NEW MEXICO
PUBLIC SCHOOLS INSURANCE AUTHORITY

PROGRAM GUIDE • JULY 2021

NMPSIA Carriers and Consultants

BENEFITS, ELIGIBILITY, AND ENROLLMENT

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 13895 – 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://my.cigna.com/web/public/guest
Video Visits: visit myCigna.com for 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

EXPRESS SCRIPTS	RxBIN 610014 NMPSIARX	1.800.498.4904	https://www.express-scripts.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 #)	1.888.878.0370	https://www.unitedconcordia.com/dental- insurance/

VISION

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
Letter from the Executive Director

Greetings from the Executive Director!

NMPSIA is pleased to offer the 2021 Program Guide for your employee benefits offered through the Authority. 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 60,000 total members (37,000 employees).

NMPSIA, as a member of the Interagency Benefits Advisory Committee, procures benefits for medical, dental, vision, life and disability options in accordance with the Health Care Purchasing Act. Effective July 1, 2021, High and Low Option medical plans, administered through BlueCross BlueShield of New Mexico, Cigna Health, and Presbyterian Health Plans will be offered. 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 plan may work well for individuals with minimal health care needs. The Exclusive Provider Organization (EPO) plan 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 this plan is limited, so please be sure to review the contracted providers in your area of the state.

This has been a very challenging time as we continue to work through COVID-19 and the effects that it has had surrounding the pandemic. NMPSIA will continue to cover, at no cost to members, the testing and treatment of a COVID-19 diagnosis. Enhanced behavioral health and access to care benefits will continue to be offered for all benefit plan options. For detailed information please visit https://nmpsia.com/COVID-19.html.

Take advantage of no-cost routine/preventive services and the additional option for virtual visits. There is $0 cost to you when scheduling an immediate or non-urgent virtual visit through your medical carrier's process. This is a great opportunity for you to seek non-urgent care at no cost.

High and Low Option dental plans are offered through Delta Dental and United Concordia. Both plans will continue to cover diagnostic/preventive services at no charge, with the deductible waived.

NMPSIA offers a Premier Vision plan through Davis Vision. Davis Vision offers paid-in-full eye examinations (covered in full after $10 copayment), eyeglasses and contacts from certain Davis Vision collections. In addition, you will have access to value-added benefits such as mail order contact lenses, discounted laser vision correction and access to Your Hearing Network for a savings of up to 40% off the national average selling prices for brand name hearing aids.

NMPSIA offers prescription drug coverage through Express Scripts and Life and Disability plans through The Standard.

A robust wellness program is offered which includes opportunities for no-cost digital health management programs and personalized nutrition coaching with a health care professional such as a registered dietician. 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/ for detailed information.

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/.

Please visit your employer's benefit office for guidance on enrolling, disenrolling, or making changes to your coverages.

Thank you for participating in NMPSIA's benefits.

Sincerely,

Richard Valerio
Executive Director

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 OF 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
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 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 PUBLIC 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 MUNICIPAL 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 DIT LOOI 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	N/A	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 PUBLIC SCHOOLS	$25,000	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 MUNICIPAL 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 CHARTER SCHOOL	$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
HOZHO 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 CHARTER SCHOOL	$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 SCHOOL	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
LAS VEGAS CITY PUBLIC 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 PUBLIC 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 SCHOOLS	$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 PUBLIC 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

Participating Employers

NMPSIA Participating Employers	Basic Life	Medical Plan Choices	Dental	Vision	Disability Plan	Add. Life
MIDDLE COLLEGE HIGH SCHOOL	$25,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	N/A	YES
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	$25,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
MORA INDEPENDENT SCHOOLS	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	60 days	YES
MORENO VALLEY CHARTER 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	90 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 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 – *effective 1/1/2022	*$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	*90 days	*1X
NEW MEXICO TECH RETIREES – *effective 1/1/2022	N/A	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	N/A	*$10,000
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 CONNECTIONS ACADEMY	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
PECOS INDEPENDENT SCHOOLS	$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 SCHOOLS	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
POJOAQUE VALLEY PUBLIC SCHOOLS	$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 SCHOOLS	$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 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 SCHOOLS	$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 CITY 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	$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 CHARTER SCHOOL	$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 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 ALBUQUERQUE TALENT DEVELOPMENT	$25,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	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 SCHOOL	$10,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	N/A	YES
THE NEW AMERICA SCHOOL	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
THE NEW AMERICA SCHOOL - LAS CRUCES	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
THE NEW MEXICO INTERNATIONAL SCHOOL	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 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 SCHOOLS	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	30 days	YES
TURQUOISE TRAIL CHARTER SCHOOL	$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 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 CHARTER HIGH SCHOOL	$50,000	BCBSNM, CIGNA and PRESBYTERIAN	YES	YES	90 days	YES
WEST LAS VEGAS PUBLIC SCHOOLS	$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 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

Benefits Enrollment and Eligibility

Introduction

The information below is designed 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 drivers.

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.)*

Benefits Enrollment and Eligibility (cont'd)

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 **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 any 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.

- Charter school board members are not eligible to enroll in NMPSIA Benefits.

- 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 **wholly dependent on the eligible employee** for maintenance and support, who is incapable of self-sustaining employment because of mental or physical impairment. **If your child is not enrolled and covered under the NMPSIA Group Plan prior to reaching age 26, your child is not an eligible dependent.*	Evidence of 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.** *Final determination is made **by the insurance carrier. Cigna members 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 listed 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 **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 medical coverage only. *(See 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. Coverage is 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 Some of the Many Programs Listed Below

- 24/7 Nurse Advice Line & Virtual Health/Video Visits
- Behavioral Health Programs – virtually or face to face
- Consulting to Create Your Own Customized Wellness Plan
- Diabetes Supplies from Approved Formulary List and OneTouch Glucose Meter
- 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
- 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. You must apply to enroll your newborn within **31 days from the newborn's date of birth.** 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. A premium increase change will become effective the 1st of the month after the date of birth. **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 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 child within **31 days from the date of adoption or date of placement** (whichever comes first). 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 adoption or date of placement **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 page 15 **Special Enrollment Event for Medical Coverage Only** for details.

