employees are trained regarding the appropriate way to handle your private health information.
 106-50181A 091021

CVS caremark™

Rx Delivery by Mail

Convenience, savings and safety.

Why get your Rx delivered by mail? Not only is delivery by mail a safe and secure way to get the medications you take regularly (like medication for asthma or high blood pressure) — you'll probably save money, too.

Want more convenience?
With delivery, you have one less thing to worry about. Your 90-day supplies will arrive at your door from CVS Caremark® Mail Service Pharmacy.

Like to save?
Filling your Rx in 90-day supplies usually comes with savings. Plus, there's no extra cost for shipping.

Looking to stay safe?
Contactless delivery keeps you and your loved ones safe. And our secure, nondescript packaging protects your privacy.

90-day supplies typically cost less than 30-day supplies.

Start Rx Delivery by Mail at Caremark.com/RxDelivery (after your benefits begin).

Your privacy is important to us. Our employees are trained regarding the appropriate way to handle your private health information.
 106-50571A 091021

DELTA DENTAL®

Your Local Choice in Dental

To enroll or switch your NMPSIA dental plan to Delta Dental of New Mexico, please contact your benefits administrator!

For questions about **Delta Dental of New Mexico plan options**, contact your HR Department, or call **NMPSIA** at **1-800-548-3724** or **ERISA** at **1-800-233-3164**

50 YEARS OF SMILES
SINCE 1971

www.DeltaDentalNM.com

DELTA DENTAL®

Why Delta Dental

About Delta Dental of New Mexico

Delta Dental of New Mexico in New Mexico's local, not-for-profit dental insurance carrier. Since 1971, our goal has been to leverage our market leader position to advance, innovate, and improve oral and overall health for all New Mexicans. We not only offer a wide variety of high-quality dental plans to businesses and individuals across the state, we assist local communities through philanthropic donations and volunteer support.

Leased Networks and the Delta Dental New Mexico Difference

In today's marketplace, nothing is certain. Each day brings new struggles, uncertainty, and change. But one thing remains consistent and unwavering - our promise of stability and high-quality, especially when it comes to our network. The same can't be said when it comes to leased networks. Not all carriers provide the same quality, strength or value as the Delta Dental network and with leased networks, the carrier typically has no direct contact with the dentist. With Delta Dental, you can be confident you are getting the widest network of high-quality dentists in-state and nation-wide.

No Additional Fees=No Surprises

We never charge additional fees for patients to access any of our networks, a common practice with leased networks. These hidden fees lead to surprise out-of-pocket expenses for patients and decreased overall satisfaction. If a problem occurs concerning fees or charges with one of our network dentists, we work directly with the dentist to resolve the issue on behalf of the patient.

Avoid Surprises with Pre-Treatment Estimates

Unexpected bills aren't fun for anyone. That's why Delta Dental makes it easy for you to find out whether a proposed dental treatment is covered, what amount the plan will pay and the difference you will be responsible for.

Here's how: When you are having extensive work done and want to know what your share of the cost will be, ask your dentist to submit the proposed treatment plan to us for a pre-treatment estimate. A pre-treatment estimate allows us to review the proposed treatment in accordance with your dental coverage. We can then determine what portion of the treatment will be covered under the plan chosen by your employer, if you will exceed your maximum and what portion will be your financial responsibility.

Once completed, we will send a pre-treatment estimate notice to you and your dentist. We encourage you to review this notice together and discuss treatment options before deciding on treatment.

DELTA DENTAL® Network Information

FEATURING: Delta Dental PPO™ Point-of-Service

The Delta Dental New Mexico Public School Insurance Authority (NMPSIA) dental plans feature the Delta Dental PPO™ Point-of-Service network. The plans give enrollees the option to select from two different networks (Delta Dental PPO™ or Delta Dental Premier®) depending on their needs.

Patients selecting a Delta Dental PPO™ dentist receive the plan's highest level of discounts while patients choosing to utilize Delta Dental Premier® will have the broadest selection of dentists but at a lower level of discounts. Please note that there is no **quality** of care difference between networks.

Choosing an In-Network Provider

When asking a provider if they participate with Delta Dental, make sure to ask them if they are a contacted in-network Delta Dental PPO™, or Delta Dental Premier® provider.

You can search for providers on www.deltadentalnm.com under the "Find a Dentist" link, or in the Delta Dental mobile app.

In-Network Providers Nationwide: Delta Dental PPO™ & Delta Dental Premier®

Whether you just traveled across the New Mexico border, or across the nation, know that the Delta Dental PPO™ Point-of-Service network provides you with the same benefit levels as if you were in-state utilizing either the Delta Dental PPO™ or Delta Dental Premier® nationwide networks.

Out-of-Network Providers

Out-of-network providers have not agreed to the provider fee maximums applicable under the dental plan. Your out-of-pocket costs can be much higher because you may be balance billed for the difference up to the full amount charged by the provider and what the plan may pay. Further, you may have to pay the full amount at the time you receive services and submit a claim for reimbursement. Reduced benefit levels apply to out-of-network services.

Delta Dental Members Have 24/7 Access

Once your plan is effective, Delta Dental's automated voice response system is available 24/7 to help you with topics such as benefit/eligibility verification, requesting an ID card, provider directories, and checking claim/pre-treatment estimate status. To access the Delta Dental New Mexico automated voice response system, please call us 24/7 at (877) 395-9420.

DELTA DENTAL

Delta Dental of New Mexico Plan Options

New Mexico Public School Insurance Authority (NMPSIA)

Delta Dental PPO™ Point-of-Service	Basic Plan		Comprehensive Plan	
Benefit Category	***Contracted In-Network: You Pay***	***Out-of-Network: You Pay****	***Contracted In-Network: You Pay***	***Out-of-Network: You Pay****
Diagnostic and Preventive Services	***No Deductible Applies***			
Oral Exams, Routine Cleanings & Periodontal maintenance cleanings (2 per calendar year). *Members with specified medical conditions may be eligible for additional cleanings & periodontal surgeries.*	No Charge	75% of Allowed Amount + Balance Billing	No Charge	0% of Allowed Amount + Balance Billing
Sealants to age 16 (first and second molars only)				
Fluoride treatments (2 per calendar year to age 20)				
Radiographic Images (full mouth: once every 5 years; bitewings: twice per calendar year through age 13, once per calendar year thereafter)				
Emergency Treatment for Relief of Pain				
Basic Services	***Deductible Applies***			
Amalgam or Composite Fillings	20%	75% of Allowed Amount + Balance Billing	20%	45% of Allowed Amount + Balance Billing
Extractions (non-surgical)				
Endodontics				
Non-Surgical Periodontics				
Oral Surgery (including surgical extractions)	100% (Not Covered)			
Surgical Periodontics				
Repairs to Crowns, Onlays, Dentures, and Bridgework	20%	75% of Allowed Amount + Balance Billing		
Major Services	***Deductible Applies***			
Prosthodontic Procedures—for construction of fixed bridges, partials, or complete dentures	100% (Not Covered)		50%	65% of Allowed Amount + Balance Billing
Implants—specified services, including repairs, and related prosthodontics				
Onlays, Crowns, and Cast Restorations—when teeth cannot be restored with amalgam or composite resin restorations				
Orthodontic Services (Children and Adults)	***No Deductible Applies***			
Diagnostic, Active, Retention Treatment —in and out-of-network orthodontic lifetime (maximums cannot be combined)	100% (Not Covered)		50%, No Deductible, $1500 Lifetime Max	50% of Allowed Amount, No Deductible, $500 Lifetime Max
Deductibles and Maximums				
Calendar Year Deductible—Jan. 1 – Dec. 31. Applies to all services except where noted above.	$50 ($150 per Family)		$50 ($150 per Family)	
Calendar Year Maximum—Jan. 1 – Dec. 31 (per person). In and out-of-network maximum benefit amounts cannot be combined.	$1500 Maximum		$1500 Maximum	$1000 Maximum

*Selecting a non-participating provider may result in higher out-of-pocket expenses, even when there is no change in benefit level between in-network and out-of-network benefits. Non-participating providers do not accept Delta Dental's maximum approved fees as payment in full. You will be financially responsible for balance billed amounts, or amounts that exceed the non-participating provider's reimbursement.