Working Well tip #1…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, routine vision, and hearing screenings. Schedule your no cost annual preventative dental services and an affordable eye exam. (Learn more on pages 67-80).

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 cancelled 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

Benefits Enrollment and Eligibility (cont'd)

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….** There are many lifestyle management programs offered to you through your medical benefits. No-cost diabetes, blood pressure, diabetes prevention and weight management programs to include digital devices and health coaching. *(Learn more on pages 24-46).*

Benefits Enrollment and Eligibility (cont'd)

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

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 NMPSIA form to your employer's benefits office or via the NMPSIA online benefit 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 require 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
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 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.

Cost Effective Benefits and Access to Care

No-Cost Basic Life Insurance Coverage for the Employee (See details on page 19.)
No-Cost Services Provided by all the Medical Plans (See details starting on page 24.)

- 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 (See details starting on page 60.)

- 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 (See details starting on page 67.)

- 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 (See details starting on page 79.)

- 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 and 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

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 variety of life benefit options and 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.

bcbsnm.com

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.

BlueCross BlueShield of New Mexico

New Mexico Public Schools Insurance Authority

Care When and Where You Need It Just Got Easier

Virtual Visits

Convenient health care at your fingertips

$0 Copay

Powered by MDLIVE®

Getting sick is never convenient, and finding time to get to the doctor can be hard. Blue Cross and Blue Shield of New Mexico (BCBSNM) provides you and your covered dependents access to care for non-emergency medical issues and behavioral health needs through MDLIVE.

Whether you're at home or traveling, access to an independently contracted board-certified 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 center.

MDLIVE doctors or therapists can help treat the following conditions and more:

General Health
- Allergies
- Asthma
- Nausea
- Sinus infections

Pediatric Care
- Cold
- Flu
- Ear problems
- Pinkeye

Behavioral Health
- Anxiety/depression
- Child behavior/learning issues
- Marriage problems

Connect
Computer, smartphone, tablet or telephone

Interact
Real-time consultation with a board-certified doctor or therapist

Diagnose
Prescriptions sent electronically to a pharmacy of your choice (when appropriate)

Website:
Visit the website
MDLIVE.com/nmpsia

- Choose a doctor
- Video chat with the doctor
- You can also access through Blue Access for Members℠

Mobile app:

- Download the MDLIVE app from the Apple App Store℠ or Google Play™ Store
- Open the app and choose an MDLIVE doctor
- Chat with the doctor from your mobile device

Telephone:

- Call MDLIVE **(800) 770-4622**
- Speak with a health service specialist to schedule a consultation
- Use website or mobile app to video chat with a doctor

Chat services available for hearing impaired.

Get connected today!
To register, you'll need to provide your first and last name, date of birth and BCBSNM member ID number.

Internet/Wi-Fi connection is needed for computer access. Data charges may apply. Check your cellular data or internet service provider's plan for details. Non-emergency medical service in Idaho, Montana and New Mexico is limited to interactive audio/video (video only), along with the ability to prescribe. Non-emergency medical service in Arkansas is limited to interactive audio/video (video only) for initial consultation, along with the ability to prescribe. Behavioral health service is limited to interactive audio/video (video only), along with the ability to prescribe in all states. Service availability depends on location at the time of consultation.

Virtual visits, powered by MDLIVE, may not be available on all plans. Virtual visits are subject to the terms and conditions of your benefit plan, including benefits, limitations, and exclusions. MDLIVE operates subject to state regulations and may not be available in certain states. MDLIVE is not an insurance product or a prescription fulfillment warehouse. 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.

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

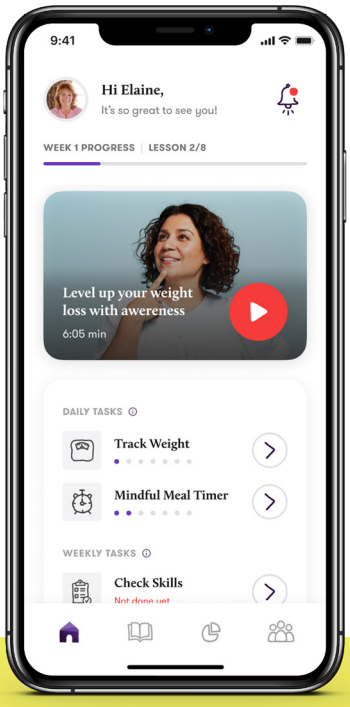
61% HAVE MORE ENERGY

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

BlueCross BlueShield of New Mexico

Be Your Healthiest Self...We'll Help

Online...on the phone...on the go. However you choose to fit good health into your daily life, you've got tools to help you. Follow these simple steps to sign up for Blue Access for Members℠ (BAM℠) – where you can access all the health and wellness programs included with your plan.

1. **Go to bcbsnm.com.**
2. **Sign up for BAM.**
3. **Click the My Health tab.**

A Path to Wellness

Complete self-management online programs to help reach your wellness goals with Well onTarget®. Plus earn rewards for healthy activities.[1]

Commit to Be Fit

Get unlimited access to a national network of fitness centers, so you can exercise wherever life takes you.[2]

Quick Answers to Health Questions

Should you go to the emergency room? Urgent care? Wait to see your doctor? 24/7 Nurseline can help you decide – any day, any time.[3]

Behavioral Health Support

Your mental health is vital to your wellbeing. Your plan gives you access to treatment options to help with anxiety, depression, substance use and more.

Guidance for Your Growing Family

Check out apps from Ovia Health® for expert advice to support you through all the stages of planning for and having a baby.[4]

Get healthy reminders and tips for using your benefits.

Text **MYCONTACTNM** to **33633** or go to **upp.bcbsnm.com** to let us know how we should contact you.[5]

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. 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.
2. Individuals must be at least 18 years old to purchase a membership. The Fitness Program is provided by Tivity Health™, an independent contractor that administers the Prime Network of fitness centers. The Prime Network is made up of independently owned and operated fitness centers.
3. For medical emergencies, call 911. This program is not a substitute for a doctor's care. Talk to your doctor about any health questions or concerns.
4. Ovia Health is an independent company that provides maternity and family benefits solutions for Blue Cross and Blue Shield of New Mexico.
5. Message and data rates may apply. Terms and conditions and our privacy policy are available at bcbsnm.com/mobile/text-messaging.

BlueCross BlueShield of New Mexico

Here's One Call You Don't Want to Miss

If you get a call from Blue Cross and Blue Shield of New Mexico (BCBSNM), we're calling to help you take good care of your health. Please answer or call us back.

Your health plan includes support for you and your covered family members from nurses and other professionals called health advisors. This extra help is available at no added cost to you.

BCBSNM may call to help you:

- Get the care you need for serious illnesses or injuries
- Have a healthy pregnancy and baby
- If you have been in the hospital or have had a major surgery

BCBSNM health advisors* are licensed health professionals located in the United States. Calls from health advisors are not sales calls.

We may ask you for information, like your name, date of birth or home address, to make sure that we are talking to you. Any information you provide to BCBSNM is confidential, as required by law. We will not share it with your employer.

If we miss you, ring us back. We're here for you!

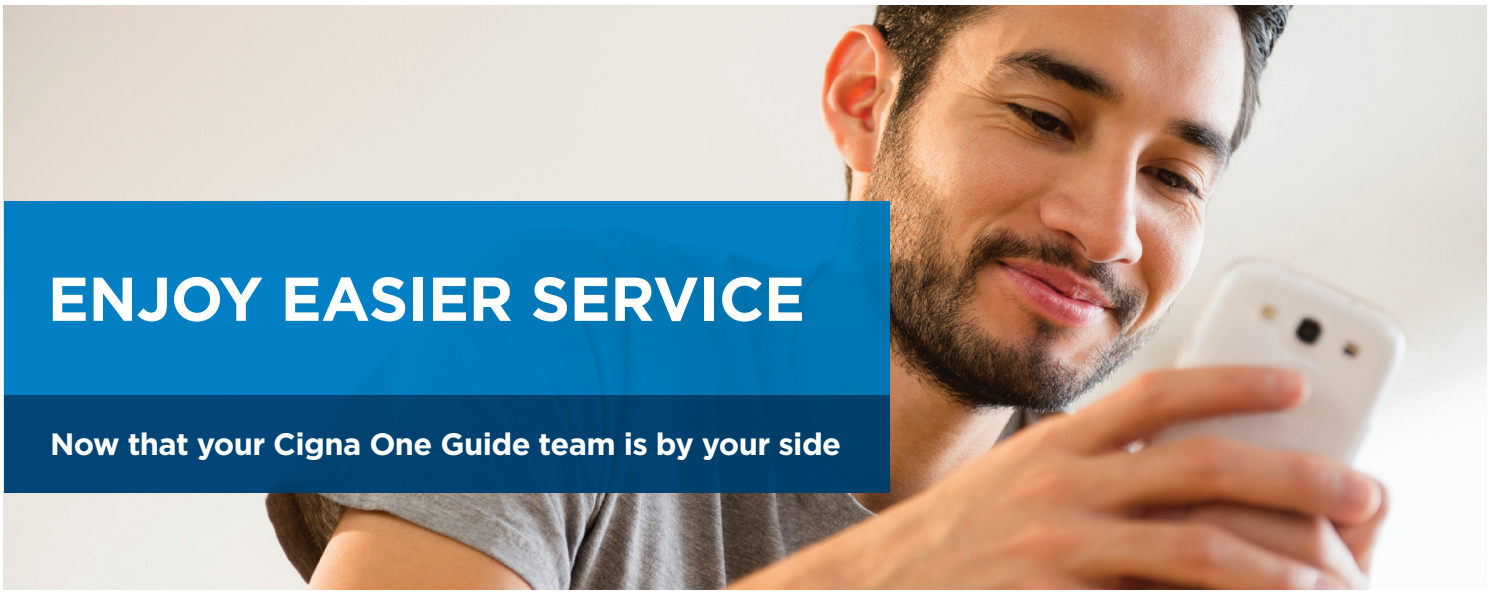
* Health advisors do not replace the care of a doctor. You should talk to your doctor about any medical questions or concerns.

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.



ENJOY EASIER SERVICE

Now that your Cigna One Guide team is by your side

Ready to answer all your health plan questions. And so much more.

Let's face it, understanding and using your health plan isn't always easy. Well, not to worry. Your Cigna One Guide® team is ready and waiting to help. It's our highest level of personal support available.

Simply call us, click-to-chat on **myCigna.com** or use the **myCigna® App**. You'll automatically be connected with a One Guide representative who will help guide you where you need to go.

Helping you save money. And stay healthy. Your Cigna One Guide team can help you:

Understand your plan

- Learn how your coverage works
- Get answers to your health care or plan questions

Get care

- Find an in-network health care provider, lab or urgent care center
- Connect with health coaches, pharmacists and more
- Help schedule your annual check-up and other appointments
- Connect with dedicated, one-on-one support for complex health situations

Save and earn

- Earn incentives (if provided by your employer)
- Get cost estimates to avoid surprises

Click, call or chat. Your personal guide is ready and waiting to help.

myCigna.com

myCigna App

Call the number on the back of your ID card.

GET IT ON Google play | Available on amazon apps kindle fire | Download on the App Store

Together, all the way.®

Cigna®

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

YOUR HEALTH HAS MET ITS APP®

Access your health plan anytime and just about anywhere you go.