DELTA DENTAL®

Supporting New Mexico

By creating more smiles, Delta Dental hopes to improve health and enhance lives across the state of New Mexico

At Delta Dental of New Mexico, we believe in providing exceptional dental benefits as well as improving the dental and overall health of all New Mexicans. That's why we make it a priority to support groups, organizations and charities with the goal of building healthier, happier communities.

From volunteering with food banks, to sponsoring school supply drives, Delta Dental of New Mexico engages with our local communities across the state of New Mexico to help them thrive, no matter what comes their way.

50 YEARS OF SMILES
SINCE 1971

Serving New Mexico Since 1971

Delta Dental of New Mexico is proud to support many communities & organizations including:

- American Heart Association
- Albuquerque Health Care for the Homeless
- ECHO Food Bank (Farmington, NM)
- New Mexico State University Dental Hygiene Program
- New Mexican School-Based Dental Clinics
- The Community Pantry (Gallup & Grants, NM)
- Special Olympics & many more!

DELTA DENTAL®

Save Money on Out-of-Pocket Costs

How Can I Save Money on My Out-of-Pocket Costs?

With your Delta Dental PPO™ Point-of-Service plan, you may save more money and receive higher levels of coverage when visiting a Delta Dental PPO™ dentist. Our PPO dentists have agreed to accept lower fees as full payment for covered services. However, if you go to a dentist who doesn't participate in Delta Dental PPO™, you can still save money if your dentist participates in Delta Dental Premier®. Like our PPO dentists, Delta Dental Premier® dentists agree to accept Delta Dental's fee determination as full payment for covered services.

Delta Dental Networks	**Delta Dental PPO™**	• No balance billing on covered services • Most significant network discounts with more than 269,800 office locations nationwide* • Dentists file claims for member
	Delta Dental Premier®	• No balance billing on covered services • Significant network discounts with the most office locations nationwide—340,500* • Dentists file claims for member
Out-of-Network	**Out-of-Network**	• May be balance billed • No discounts • May need to file own claims

*National network statistics: Delta Dental Plans Association, April 2017.

Example of how it works

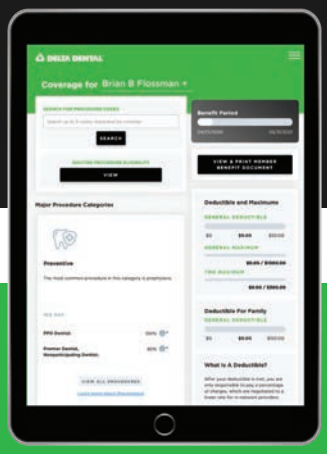
As shown below, your lowest out-of-pocket costs result from going to either a Delta Dental PPO™ or Delta Dental Premier® dentist.

		Delta Dental PPO™ Dentist	Delta Dental Premier® Dentist
Adult Cleaning	Submitted fee	$80	$80
	Maximum allowed fee	$54	$77
	Coverage level	100%	100%
	Amount Delta Dental pays	$54	$77
	AMOUNT YOU PAY	$0	$0
Crown	Submitted fee	$1,100	$1,100
	Maximum allowed fee	$754	$989
	Coverage level	50%	50%
	Amount Delta Dental pays	$377	$494.50
	AMOUNT YOU PAY	$377	$494.50

NOTE: Payment examples above are illustrative only. Fees and reimbursements can vary by location and dentist. They do however represent how payment is determined.

DELTA DENTAL®

Stay Informed About Your Dental Benefits With Member Portal



Member Portal gives you 24/7 access to important information about your dental benefits.

With Member Portal, you can:

- See which members are covered on your plan, now and in the future
- Find an in-network dentist
- See common procedures
- Access an online ID card
- View the status of all claims and toggle between different family member claims
- View and print Explanation of Benefits (EOBs)

NOTE: Member Portal has replaced Consumer Toolkit.

Get started today

Visit www.memberportal.com

Log in using your existing Consumer Toolkit® credentials

OR

If you do not have existing credentials, click "Sign up"

Complete the required fields and follow the on-screen instructions to register as a new user

NOTE: You will need the subscriber's ID (the person whose name is on the benefit package). The member ID is an assigned number unique to the subscriber. In many cases, the member ID is the same as the subscriber's Social Security number.

Questions? Call Toolkit Support at 866-356-0301

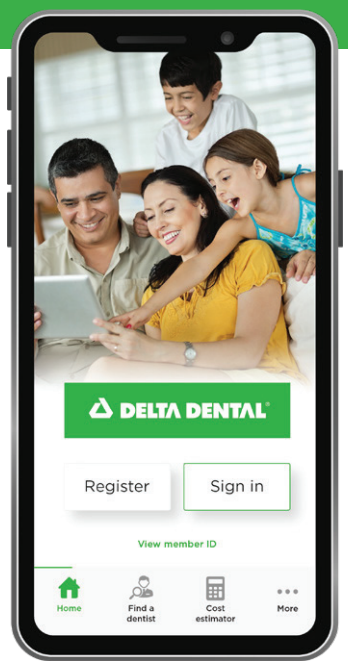
Privacy of your online benefit information is assured through highly secure encryption technology.

FLI-6592 v1 Delta Dental of Arkansas, Indiana, Kentucky, Michigan, New Mexico, North Carolina, Ohio, and Tennessee PA 1/21

Delta Dental Mobile

Helping members manage their oral health

Oral health is important to Delta Dental — and to your overall health! Our mobile app makes it easy for employees to make the most of their dental benefits. Members can access their ID card, find a dentist and estimate costs for dental procedures right from their mobile device.



SCAN TO DOWNLOAD THE DELTA DENTAL MOBILE APP

Getting started

Delta Dental's mobile app is available for iOS (Apple) and Android. To download the app, visit the App Store (Apple) or Google Play (Android) and search for Delta Dental Mobile App or scan the QR code below. You will need an internet connection to download and use most of the features of our free app.

Delta Dental Mobile App Features

- Quick and easy access to your Delta Dental member ID card — no more looking for ID cards!
- A dentist search tool that helps members quickly find an in-network dentist nearby.
- Save your preferred dentist for quick access.
- Our easy-to-use Dental Care Cost Estimator tool provides estimated cost ranges for common dental services.*

Please note information displayed may vary based on your particular coverage. For more information on your coverage, contact your Delta Dental company. "Delta Dental" refers to the national network of 39 independent Delta Dental companies that provide dental benefits and is a registered trademark of Delta Dental Plans Association.