Life can be busy and complicated. So, we created a simple-to-use tool that can help make your life easier (and healthier) while you're on the go. The myCigna® App helps you personalize, organize and access your important plan information on your phone or tablet. The app has a new look and feel and it's available in Spanish too! Use the myCigna app, to log in anytime, just about anywhere to:*

- **Manage** and track claims
- **View**, fax or email ID card information
- **Find** in-network doctors and compare cost and quality information
- **Review** your coverage
- **Track** your account balances and deductibles
- **Submit** receipts for reimbursement from your Cigna HRA and/or FSA
- **Order** your Cigna Home Delivery Pharmacy℠ prescriptions online and view order history
- **Compare** prescription drug prices for Retail and Home Delivery pharmacies**

* Actual myCigna features may vary by plan and individual security profile.
** Prescription savings opportunities may not be available for some medications.
*** The downloading and use of the myCigna App is subject to the terms and conditions of the App and the online stores from which it is downloaded. Standard mobile phone carrier and data usage charges apply.

Feel better protected

Cigna is as committed to helping protect your health information as we are to protecting your health and well-being. That's why we take certain steps to enhance the security of your personal health information on myCigna.

Download the myCigna App for your mobile device.***

GET IT ON Google play | Download on the App Store | amazon apps Available on kindle fire

Disponible en Español.

Don't forget! myCigna App users log in with just one touch

When you download the myCigna App you can access your account with just a fingerprint on any compatible device.

Together, all the way.®

Cigna®

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

WHEN LEAVING THE HOUSE IS EASIER SAID THAN DONE.

Get care whenever and wherever with minor medical and behavioral/mental health virtual care.

Life is demanding. It's hard to find time to take care of yourself and your family members as it is, never mind when one of you isn't feeling well. That's why your health plan through Cigna includes access to minor medical and behavioral/mental health virtual care.

Whether it's late at night and your doctor or therapist isn't available or you just don't have the time or energy to leave the house, you can:

- Access care from anywhere via video or phone.
- Get minor medical virtual care 24/7/365 – even on weekends and holidays.
- Schedule a behavioral/mental health virtual care appointment online in minutes.
- Connect with quality board-certified doctors and pediatricians as well as licensed counselors and psychiatrists.
- Have a prescription sent directly to your local pharmacy, if appropriate.

Convenient? Yes. Costly? No.

Medical virtual care for minor conditions costs less than ER or urgent care center visits, and maybe even less than an in-office primary care provider visit.

Together, all the way.®

Cigna®

937207 b 08/20

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

Minor medical virtual care

Board-certified doctors and pediatricians can diagnose, treat and prescribe most medications for minor medical conditions, such as:

- Acne
- Allergies
- Asthma
- Bronchitis
- Cold and flu
- Constipation
- Diarrhea
- Earaches
- Fever
- Headaches
- Infections
- Insect bites
- Joint aches
- Nausea
- Pink eye
- Rashes
- Respiratory infections
- Shingles
- Sinus infections
- Skin infections
- Sore throats
- Urinary tract infections

MDLIVE providers can also conduct virtual wellness screenings.

Behavioral/Mental health virtual care

Licensed counselors and psychiatrists can diagnose, treat and prescribe most medications for nonemergency behavioral/mental health conditions, such as:

- Addictions
- Bipolar disorders
- Child/Adolescent issues
- Depression
- Eating disorders
- Grief/Loss
- Life changes
- Men's issues
- Panic disorders
- Parenting issues
- Postpartum depression
- Relationship and marriage issues
- Stress
- Trauma/PTSD
- Women's issues

Connect with virtual care your way.

- Contact your in-network provider or counselor
- Talk to an MDLIVE medical provider on demand on **myCigna.com**
- Schedule an appointment with an MDLIVE provider or licensed therapist on **myCigna.com**
- Call MDLIVE 24/7 at 888.726.3171

To connect with an MDLIVE virtual provider, visit myCigna.com, locate the "Talk to a doctor or nurse 24/7" callout and click "Connect Now."

To locate a Cigna Behavioral Health provider, visit myCigna.com, go to "Find Care & Costs" and enter "Virtual counselor" under "Doctor by Type," or call the number on the back of your Cigna ID card 24/7.

Medical and behavioral/mental health virtual care is available from MDLIVE.

*Availability may vary by location and plan type and is subject to change. See vendor sites 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 or under all plan types. 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.

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.

HEALTHY CHOICES DESERVE HEALTHY DISCOUNTS

Start saving today with Cigna Healthy Rewards®*

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

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

- Weight management and nutrition
- Fitness
- Mind/body
- Vision and hearing care
- Alternative medicine
- Healthy lifestyle

Real brands. Real discounts. Real awesomeness.

To start saving today, visit **mycigna.com** or call **1-866-494-2111**

* 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.

Together, all the way.®

Cigna®

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

SR

Active&Fit DIRECT®

Cigna®

home or gym?

we'll keep you active either way.

2,500+ DIGITAL WORKOUT VIDEOS

11,000+ FITNESS CENTERS AND STUDIOS
Members can change anytime

NO LONG-TERM CONTRACT

Try us out for free!

1. Enjoy **200 free digital workout videos** available to all eligible members, even before you enroll.
2. Join us for a variety of workout classes available anytime on YouTube and Facebook, designed for all levels!

YouTube

Get Started: Visit the wellness offers on mycigna.com.

FITNESS PROGRAM MEMBERSHIP
$25/mo*
11,000+ FITNESS CENTERS
2,500+ WORKOUT VIDEOS
Active&Fit® DIRECT™

Over 2,500 digital workout videos including programs from:

JILLIAN MICHAELS
LatinVa FITNESS
STRONG BY ZUMBA
FITSTEPS®
YogaFit

Over 11,000 fitness centers and studios nationwide including:

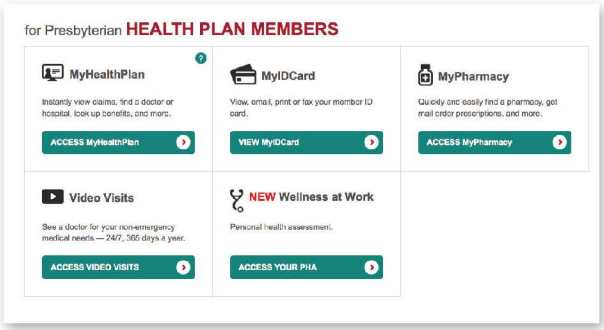
LA FITNESS
SNAP FITNESS 24-7
ANYTIME FITNESS
Curves
GOLD'S GYM
WORKOUT ANYTIME Your Fitness. Your Schedule.