UNITED CONCORDIA® DENTAL

Protecting More Than Just Your Smile®

NMPSIA's Trusted Dental Plan FOR 20 OVER YEARS

At United Concordia Dental, we love smiles—especially yours. We're excited to provide the dental insurance you need to keep it healthy and beautiful.

We make it easy—and affordable—to visit the dentist. Most plans cover:

- ✓ **ROUTINE CARE** including checkups, cleanings and X-rays
- ✓ **BASIC PROCEDURES** like fillings and pulled teeth
- ✓ **MAJOR SERVICES** such as crowns, bridges and dentures

Your plan also includes additional coverage for gum disease treatment if you have certain medical conditions. Plus, a program to help make college more affordable.

To learn more great benefits of enrolling in United Concordia, keep reading.

We look forward to having you as a member this year.

EEM-0143-0522

UNITED CONCORDIA® DENTAL
Protecting More Than Just Your Smile®

HIGH OPTION

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 calendar year) ■ Routine Cleanings (twice every calendar year) ■ Periodontal Cleanings (twice every calendar year) ■ X-rays—complete mouth (once every 5 years); bitewings (twice every calendar year through age 13, once every calendar year thereafter) ■ Sealants (through age 15): permanent first and second molars only ■ Emergency Treatment for Relief of Pain ■ Fluoride Treatment (twice every calendar year 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) [5]	$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 ***MyDental****Benefits* on UnitedConcordia.com.
3. Network and non-network maximums cannot be combined.
4. Non-network reimbursed at the 80th percentile.
5. Orthodontic benefit is paid on a prorated basis. Payments are made quarterly. If coverage ends before the treatment plan is completed, the full benefit of $1,500 may not be paid.

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.

EEM-0143-0522

UNITED CONCORDIA® DENTAL
Protecting More Than Just Your Smile®

LOW OPTION

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 calendar year) ■ Routine Cleanings (twice every calendar year) ■ Periodontal Cleanings (twice every calendar year) ■ X-rays—complete mouth (once every 5 years); bitewings (twice every 12 months through age 13, once every calendar year thereafter) ■ Sealants (through age 15), permanent first and second molars only ■ Emergency Treatment for Relief of Pain ■ Fluoride Treatment (twice every calendar year 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 ***MyDental****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.

EEM-0143-0522

UNITED CONCORDIA® DENTAL

Protecting More Than Just Your Smile®

Choose from 3,000+ in-network dentists in New Mexico

When you stay in network, you'll enjoy benefits like:

- **Lower out-of-pocket costs.**[1] We've negotiated better fees, so you pay less.
- **High-quality care.** Dentists' credentials are verified, and offices are inspected.
- **Time savings.** Most dentists file claims, so there's no paperwork for you.

To find an in-network dentist:

- Visit **UnitedConcordia.com**.
- Click on **Find a Dentist**.
- Type in an office location or dentist's **name**.
- Select your **Alliance network** from the drop-down list.

Create a *MyDental*Benefits account

It's the online hub where you can check your coverage details, see claims and payments, print extra ID cards and more.

Visit **UnitedConcordia.com/GetMDB** after your plan's effective date to set up an account. Make sure to have your member ID or social security number handy.

Your plan includes Smile for Health®–Wellness

If you have diabetes, heart disease, rheumatoid arthritis, lupus or oral cancer, or if you've had a stroke or organ transplant, you're eligible for additional periodontal services to care for gum disease.

Benefits with no additional cost	In-network coverage[2]	Out-of-network coverage[2, 4]
One additional gum disease treatment per year	100%	100%
Deep cleaning treatment for gum disease		
Up to four surgeries to treat gum disease[3]		

Here's how to sign up:

- Visit **UnitedConcordia.com**.
- Sign in to ***MyDental***Benefits (or create an account).
- Click the **Wellness** tab at the top menu.
- Add **+Add a new condition** and complete the fields as prompted.

Paying for college just got easier

Enroll in the **College Tuition Benefit®** and help the students in your family afford college. You'll earn Tuition Rewards® points redeemable for tuition discounts at 400+ participating private colleges and universities.

One point equals a $1 tuition discount. You earn 2,000 points when you enroll, and 2,000 points each year you're covered by United Concordia. That's $4,000 in tuition discounts your first year! Sign up in your ***MyDental***Benefits account.

Scan to learn more online in Clients' Corner

1. In most cases. 2. Your standard plan's frequency limitations (how often services are covered), annual maximum (the maximum amount your plan will pay toward services during the plan year), and other details still apply. 3. Four procedures related to gingival flap or osseous surgeries. 4. Balance billing may app.ly.

Tuition Rewards® is a Registered Trademark of SAGE Scholars, Inc. SAGE is not a subsidiary or affiliate of United Concordia Insurance Company (UCIC). Subject to eligibility requirements and terms and conditions. Tuition Rewards are a value-added program and not an insured benefit. Program participation subject to enrollment with SAGE. "Points" are credits that may be used to discount the cost of Tuition and have no cash value. UCIC does not provide services related to this program. Tuition Rewards not available in all jurisdictions. Program subject to change without notice.

EEM-0143-0522

VersantHealth®
bringing you DavisVision®

davisvision.com | 1 (877) 923-2847, Client Code 7129

Underwritten by HM Life Insurance Company

Vision Care Plan for 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.

Your vision plan offers paid-in-full eye examinations, eyeglasses, and contacts.

- Davis Vision Exclusive Collection Frames: Your plan includes a selection of designer, name-brand frames that are fully covered.[1]
- Davis Vision Exclusive Collection Contact Lenses: Select from some of the most popular contact lenses on the market today.[1]

Locate an In-Network Provider

Davis Vision maintains a national network of credentialed, independent providers throughout the United States. Select from private practice optometrists and ophthalmologists, or a wide variety of retail locations. To find an in-network provider near you, log on to the open enrollment section of the member site at davisvision.com and enter client code 7129.

Extra Features

- Davis Vision provides you and your eligible dependents with the opportunity to receive laser vision correction, often referred to as LASIK, at a discount from national average prices. For more information, visit davisvision.com. [2]
- Davis Vision members have access to discounts with Your Hearing Network. Enjoy savings of up to 40% off the national average selling prices for brand-name hearing aids.[2]

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 on these pages. 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 you are enrolled, log onto our member site at davisvision.com or call us at 1 (800) 999-5431 for more information.

Shop with convenience while using your benefits through these in-network online retailers.

1800contacts® GLASSES.COM Visionworks befitting eyewear

1 The Davis Vision Collection is not available at all network locations. The Davis Vision Collection is available at most participating independent provider locations. Members should call to verify availability of the Exclusive Collection and program participation status when making appointment. The Exclusive Collection is subject to change. Collection is inclusive of select toric and multifocal contacts.

2 Not available at all service areas.

1-800 Contacts, Glasses.com, Visionworks, and Befitting are registered trademarks of their respective companies.

In-Network Benefits

Eye Examination[6]	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 $195) **OR** $100 retail allowance toward any frame from provider, plus 20% off balance[3] **OR** $150 allowance, plus 20% off balance to go toward any frame from a Visionworks family of store locations[5]
Contact Lenses (in lieu of eyeglasses)	
Contact Lens Evaluation, Fitting, and Follow-Up Care	Every 12 months. Collection Contacts (covered in full) **OR** Non-Collection Contacts (15% discount)
Contact Lenses	Every 12 months. Covered in full: Any contact lenses from Davis Vision's Contact Lens Collection[1] **OR** $100 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 and Coatings	
Scratch-Resistant Coating	$0
Polycarbonate Lenses	$0[2] – $30
Standard Anti-Reflective (AR) Coating	$35
Standard Progressives (No-Line Bifocal)	$50
Plastic Photosensitive (Transitions®[4])	$65

Out-of-Network Benefits

You may receive services from an out-of-network provider, even though you may receive greater value for your benefit dollars if you select a provider who participates in the network. If you choose and 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

The Davis Vision Collection is not available at all network locations. The Davis Vision Collection is available at most participating independent provider locations. Members should call to verify availability of the Exclusive Collection and program participation status when making appointment. The Exclusive 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 a 6.00 diopters or greater.
3 Additional discounts not applicable at Walmart, Sam's Club, or Costco locations.
4 Transitions® is a registered trademark of Transitions Optical, Inc.
5 Enhanced frame allowance available at all Visionworks locations nationwide.
6 A refraction-only exam is available in lieu of the full comprehensive eye exam.

Copays for Options and Upgrades	
Frames	
Fashion Frame (From the Davis Vision Collection)	$0
Designer Frames (From the Davis Vision Collection)	$0
Premier Frame (From the Davis Vision Collection)	$0
Lenses	
Plastic Lenses	$0
Oversized Lenses	$0
Tinting of Plastic Lenses	$0
Scratch-Resistant Coating	$0
Premium Scratch-Resistant Coating	$30
Polycarbonate Lenses	$0* or $30
Ultraviolet Coating	$12
Standard Anti-Reflective (AR) Coating	$35
Premium AR Coating	$48
Ultra AR Coating	$60
Ultimate AR Coating	$85
Digital Single Vision Lenses	$30
Standard Progressive Addition Lenses	$50
Select Progressive Addition Lenses	$50
Premium Progressive Addition Lenses	$90
Ultra Progressive Addition Lenses	$140
Ultimate Progressive Addition Lenses	$175
High-Index Lenses 1.67	$55
High-Index Lenses 1.74	$120
Plastic Photosensitive Lenses	$65
Polarized Lenses	$75
Trivex Lenses	$50
Blue Light Filtering	$15
Scratch Protection Plan (Single Vision / Multifocal Lenses)	$20 / $40

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

DV-MKG22-0130v001 PDF 5/2022

Contact Us

For more details about the plan prior to enrolling, 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.

MONTHLY CONTRIBUTIONS EFFECTIVE OCTOBER 1, 2022

NEW MEXICO PUBLIC SCHOOLS INSURANCE AUTHORITY

THE STANDARD: BASIC LIFE
ACCIDENTAL DEATH & DISMEMBERMENT
Employer pays 100% of premium

$10,000 Life/AD&D	**$1.06 per month**
$25,000 Life/AD&D	**$2.64 per month**
$50,000 Life/AD&D	**$5.26 per month**

THE STANDARD: LONG TERM DISABILITY
Employer contributes premium

30 Day Wait	**$0.58 per $100 payroll**
60 Day Wait	**$0.38 per $100 payroll**
90 Day Wait	**$0.30 per $100 payroll**

THE STANDARD: ADDITIONAL LIFE (Employee, Spouse, & Children) and **AD&D** (Employee Only)
Employee pays 100% of premium

Person's Age	Rate per $1,000
under 30	$0.06
30 - 39	$0.08
40 - 44	$0.08
45 - 49	$0.14
50 - 54	$0.22
55 - 59	$0.36
60 - 64	$0.54
65 - 69	$0.80
70 & over	$1.04
Child(ren)	$0.26/mo.

HEALTH COVERAGES *Employer contributes premium (see reverse side)*	**Single**	**Two-Party**	**Family**
Blue Cross Blue Shield New Mexico – High Option	**$860.40**	**$1,636.30**	**$2,185.48**
Blue Cross Blue Shield New Mexico – Low Option	**$596.52**	**$1,134.52**	**$1,515.36**
Blue Cross Blue Shield New Mexico – Exclusive Provider Organization (EPO) Option*	**$774.34**	**$1,472.64**	**$1,966.90**
Cigna – High Option	**$821.54**	**$1,585.92**	**$2,125.66**
Cigna – Low Option	**$572.26**	**$1,104.70**	**$1,480.68**
Presbyterian – High Option	**$695.76**	**$1,461.02**	**$1,948.18**
Presbyterian – Low Option	**$482.46**	**$1,013.02**	**$1,350.76**
Delta Dental – High Option	**$28.60**	**$54.44**	**$85.54**
Delta Dental – Low Option	**$14.32**	**$27.26**	**$42.78**
United Concordia Dental – High Option	**$28.60**	**$54.44**	**$85.54**
United Concordia Dental – Low Option	**$14.32**	**$27.26**	**$42.78**
Davis Vision Plan	**$6.26**	**$10.48**	**$14.14**

** EPO Plan – A managed care plan where services are covered only if you go to providers (doctors, specialists, hospitals, etc.) in the plan's network (except in an emergency).*

(6.0% increase on High and EPO medical plan options;
3.2% increase on Low medical plan options)