*Plus applicable taxes.

PRESBYTERIAN
Health Plan, Inc.

Membership has its benefits.

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



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

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

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

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

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

Wherever you go, we've got you covered.

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

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

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

As the provider of healthcare benefits to nearly 600,000 New Mexicans, Presbyterian Health Plan offers the coverage you need to live the life you want – anytime, anywhere.

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

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

PRESBYTERIAN
Health Plan, Inc.

Supporting you in your wellness journey.

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

Wellness at WORK

Innovative digital care options at no additional cost

- Clickotine is a no-cost smoking cessation program that uses clinically driven app technology to help members stick to a quit plan and overcome nicotine cravings.
- Talkspace 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.
- Computerized Cognitive Behavioral Therapy is interactive software that provides members an alternative to traditional mental health and substance abuse care.

For more information on these programs, call the number on the back of your Presbyterian member ID card.

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

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.
- 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.

MPC032001

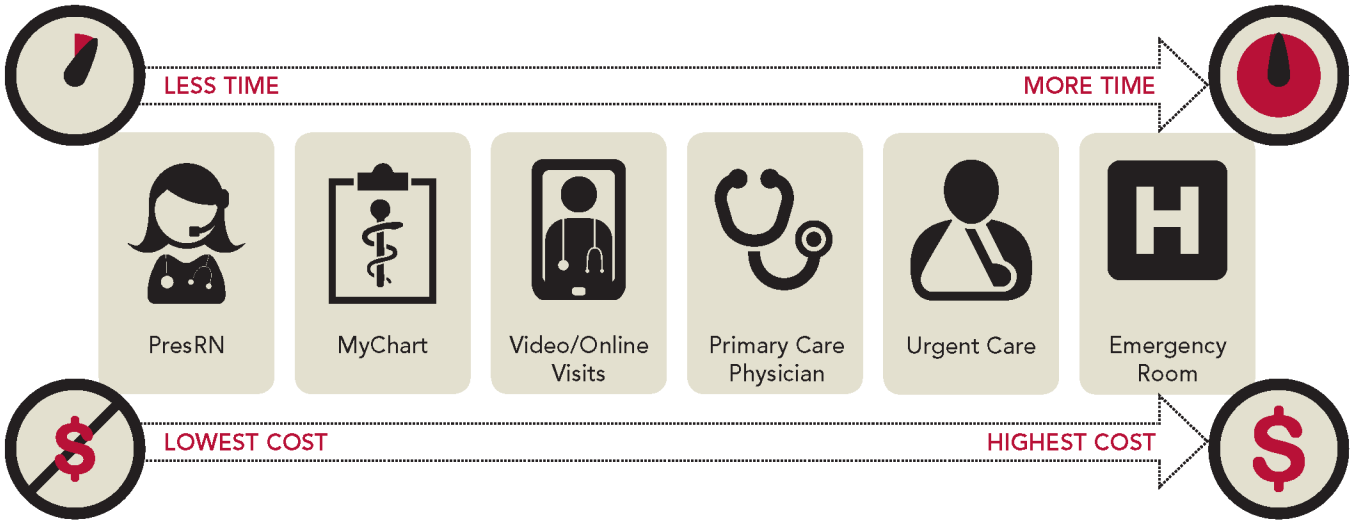
As a Presbyterian Health Plan member, you and your dependents have access to more than 10,000 national, regional and local fitness, recreation and community centers for a small fee. These facilities include all Defined Fitness locations in Albuquerque, Rio Rancho and Farmington, as well as the nationwide Prime Fitness network. Discounts are available for all Sports & Wellness facilities.

We know that staying active and healthy is important to you, to live your best life. Whether you are at home, traveling, or just want to try something new, there are convenient locations, hours that fit your busy lifestyle, and a variety of classes and programs that let you manage fitness *your* way!

	prime	DEFINED FITNESS	SPORTS & WELLNESS
Description	Visit more than 10,000 participating locations nationwide as often as you like, including select YMCAs, Snap Fitness, Curves®, Crunch® Fitness, Planet Fitness and Anytime Fitness. Visit any location in the network – your fitness benefit travels with you, wherever you go. Classes and amenities vary by location.	These facilities include all nine Defined Fitness locations in Albuquerque, Rio Rancho and Farmington, as well as the nationwide Prime Fitness network. Defined Fitness is one of New Mexico's premier health clubs.	Sports & Wellness is where Albuquerque has gone to find fun, friends and fitness for more than 25 years. Enjoy a special Presbyterian Health Plan member rate and experience five-star service and first-rate amenities at five New Mexico locations.
Participating Locations	Nationwide	Albuquerque, Rio Rancho, Santa Fe and Farmington, NM	Albuquerque, NM
Fees	$12.50 per enrolled member per month entitles you to full access to Prime and Defined Fitness and a discount on Sports & Wellness gym fees.		
How to access	On the first of the month after enrolling, visit **www.primemember.com** to get a Prime ID Card before visiting the gym of your choice	On the first of the month after enrolling, show your Presbyterian Member ID card to gain access and you will be issued an ID card directly by the gym	On the first of the month after enrolling, show your Presbyterian Member ID card to gain access and you will be issued an ID card directly by the gym
Network	**www.primemember.com**	**www.defined.com**	**www.sportsandwellness.com**
Available services (some may have an additional cost)			
Fitness equipment	Yes	Yes	Yes
Group exercise classes	Yes	Yes	Yes
Personal Training	Most locations	Yes	Yes
Pool	Indoor/outdoor	Indoor	Indoor/outdoor
Sauna/Whirlpools	Yes	Yes	No
Sports courts	Yes	No	Yes
Track	Yes	No	No
Childcare	Some locations	Yes	Yes

PRESBYTERIAN Health Plan, Inc. www.phs.org

Convenient Ways to Access Care



PRESBYTERIAN
Health Plan, Inc.