Date prepared: 04.12.2022

CONTRIBUTIONS EFFECTIVE OCTOBER 1, 2022 *MONTHLY COST SHARING based on salary and EMPLOYER MINIMUM CONTRIBUTION REQUIREMENTS set for in NM State Statute*		Less than $15,000 *25%/75%*	$15,000 - $19,999 *30%/70%*	$20,000 - $24,999 *35%/65%*	$25,000 and Over *40%/60%*
MEDICAL	**Single (employee deduction)**	**$215.10**	**$258.12**	**$301.14**	**$344.16**
BCBS	Single (district/employer contribution)	$645.30	$602.28	$559.26	$516.24
High Option	**Two-Party (employee deduction)**	**$409.08**	**$490.88**	**$572.70**	**$654.52**
	Two-Party (district/employer contribution)	$1,227.22	$1,145.42	$1,063.60	$981.78
	Family (employee deduction)	**$546.36**	**$655.64**	**$764.92**	**$874.18**
	Family (district/employer contribution	$1,639.12	$1,529.84	$1,420.56	$1,311.30
BCBS	**Single (employee deduction)**	**$149.12**	**$178.96**	**$208.78**	**$238.60**
Low Option	Single (district/employer contribution)	$447.40	$417.56	$387.74	$357.92
	Two-Party (employee deduction)	**$283.62**	**$340.36**	**$397.08**	**$453.80**
	Two-Party (district/employer contribution)	$850.90	$794.16	$737.44	$680.72
	Family (employee deduction)	**$378.84**	**$454.60**	**$530.38**	**$606.14**
	Family (district/employer contribution	$1,136.52	$1,060.76	$984.98	$909.22
BCBS	**Single (employee deduction)**	**$193.58**	**$232.30**	**$271.02**	**$309.74**
EPO Option	Single (district/employer contribution)	$580.76	$542.04	$503.32	$464.60
	Two-Party (employee deduction)	**$368.16**	**$441.78**	**$515.42**	**$589.06**
	Two-Party (district/employer contribution)	$1,104.48	$1,030.86	$957.22	$883.58
	Family (employee deduction)	**$491.72**	**$590.06**	**$688.42**	**$786.76**
	Family (district/employer contribution	$1,475.18	$1,376.84	$1,278.48	$1,180.14
Cigna	**Single (employee deduction)**	**$205.38**	**$246.46**	**$287.54**	**$328.62**
High Option	Single (district/employer contribution)	$616.16	$575.08	$534.00	$492.92
	Two-Party (employee deduction)	**$396.48**	**$475.78**	**$555.06**	**$634.36**
	Two-Party (district/employer contribution)	$1,189.44	$1,110.14	$1,030.86	$951.56
	Family (employee deduction)	**$531.42**	**$637.70**	**$743.98**	**$850.26**
	Family (district/employer contribution	$1,594.24	$1,487.96	$1,381.68	$1,275.40
Cigna	**Single (employee deduction)**	**$143.06**	**$171.68**	**$200.28**	**$228.90**
Low Option	Single (district/employer contribution)	$429.20	$400.58	$371.98	$343.36
	Two-Party (employee deduction)	**$276.16**	**$331.40**	**$386.64**	**$441.88**
	Two-Party (district/employer contribution)	$828.54	$773.30	$718.06	$662.82
	Family (employee deduction)	**$370.16**	**$444.20**	**$518.24**	**$592.26**
	Family (district/employer contribution	$1,110.52	$1,036.48	$962.44	$888.42
Presbyterian	**Single (employee deduction)**	**$173.94**	**$208.72**	**$243.52**	**$278.30**
High Option	Single (district/employer contribution)	$521.82	$487.04	$452.24	$417.46
	Two-Party (employee deduction)	**$365.26**	**$438.30**	**$511.36**	**$584.40**
	Two-Party (district/employer contribution)	$1,095.76	$1,022.72	$949.66	$876.62
	Family (employee deduction)	**$487.04**	**$584.44**	**$681.86**	**$779.26**
	Family (district/employer contribution	$1,461.14	$1,363.74	$1,266.32	$1,168.92
Presbyterian	**Single (employee deduction)**	**$120.62**	**$144.74**	**$168.86**	**$192.98**
Low Option	Single (district/employer contribution)	$361.84	$337.72	$313.60	$289.48
	Two-Party (employee deduction)	**$253.26**	**$303.90**	**$354.56**	**$405.20**
	Two-Party (district/employer contribution)	$759.76	$709.12	$658.46	$607.82
	Family (employee deduction)	**$337.68**	**$405.22**	**$472.76**	**$540.30**
	Family (district/employer contribution	$1,013.08	$945.54	$878.00	$810.46
DENTAL	**Single (employee deduction)**	**$7.16**	**$8.58**	**$10.00**	**$11.44**
Delta Dental or	Single (district/employer contribution)	$21.44	$20.02	$18.60	$17.16
United Concordia	**Two-Party (employee deduction)**	**$13.62**	**$16.34**	**$19.06**	**$21.78**
High Option	Two-Party (district/employer contribution)	$40.82	$38.10	$35.38	$32.66
	Family (employee deduction)	**$21.38**	**$25.66**	**$29.94**	**$34.22**
	Family (district/employer contribution	$64.16	$59.88	$55.60	$51.32
Delta Dental or	**Single (employee deduction)**	**$3.58**	**$4.30**	**$5.00**	**$5.74**
United Concordia	Single (district/employer contribution)	$10.74	$10.02	$9.32	$8.58
Low Option	**Two-Party (employee deduction)**	**$6.82**	**$8.18**	**$9.54**	**$10.90**
	Two-Party (district/employer contribution)	$20.44	$19.08	$17.72	$16.36
	Family (employee deduction)	**$10.70**	**$12.82**	**$14.98**	**$17.12**
	Family (district/employer contribution	$32.08	$29.96	$27.80	$25.66
VISION	**Single (employee deduction)**	**$1.58**	**$1.88**	**$2.20**	**$2.50**
Davis Vision	Single (district/employer contribution)	$4.68	$4.38	$4.06	$3.76
	Two-Party (employee deduction)	**$2.64**	**$3.14**	**$3.68**	**$4.18**
	Two-Party (district/employer contribution)	$7.84	$7.34	$6.80	$6.30
	Family (employee deduction)	**$3.54**	**$4.24**	**$4.94**	**$5.66**
	Family (district/employer contribution	$10.60	$9.90	$9.20	$8.48

(6.0% increase on High and EPO medical plan options;
3.2% increase on Low medical plan options)