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

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

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

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

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

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

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

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 Health Plan medical benefits. The High Option Plan is available under BlueCross BlueShield of New Mexico (BCBSNM), Cigna Health and Presbyterian Health Plan.
The Summary Plan Description supersedes any information outlined in this summary.
NOTE: 2021 and 2022 Benefit Summaries are both displayed here

NMPSIA High Option Health Plan Benefits There is no overall lifetime maximum benefit. However, certain services have maximum annual limits. See below:	High Option PPO Benefits Member's Share of Covered Charges (Deductible applies unless specified as "deductible waived") In-Network Provider	 Out-Of-Network Provider
2021 Calendar Year Deductible Individual Family	$750 $1,500	$1,500 $3,000
2022 Calendar Year Deductible Individual Family	$750 $1,500	$1,500 $3,000
2021 Calendar Year Annual Out-Of-Pocket Limit (Includes copayments, coinsurance, and deductibles) Individual Family	$3,750 $7,500	$9,000 $18,000
2022 Calendar Year Annual Out-Of-Pocket Limit (Includes copayments, coinsurance, and deductibles) Individual Family	$4,100 $8,200	$9,500 $19,000
2021 Calendar Year 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** (Cost varies dependent on specific plan details - see your health plan for more information)	Office Visit Copay *(deductible waived)* $30 $50 Varies	 30% 30% Not Covered
2022 Calendar Year 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** (Cost varies dependent on specific plan details - see your health plan for more information)	Office Visit Copay *(deductible waived)* $25 $50 Varies	 40% 40% Not Covered
2021 Calendar Year Office Surgery (Including casts, splints, and dressings)	20%	30%
2022 Calendar Year Office Surgery (Including casts, splints, and dressings)	20%	40%
2021 Calendar Year Allergy injections (only), Extract Preparation	No Charge *(deductible waived)*	30%
2022 Calendar Year Allergy injections (only), Extract Preparation	No Charge *(deductible waived)*	40%
2021 Calendar Year Therapeutic injections: Allergy Testing	Office Visit Copay	30%
2022 Calendar Year Therapeutic injections: Allergy Testing	Office Visit Copay	40%
2021 Calendar Year 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)*	30% *(deductible waived)*

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 Health Plan medical benefits. The High Option Plan is available under BlueCross BlueShield of New Mexico (BCBSNM), Cigna Health and Presbyterian Health Plan.
The Summary Plan Description supersedes any information outlined in this summary.
NOTE: 2021 and 2022 Benefit Summaries are both displayed here

NMPSIA High Option Health Plan Benefits There is no overall lifetime maximum benefit. However, certain services have maximum annual limits. See below:	High Option PPO Benefits Member's Share of Covered Charges (Deductible applies unless specified as "deductible waived")	
	In-Network Provider	Out-Of-Network Provider
2022 Calendar Year 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) **Naprapathy and Rolfing**	$50 copay *(deductible waived);* (combined max. benefit of 30 visits/calendar year)	50% Naprapathy and Rolfing Not Covered
2021 Calendar Year Ambulance Service: Ground and Emergency Air Transport	$30 copay *(deductible waived)*	
2022 Calendar Year Ambulance Service: Ground and Emergency Air Transport	$50 copay *(deductible waived)*	
Ambulance Services: Inter-facility Transport	$0 *(deductible waived)*	
2021 Calendar Year Autism Spectrum Disorder Up to 90 visits per member per year (in & out-of-network combined) PCP copay for Applied Behavioral Analysis (ABA). Specialist includes outpatient physical therapy, occupational therapy & speech therapy.	PCP $30 copay Specialist $50 copay *(deductible waived)*	30%
2022 Calendar Year Autism Spectrum Disorder Up to 90 visits per member per year (in & out-of-network combined) PCP copay for Applied Behavioral Analysis (ABA). Specialist includes outpatient physical therapy, occupational therapy & speech therapy.	PCP $25 copay Specialist $50 copay *(deductible waived)*	40%
2021 Calendar Year Biofeedback (For specified medical conditions only)	$50 copay *(deductible waived)*	30%
2022 Calendar Year Biofeedback (For specified medical conditions only)	$50 copay *(deductible waived)*	40%
2021 Calendar Year Cardiac and Pulmonary Rehabilitation (Office/Outpatient)	$50 copay *(deductible waived)*	30%
2022 Calendar Year Cardiac and Pulmonary Rehabilitation (Office/Outpatient)	$50 copay *(deductible waived)*	40%
2021 Calendar Year Dental/Facial Accident, Oral Surgery & TMJ/CMJ Services	Varies by Services	30%
2022 Calendar Year Dental/Facial Accident, Oral Surgery & TMJ/CMJ Services	Varies by Services	40%
2021 Calendar Year Emergency Room Treatment Physician and other professional provider charges	$150 copay plus 20% coinsurance after deducible	
2022 Calendar Year 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	

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 Health Plan medical benefits. The High Option Plan is available under BlueCross BlueShield of New Mexico (BCBSNM), Cigna Health and Presbyterian Health Plan.
The Summary Plan Description supersedes any information outlined in this summary.