Date prepared: 04.12.2022

NMPSIA PREMIUM
CONTRIBUTIONS EFFECTIVE OCTOBER 1, 2022
24 PAY PERIOD BREAKDOWN

			Less than $15,000 *25%/75%*	1/2 *25%/75%*	$15,000 - $19,999 *30%/70%*	1/2 *30%/70%*	$20,000 - $24,999 *35%/65%*	1/2 *35%/65%*	$25,000 and Over *40%/60%*	1/2 *40%/60%*
MEDICAL	**Single**	**Employee share**	**$215.10**	**$107.54**	**$258.12**	**$129.06**	**$301.14**	**$150.56**	**$344.16**	**$172.08**
BCBS		Employer	$645.30	$322.66	$602.28	$301.14	$559.26	$279.64	$516.24	$258.12
High Option	**Two-Party**	**Employee share**	**$409.08**	**$204.54**	**$490.88**	**$245.44**	**$572.70**	**$286.35**	**$654.52**	**$327.26**
		Employer	$1,227.22	$613.61	$1,145.42	$572.71	$1,063.60	$531.80	$981.78	$490.89
	Family	**Employee share**	**$546.36**	**$273.18**	**$655.64**	**$327.82**	**$764.92**	**$382.46**	**$874.18**	**$437.08**
		Employer	$1,639.12	$819.56	$1,529.84	$764.92	$1,420.56	$710.28	$1,311.30	$655.66
BCBS	**Single**	**Employee share**	**$149.12**	**$74.56**	**$178.96**	**$89.48**	**$208.78**	**$104.38**	**$238.60**	**$119.30**
Low Option		Employer	$447.40	$223.70	$417.56	$208.78	$387.74	$193.88	$357.92	$178.96
	Two-Party	**Employee share**	**$283.62**	**$141.80**	**$340.36**	**$170.18**	**$397.08**	**$198.54**	**$453.80**	**$226.90**
		Employer	$850.90	$425.46	$794.16	$397.08	$737.44	$368.72	$680.72	$340.36
	Family	**Employee share**	**$378.84**	**$189.42**	**$454.60**	**$227.30**	**$530.38**	**$265.18**	**$606.14**	**$303.06**
		Employer	$1,136.52	$568.26	$1,060.76	$530.38	$984.98	$492.50	$909.22	$454.62
BCBS	**Single**	**Employee share**	**$193.58**	**$96.79**	**$232.30**	**$116.15**	**$271.02**	**$135.51**	**$309.74**	**$154.87**
EPO Option		Employer	$580.76	$290.38	$542.04	$271.02	$503.32	$251.66	$464.60	$232.30
	Two-Party	**Employee share**	**$368.16**	**$184.08**	**$441.78**	**$220.88**	**$515.42**	**$257.70**	**$589.06**	**$294.52**
		Employer	$1,104.48	$552.24	$1,030.86	$515.44	$957.22	$478.62	$883.58	$441.80
	Family	**Employee share**	**$491.72**	**$245.86**	**$590.06**	**$295.03**	**$688.42**	**$344.21**	**$786.76**	**$393.38**
		Employer	$1,475.18	$737.59	$1,376.84	$688.42	$1,278.48	$639.24	$1,180.14	$590.07
Cigna	**Single**	**Employee share**	**$205.38**	**$102.69**	**$246.46**	**$123.23**	**$287.54**	**$143.77**	**$328.62**	**$164.31**
High Option		Employer	$616.16	$308.08	$575.08	$287.54	$534.00	$267.00	$492.92	$246.46
	Two-Party	**Employee share**	**$396.48**	**$198.24**	**$475.78**	**$237.88**	**$555.06**	**$277.52**	**$634.36**	**$317.18**
		Employer	$1,189.44	$594.72	$1,110.14	$555.08	$1,030.86	$515.44	$951.56	$475.78
	Family	**Employee share**	**$531.42**	**$265.71**	**$637.70**	**$318.85**	**$743.98**	**$371.99**	**$850.26**	**$425.13**
		Employer	$1,594.24	$797.12	$1,487.96	$743.98	$1,381.68	$690.84	$1,275.40	$637.70
Cigna	**Single**	**Employee share**	**$143.06**	**$71.53**	**$171.68**	**$85.84**	**$200.28**	**$100.14**	**$228.90**	**$114.45**
Low Option		Employer	$429.20	$214.60	$400.58	$200.29	$371.98	$185.99	$343.36	$171.68
	Two-Party	**Employee share**	**$276.16**	**$138.08**	**$331.40**	**$165.70**	**$386.64**	**$193.32**	**$441.88**	**$220.94**
		Employer	$828.54	$414.27	$773.30	$386.65	$718.06	$359.03	$662.82	$331.41
	Family	**Employee share**	**$370.16**	**$185.08**	**$444.20**	**$222.10**	**$518.24**	**$259.12**	**$592.26**	**$296.12**
		Employer	$1,110.52	$555.26	$1,036.48	$518.24	$962.44	$481.22	$888.42	$444.22
Presbyterian	**Single**	**Employee share**	**$173.94**	**$86.96**	**$208.72**	**$104.36**	**$243.52**	**$121.76**	**$278.30**	**$139.14**
High Option		Employer	$521.82	$260.92	$487.04	$243.52	$452.24	$226.12	$417.46	$208.74
	Two-Party	**Employee share**	**$365.26**	**$182.63**	**$438.30**	**$219.15**	**$511.36**	**$255.68**	**$584.40**	**$292.20**
		Employer	$1,095.76	$547.88	$1,022.72	$511.36	$949.66	$474.83	$876.62	$438.31
	Family	**Employee share**	**$487.04**	**$243.52**	**$584.44**	**$292.22**	**$681.86**	**$340.93**	**$779.26**	**$389.63**
		Employer	$1,461.14	$730.57	$1,363.74	$681.87	$1,266.32	$633.16	$1,168.92	$584.46
Presbyterian	**Single**	**Employee share**	**$120.62**	**$60.31**	**$144.74**	**$72.37**	**$168.86**	**$84.43**	**$192.98**	**$96.49**
Low Option		Employer	$361.84	$180.92	$337.72	$168.86	$313.60	$156.80	$289.48	$144.74
	Two-Party	**Employee share**	**$253.26**	**$126.63**	**$303.90**	**$151.95**	**$354.56**	**$177.28**	**$405.20**	**$202.60**
		Employer	$759.76	$379.88	$709.12	$354.56	$658.46	$329.23	$607.82	$303.91
	Family	**Employee share**	**$337.68**	**$168.84**	**$405.22**	**$202.60**	**$472.76**	**$236.38**	**$540.30**	**$270.14**
		Employer	$1,013.08	$506.54	$945.54	$472.78	$878.00	$439.00	$810.46	$405.24
DENTAL	**Single**	**Employee share**	**$7.16**	**$3.58**	**$8.58**	**$4.29**	**$10.00**	**$5.00**	**$11.44**	**$5.72**
Delta Dental or		Employer	$21.44	$10.72	$20.02	$10.01	$18.60	$9.30	$17.16	$8.58
United Concordia	**Two-Party**	**Employee share**	**$13.62**	**$6.81**	**$16.34**	**$8.17**	**$19.06**	**$9.53**	**$21.78**	**$10.89**
High Option		Employer	$40.82	$20.41	$38.10	$19.05	$35.38	$17.69	$32.66	$16.33
	Family	**Employee share**	**$21.38**	**$10.69**	**$25.66**	**$12.83**	**$29.94**	**$14.97**	**$34.22**	**$17.11**
		Employer	$64.16	$32.08	$59.88	$29.94	$55.60	$27.80	$51.32	$25.66
DENTAL	**Single**	**Employee share**	**$3.58**	**$1.79**	**$4.30**	**$2.15**	**$5.00**	**$2.50**	**$5.74**	**$2.87**
Delta Dental or		Employer	$10.74	$5.37	$10.02	$5.01	$9.32	$4.66	$8.58	$4.29
United Concordia	**Two-Party**	**Employee share**	**$6.82**	**$3.41**	**$8.18**	**$4.09**	**$9.54**	**$4.77**	**$10.90**	**$5.45**
Low Option		Employer	$20.44	$10.22	$19.08	$9.54	$17.72	$8.86	$16.36	$8.18
	Family	**Employee share**	**$10.70**	**$5.35**	**$12.82**	**$6.41**	**$14.98**	**$7.49**	**$17.12**	**$8.56**
		Employer	$32.08	$16.04	$29.96	$14.98	$27.80	$13.90	$25.66	$12.83
VISION	**Single**	**Employee share**	**$1.58**	**$0.79**	**$1.88**	**$0.94**	**$2.20**	**$1.10**	**$2.50**	**$1.25**
Davis Vision		Employer	$4.68	$2.34	$4.38	$2.19	$4.06	$2.03	$3.76	$1.88
	Two-Party	**Employee share**	**$2.64**	**$1.32**	**$3.14**	**$1.57**	**$3.68**	**$1.84**	**$4.18**	**$2.09**
		Employer	$7.84	$3.92	$7.34	$3.67	$6.80	$3.40	$6.30	$3.15
	Family	**Employee share**	**$3.54**	**$1.77**	**$4.24**	**$2.12**	**$4.94**	**$2.47**	**$5.66**	**$2.83**
		Employer	$10.60	$5.30	$9.90	$4.95	$9.20	$4.60	$8.48	$4.24

(6.0% increase on High and EPO medical plan options;
3.2% increase on Low medical plan options)

Date prepared: 04.12.2022

CONTRIBUTIONS EFFECTIVE OCTOBER 1, 2022

MONTHLY COST SHARING ***20%/80%***

MEDICAL	**Single (employee deduction)**	**$172.08**
BCBS	Single (district/employer contribution)	$688.32
High Option	**Two-Party (employee deduction)**	**$327.26**
	Two-Party (district/employer contribution)	$1,309.04
	Family (employee deduction)	**$437.10**
	Family (district/employer contribution)	$1,748.38
BCBS	**Single (employee deduction)**	**$119.30**
Low Option	Single (district/employer contribution)	$477.22
	Two-Party (employee deduction)	**$226.90**
	Two-Party (district/employer contribution)	$907.62
	Family (employee deduction)	**$303.06**
	Family (district/employer contribution)	$1,212.30
BCBS	**Single (employee deduction)**	**$154.86**
EPO Option	Single (district/employer contribution)	$619.48
	Two-Party (employee deduction)	**$294.52**
	Two-Party (district/employer contribution)	$1,178.12
	Family (employee deduction)	**$393.38**
	Family (district/employer contribution)	$1,573.52
Cigna	**Single (employee deduction)**	**$164.30**
High Option	Single (district/employer contribution)	$657.24
	Two-Party (employee deduction)	**$317.18**
	Two-Party (district/employer contribution)	$1,268.74
	Family (employee deduction)	**$425.12**
	Family (district/employer contribution)	$1,700.54
Cigna	**Single (employee deduction)**	**$114.44**
Low Option	Single (district/employer contribution)	$457.82
	Two-Party (employee deduction)	**$220.94**
	Two-Party (district/employer contribution)	$883.76
	Family (employee deduction)	**$296.14**
	Family (district/employer contribution)	$1,184.54
Presbyterian	**Single (employee deduction)**	**$139.14**
High Option	Single (district/employer contribution)	$556.62
	Two-Party (employee deduction)	**$292.20**
	Two-Party (district/employer contribution)	$1,168.82
	Family (employee deduction)	**$389.64**
	Family (district/employer contribution)	$1,558.54
Presbyterian	**Single (employee deduction)**	**$96.48**
Low Option	Single (district/employer contribution)	$385.98
	Two-Party (employee deduction)	**$202.60**
	Two-Party (district/employer contribution)	$810.42
	Family (employee deduction)	**$270.14**
	Family (district/employer contribution)	$1,080.62
DENTAL	**Single (employee deduction)**	**$5.72**
Delta Dental or	Single (district/employer contribution)	$22.88
United Concordia	**Two-Party (employee deduction)**	**$10.88**
High Option	Two-Party (district/employer contribution)	$43.56
	Family (employee deduction)	**$17.10**
	Family (district/employer contribution)	$68.44
Delta Dental or	**Single (employee deduction)**	**$2.86**
United Concordia	Single (district/employer contribution)	$11.46
Low Option	**Two-Party (employee deduction)**	**$5.44**
	Two-Party (district/employer contribution)	$21.82
	Family (employee deduction)	**$8.56**
	Family (district/employer contribution)	$34.22
VISION	**Single (employee deduction)**	**$1.24**
Davis Vision	Single (district/employer contribution)	$5.02
	Two-Party (employee deduction)	**$2.10**
	Two-Party (district/employer contribution)	$8.38
	Family (employee deduction)	**$2.82**
	Family (district/employer contribution)	$11.32

(6.0% increase on High and EPO medical plan options;
3.2% increase on Low medical plan option)

Date prepared: 04.12.2022

THE STANDARD ADDITIONAL LIFE Employee pays 100% of the premium.

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

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	$.06	$.08	$.08	$.14	$.22	$.36	$.54	$.80	$1.04	$.26/mo.

To calculate your Additional Life monthly payroll deduction, follow these steps, or go to nmpsia.com and find the online calculator under the "Employee" section.	*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 $.14; 105 x $.14 = $14.70*
If insuring Spouse, enter the lesser of: (a) 50% of your Additional Life Insurance or 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 $.08; 35 x $.08 = $2.80*
If insuring Child(ren) for the Children's Additional Life Coverage of $5,000, add $.26	*$.26*
Add amounts in shaded rows for your total deduction for Additional Life	*$14.70 for $105,000 on Employee $ 2.80 for $35,000 on Spouse $ .26 for $5,000 on Children $17.76 per month*

THE STANDARD LONG TERM DISABILITY PLAN Employer contributes to the premium

Benefit Waiting Period *(Selected by your employer)*	Monthly Premium
30 Day Wait	$0.58 per $100 payroll
60 Day Wait	$0.38 per $100 payroll
90 Day Wait	$0.30 per $100 payroll

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 2022

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 review 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 an 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 contact your employer's benefits office or obtain more information at the Plan's designated Enrollment and Eligibility Administrator, ERISA Administrative Services at 800-233-3164.

- ***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 your employer's benefits office or obtain more information at ERISA Administrative Services at 800-233-3164.

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 an 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 your employer's benefits office or obtain more information at ERISA Administrative Services at 800-233-3164.

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 through 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 https://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 Cigna at 800-244-6224, 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: https://nmpsia.com/ or for a paper copy contact NMPSIA at 800-548-3724.

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 Cigna at 800-244-6224, 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 Cigna at 800-244-6224, 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 Cigna at 800-244-6224, 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 2022/2023 NMPSIA plan year beginning on July 1, 2022 through June 30, 2023. The election may be renewed for subsequent plan years.

For the 2022/2023 plan year NMPSIA is going to continue to provide mental health and substance abuse benefits. 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: https://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 certain documentation requirements, 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 NMPSIA 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 the Plan Administrator (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.

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 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 your employer's benefits office or obtain more information at ERISA Administrative Services at 800-233-3164.

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. COBRA eligibility 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 eighteen (18) months or thirty-six (36) months, depending on the qualifying event.

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 your employer's benefits office or obtain more information at ERISA Administrative Services 800-233-3164 or PO Box 9054, Santa Fe, NM 97504 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.

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 and Presbyterian High Option Plan**
- **Blue Cross Blue Shield of New Mexico Low Option Plan**
- **Blue Cross Blue Shield of New Mexico High Option Plan**
- **Blue Cross Blue Shield of New Mexico Preferred EPO Plan**
- **Cigna Low Option Plan and Cigna High Option 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 medical plan options noted above are, on average, at least as good as the standard Medicare prescription drug coverage, **you can elect or keep prescription drug coverage under the 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, Blue Cross Blue Shield of New Mexico Preferred EPO Plan, Cigna Low Option Plan or Cigna High Option 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 three (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 twelve (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 sixty-three (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 nineteen (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 sixty-three (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, Blue Cross Blue Shield of New Mexico Preferred EPO Plan, Cigna Low Option Plan or Cigna High Option 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, Blue Cross Blue Shield of New Mexico Preferred EPO Plan, Cigna Low Option Plan or Cigna High Option 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, Blue Cross Blue Shield of New Mexico Preferred EPO Plan, Cigna Low Option Plan or Cigna High Option 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 2022) is intended to serve as your Medicare Notice of Creditable Coverage, as required by law.

NEW MEXICO PUBLIC SCHOOLS INSURANCE AUTHORITY (NMPSIA)

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 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, and
6. To notify affected individuals following a breach of unsecured Protected Health Information.

The Plan Sponsor has amended its Plan documents to protect your PHI as required by Federal law.

PHI use and disclosure by the Plan is regulated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). You may find these rules in Section 45 of the Code of Federal Regulations, Parts 160 and 164. 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 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.

PHI also does not include health 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.

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: https://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 website, we will prominently post the revised Notice on that website 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 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.

  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 sales or marketing purposes if the Plan receives direct or indirect payment from the entity whose product or service is being marketed or sold. You have the right to revoke an authorization at any time.

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.

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.

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 https://www.hhs.gov/ocr/about-us/contact-us/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, 2022.