NOTE: 2021 and 2022 Benefit Summaries are both displayed here

NMPSIA High Option Health Plan Benefits There is no overall lifetime maximum benefit. However, certain services have maximum annual limits. See below:	High Option PPO Benefits Member's Share of Covered Charges (Deductible applies unless specified as "deductible waived")	
	In-Network Provider	Out-Of-Network Provider
2021 Calendar Year Home Health Care/Home I.V. Services Limitations	20% Unlimited	30% 120 visits per calendar year
2022 Calendar Year Home Health Care/Home I.V. Services Limitations	20% Unlimited	40% 120 visits per calendar year
2021 Calendar Year Hospice Services including respite care (limited to 10 days for each 6-month per hospice period - 2 periods per lifetime) & bereavement counseling (limited to 3 sessions during the hospice benefit period)	No charge *(deductible waived)*	30%
2022 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%
2021 Calendar Year Infertility: Diagnosis Only - No Treatment	Varies by services	30%
2022 Calendar Year Infertility: Diagnosis Only - No Treatment	Varies by services	40%
2021 Calendar Year 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)*	30%
2022 Calendar Year 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%
2021 Calendar Year Lab, X-Ray, and other Basic Diagnostic Tests - non-routine (Outpatient Department of Hospital)	$60 copay or actual allowable amount, whichever is less per day *(deductible waived)*	30%
2022 Calendar Year 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%
2021 Calendar Year High Tech Imaging: **MRI, MRA, CT Scan, PET Scan**	$600 copay or 20%, whichever is less per day *(deductible waived)*	30%
2022 Calendar Year High Tech Imaging: **MRI, MRA, CT Scan, PET Scan**	$600 copay or 20%, whichever is less per day *(deductible waived)*	40%
2021 Calendar Year Prothrombin Time Test	$10 copay *(deductible waived)*	30%
2022 Calendar Year Prothrombin Time Test	$10 copay *(deductible waived)*	40%
2021 Calendar Year Sleep Study	20%	30%
2022 Calendar Year Sleep Study	20%	40%

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 Health Plan medical benefits. The High Option Plan is available under BlueCross BlueShield of New Mexico (BCBSNM), Cigna Health and Presbyterian Health Plan.
The Summary Plan Description supersedes any information outlined in this summary.
NOTE: 2021 and 2022 Benefit Summaries are both displayed here

NMPSIA High Option Health Plan Benefits There is no overall lifetime maximum benefit. However, certain services have maximum annual limits. See below:	High Option PPO Benefits Member's Share of Covered Charges (Deductible applies unless specified as "deductible waived") In-Network Provider	Out-Of-Network Provider
Inpatient Hospital/Facility Services (High Option copays are waived if you are re-admitted for the same condition within 15 days of discharge or transferred to a rehab or skilled nursing facility within 15 days of discharge from an acute care facility		
2021 Calendar Year 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%	30% coinsurance after deductible
2022 Calendar Year 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
2021 Calendar Year Observation Stay including Related Professional Charges	$100 facility copay plus 20%	30%
2022 Calendar Year Observation Stay including Related Professional Charges	$100 facility copay plus 20%	40%
Maternity Services		
2021 Calendar Year Physicians Midwife Services (Delivery, pre- and post-natal care, including lab, diagnostic testing, and pre-natal genetic testing, if medically necessary)	$30 Office Visit Copay/Initial Visit	30%
2022 Calendar Year 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%
2021 Calendar Year Hospital Admission (Including routine newborn nursery charges)	$500 copay per pregnancy plus 20%	30%
2022 Calendar Year Hospital Admission (Including routine newborn nursery charges)	20% coinsurance after deductible	40%
2021 Calendar Year Extended Stay (non-routine) Charges for covered Newborn	$500 facility copay/admission plus 20%	30%
2022 Calendar Year Extended Stay (non-routine) Charges for covered Newborn	20% coinsurance after deductible	40%
2021 Calendar Year Home Birth	20%	30%
2022 Calendar Year Home Birth	20%	40%
Mental Health Services		
2021 Calendar Year Office, Home, Outpatient Facility/Physician	$30 copay *(deductible waived)*	30%
2022 Calendar Year Office, Home, Outpatient Facility/Physician	No Charge	No Charge
2021 Calendar Year Inpatient	$500 copay plus 20%	30%
2022 Calendar Year Inpatient	No Charge	No Charge
2021 Calendar Year Partial Hospitalization	$250 copay plus 20%	30%
2022 Calendar Year Partial Hospitalization	No Charge	No Charge
2021 Calendar Year Facility-Based Intensive Outpatient Programs (IOP)	$125 copay plus 20%	30%

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 Health Plan medical benefits. The High Option Plan is available under BlueCross BlueShield of New Mexico (BCBSNM), Cigna Health and Presbyterian Health Plan.
The Summary Plan Description supersedes any information outlined in this summary.

NOTE: 2021 and 2022 Benefit Summaries are both displayed here

NMPSIA High Option Health Plan Benefits There is no overall lifetime maximum benefit. However, certain services have maximum annual limits. See below:	High Option PPO Benefits Member's Share of Covered Charges (Deductible applies unless specified as "deductible waived") In-Network Provider	Out-Of-Network Provider
2022 Calendar Year Facility-Based Intensive Outpatient Programs (IOP)	No Charge	No Charge
Substance Abuse Rehabilitation (Lifetime-no limit on number of courses of treatment for all services combined)		
2021 Calendar Year Office, Home, Outpatient Facility/Physician (No limit on number of days/calendar year)	$30 copay *(deductible waived)*	30%
2022 Calendar Year Office, Home, Outpatient Facility/Physician (No limit on number of days/calendar year)	No Charge	No Charge
2021 Calendar Year Inpatient (No limit on number of days/calendar year)	$500 copay plus 20%	30%
2022 Calendar Year Inpatient (No limit on number of days/calendar year)	No Charge	No Charge
2021 Calendar Year Partial Hospitalization (No limit on number of days/calendar year combined with Inpatient)	$250 copay plus 20%	30%
2022 Calendar Year Partial Hospitalization (No limit on number of days/calendar year combined with Inpatient)	No Charge	No Charge
2021 Calendar Year Facility-Based Intensive Outpatient Programs (IOP)	$125 copay plus 20%	30%
2022 Calendar Year Facility-Based Intensive Outpatient Programs (IOP)	No Charge	No Charge
2021 Calendar Year Outpatient Hospital/Facility/Ambulatory Surgery Facility (Including Related Professional Charges)	$150 copay plus 20%	30%
2022 Calendar Year Outpatient Hospital/Facility/Ambulatory Surgery Facility (Including Related Professional Charges)	20% coinsurance after deductible	40%
2021 Calendar Year Residential Treatment Center (RTC): (For adults age 18 & older only) (No limit on number of days/calendar year and no limit on days/admit)	$250 copay plus 20%	30%
2022 Calendar Year 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	No Charge
2021 Calendar Year Short-Term Rehabilitation, Outpatient and Office: Occupational, Physical & Speech Therapy Services	$50 copay *(deductible waived)* up to $500; thereafter No Charge for the remaining calendar year	30%
2022 Calendar Year Short-Term Rehabilitation, Outpatient and Office: Occupational, Physical & Speech Therapy Services	$50 copay *(deductible waived)* up to $500; 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
2021 Calendar Year Supplies, Durable Medical Equipment, Prosthetics & Functional Orthotics (Support hose limited to 12 pair **(or 24 hose)**. Mastectomy Bras up to 6 per calendar year.) Prior Authorization needed for services over $1,000	20%	30%
2022 Calendar Year 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%