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, 2022. Contact your State for more information on eligibility –

ALABAMA – Medicaid	CALIFORNIA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax 916-440-5676 Email: hipp@dhcs.ca.gov
ALASKA – Medicaid	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
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	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711

	Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS – Medicaid	**FLORIDA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
A HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization- act-2009-chipra Phone: (678) 564-1162, Press 2	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840
INDIANA – Medicaid	**MINNESOTA – Medicaid**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
IOWA – Medicaid and CHIP (Hawki)	**MISSOURI – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KANSAS – Medicaid	**MONTANA – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KENTUCKY – Medicaid	**NEBRASKA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspxPhone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	
LOUISIANA – Medicaid	**NEVADA – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
MAINE – Medicaid	**NEW HAMPSHIRE – Medicaid**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
NEW JERSEY – Medicaid and CHIP	**SOUTH DAKOTA - Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW YORK – Medicaid	**TEXAS – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NORTH CAROLINA – Medicaid	**UTAH – Medicaid and CHIP**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH DAKOTA – Medicaid	**VERMONT– Medicaid**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OKLAHOMA – Medicaid and CHIP	**VIRGINIA – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924

	CHIP Phone: 1-800-432-5924
OREGON – Medicaid	**WASHINGTON – Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
PENNSYLVANIA – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
RHODE ISLAND – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA – Medicaid	**WYOMING – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2022, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 1/31/2023)

IMPORTANT INFORMATION ABOUT THE WELLNESS PROGRAM

The New Mexico Public Schools Insurance Authority (NMPSIA) Wellness Program is **voluntary** and is designed to **promote health or prevent disease**. The term Wellness Program includes both:

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

b. ways to help individuals with chronic conditions, like diabetes, take better care of their condition, for example by working with a coach to encourage you to take the medication the doctor prescribes for your chronic condition.

The NMPSIA Wellness Program also offers **incentives** for participation such as for completing a Health Risk Appraisal questionnaire and incentives if you positively change behavior such as increasing activity. Only employees enrolled in one of our medical plan options at a NMPSIA participating employer have the opportunity to qualify for the NMPSIA Wellness Program incentives. Incentives are able to be achieved at least **once a year**. The **time commitment required to achieve incentives in our NMPSIA Wellness Program is reasonable**. More information about our NMPSIA Wellness Program incentives are described at https://nmpsia.com/wellnessWellBeing.html.

The NMPSIA Wellness Program incentives have been reviewed and in accordance with law, do not exceed 30% of the total cost of employee-only coverage under the plan including employee & employer contributions.

- **Reasonable Alternative Standard**: If you think you might be unable to meet a standard for a certain reward under our NMPSIA Wellness Program, you might qualify for an opportunity to earn the same reward by a different means. If it is unreasonably difficult due to a medical condition for you to achieve the standards for the reward under the NMPSIA Wellness program, or if it is medically inadvisable for you to attempt to achieve the standards of the NMPSIA Wellness Program, then a reasonable alternative standard will be made available upon request. Contact the NMPSIA Benefits & Wellness team at (800) 548-3724 for information on the NMPSIA Wellness Program and for information on reasonable alternative standards and accommodations. NMPSIA will work with you and, if you wish, your doctor, to find an alternative NMPSIA Wellness Program standard with the same reward that is right for you in light of your health status. If your personal doctor states that the alternative is not medically appropriate, a more accommodating alternative will be provided.

NOTICE REGARDING THE WELLNESS PROGRAM

The New Mexico Public Schools Insurance Authority (NMPSIA) Wellness Program is a **voluntary** wellness program available to only employees enrolled in a NMPSIA medical plan and is designed to **promote health or prevent disease.** The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others.

If you choose to participate in the NMPSIA Wellness Program you may be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions, e.g., cancer, diabetes, or heart disease. You are not required to complete the HRA questionnaire, or to work with a health coach.

However, employees who choose to participate in the NMPSIA Wellness Program will receive an incentive as described by your medical plan. Although you are not required to complete the HRA or participate in health coaching, only employees who do so will receive the incentives.

Additional incentives offered by your medical plan may be available for employees who participate in certain health-related activities as described by your medical plan or achieve certain health outcomes as described by your medical plan. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting the NMPSIA Benefits & Wellness team at (800) 548-3724.

The information from your HRA questionnaire will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the NMPSIA Wellness Program, such as health couching. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

NMPSIA and your elected medical plan are required by law to maintain the privacy and security of your personally identifiable health information.

Information collected from the NMPSIA Wellness Program participants will not be received by your employer. Although the NMPSIA Wellness Program may use aggregate information it collects to design a program based on identified health risks, the NMPSIA Wellness Program and your medical plan will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the NMPSIA Wellness Program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the NMPSIA Wellness Program will not be provided to anyone at your employer and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the NMPSIA Wellness Program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the NMPSIA Wellness Program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the NMPSIA Wellness Program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) your medical plan in order to provide you with services under the NMPSIA Wellness Program.

In addition, all medical information obtained through the NMPSIA Wellness Program will be maintained by your medical plan, and no information you provide as part of the NMPSIA Wellness Program will be used in making any employment decision. Appropriate precautions will be taken by your medical plan to avoid any data breach, and in the event a HIPAA data breach occurs involving information you provide in connection with the NMPSIA Wellness Program, your elected medical plan will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the NMPSIA Wellness Program, nor may you be subjected to retaliation if you choose not to participate. If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact the NMPSIA Benefits & Wellness team at (800) 548-3724.

Carriers & Consultants			
NEW MEXICO PUBLIC SCHOOLS INSURANCE AUTHORITY			
New Mexico Public Schools Insurance Authority	Customer Service for Administrative Issues • Claim Issues • Appeals	1-800-548-3724	https://nmpsia.com
NMPSIA ELIGIBILITY ADMINISTRATION OFFICE			
EASI Erisa Administrative Services, Inc.	**Erisa Administrative Services, Inc.** Eligibility•Enrollment•Premium Billing•COBRA Administration	1-800-233-3164	https://nmpsiaonline.nmpsia.com/
MEDICAL			
Carrier	**Group Number**	**Customer Service**	**Website Address**
BlueCross BlueShield of New Mexico	N05501 – High N05502 – Low 213895 – EPO	1.888.966.7742	https://www.bcbsnm.com/nmpsia
Video Visits: mdlive.com! NMPSIA (or visit bcbsnm.com; log in as a member to locate the link)			
Cigna	3343552	1.800.244.6224	https://connections.cigna.com/newmexico/
Video Visits: visit myCigna.com for an appointment via MDLIVE			
PRESBYTERIAN Health Plan, Inc.	A0000035	1.888.275.7737	https://www.phs.org/health-plans/employer-plans/Pages/new-mexico-public-schools-insurance-authority.aspx
Video Visits: visit phs.org and click on "Login to MyPres" to locate link			
PRESCRIPTION DRUGS			
CVS caremark	Rx BIN 04336	1.877.787.0652	https://www.caremark.com/
DENTAL			
DELTA DENTAL	8564	1.877.395.9420	https://www.deltadentalnm.com/
UNITED CONCORDIA DENTAL Protecting More Than Just Your Smile®	812022 (refer to ID card for subgroup #)	1.888.898.0370	https://www.unitedconcordia.com/home
VISION			
VersantHealth bringing you DavisVision	7129	1.800.999.5431	https://www.davisvision.com/member
LIFE AND DISABILITY			
TheStandard	645549	1.888.609.9763 Ext. 0957	https://nmpsia.com/TheStandard.html

NEW MEXICO PUBLIC SCHOOLS INSURANCE AUTHORITY 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 • https://nmpsia.com/

ERISA ADMINISTRATIVE SERVICES INC. ELIGIBILITY/ENROLLMENT ADMINISTRATIVE OFFICE

Customer Service for Enrolling/Billing/Eligibility/COBRA
PO Box 9054 • Santa Fe, NM 87504-9054 / 1-800-233-3164
505-988-4974 • 505-988-8943 fax
View your enrollment information by logging into: https://nmpsiaonline.nmpsia.com