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 Health Plan medical benefits. The High Option Plan is available under BlueCross BlueShield of New Mexico (BCBSNM), Cigna Health and Presbyterian Health Plan.
The Summary Plan Description supersedes any information outlined in this summary.
NOTE: 2021 and 2022 Benefit Summaries are both displayed here

NMPSIA High Option Health Plan Benefits There is no overall lifetime maximum benefit. However, certain services have maximum annual limits. See below:	High Option PPO Benefits Member's Share of Covered Charges (Deductible applies unless specified as "deductible waived")	
	In-Network Provider	Out-Of-Network Provider
2021 Calendar Year Insulin Pump Supplies (Insertion sets, reservoirs)	No Charge *(deductible waived)*	30%
2022 Calendar Year Insulin Pump Supplies (Insertion sets, reservoirs)	No Charge *(deductible waived)*	40%
2021 Calendar Year Therapy: Chemotherapy and Radiation Therapy	No Charge *(deductible waived)*	30%
2022 Calendar Year Therapy: Chemotherapy and Radiation Therapy	No Charge *(deductible waived)*	40%
2021 Calendar Year Therapy: Dialysis	20%	30%
2022 Calendar Year 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
2021 Calendar Year Urgent Care (Includes all services and supplies such as x-ray/labs/ physician fees)	$50 copay *(deductible waived)*	30%
2022 Calendar Year 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 Express Scripts. Call Express Scripts Customer Service Center:
1-800-498-4904

LOW AND EPO OPTION - SUMMARY OF BENEFITS

This is only a summary that lists the member cost-sharing amounts and provides a brief description of NMPSIA Low and EPO Option Health Plan medical benefits.
The Low Option Plan is available under BlueCross BlueShield of New Mexico (BCBSNM), Cigna Health and Presbyterian Health Plan.
The Exclusive Provider Organization (EPO) is only offered by BlueCross BlueShield of New Mexico.
The Summary Plan Description supersedes any information outlined in this summary.
NOTE: 2021 and 2022 Benefit Summaries are both displayed here

NMPSIA Low and EPO Option Health Plan Benefits There is no overall lifetime maximum benefit. However, certain services have maximum annual limits. (Deductible applies unless specified as "deductible waived") See below:	Low Option PPO Benefits Member's Share of Covered Charges In-Network Provider	 Out-Of-Network Provider	EPO Benefits Member's Share of Covered Charges Preferred Provider
2021 Calendar Year Deductible Individual Family	$2,000 $4,000	$4,000 $8,000	$500 $1,000
2022 Calendar Year Deductible Individual Family	$2,000 $4,000	$4,000 $8,000	$500 $1,000
2021 Calendar Year Annual Out-Of-Pocket Limit (Includes copayments, coinsurance, and deductibles) Individual Family	$3,750 $7,500	$9,000 $18,000	$3,250 $6,500
2022 Calendar Year Annual Out-Of-Pocket Limit (Includes copayments, coinsurance, and deductibles) Individual Family	$4,100 $8,200	$9,500 $19,000	$500 $1,000
2021 Calendar Year 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** (Cost varies dependent on specific plan details - see your health plan for more information)	Office Visit Copay *(deductible waived)* $35 $60 Varies	 50% 50% Not Covered	Office Visit Copay (deductible waived) $25 $35 Varies
2022 Calendar Year 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** (Cost varies dependent on specific plan details - see your health plan for more information)	Office Visit Copay *(deductible waived)* $30 $60 Varies	 50% 50% Not Covered	Office Visit Copay *(deductible waived)* $25 $35 Varies
2021 Calendar Year Office Surgery (Including casts, splints, and dressings)	25%	50%	20%
2022 Calendar Year Office Surgery (Including casts, splints, and dressings)	25%	50%	20%
2021 Calendar Year Allergy injections (only), Extract Preparation	25%	50%	No Charge *(deductible waived)*
2022 Calendar Year Allergy injections (only), Extract Preparation	25%	50%	No Charge *(deductible waived)*
2021 Calendar Year Therapeutic injections: Allergy Testing	25%	50%	Office Visit Copay
2022 Calendar Year Therapeutic injections: Allergy Testing	25%	50%	Office Visit Copay
2021 Calendar Year 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)*	No Charge *(deductible waived)*

LOW AND EPO OPTION - SUMMARY OF BENEFITS

This is only a summary that lists the member cost-sharing amounts and provides a brief description of NMPSIA Low and EPO Option Health Plan medical benefits.
The Low Option Plan is available under BlueCross BlueShield of New Mexico (BCBSNM), Cigna Health and Presbyterian Health Plan.
The Exclusive Provider Organization (EPO) is only offered by BlueCross BlueShield of New Mexico.
The Summary Plan Description supersedes any information outlined in this summary.

NOTE: 2021 and 2022 Benefit Summaries are both displayed here

NMPSIA Low and EPO Option Health Plan Benefits There is no overall lifetime maximum benefit. However, certain services have maximum annual limits. (Deductible applies unless specified as "deductible waived") See below:	Low Option PPO Benefits Member's Share of Covered Charges In-Network Provider	Low Option PPO Benefits Member's Share of Covered Charges Out-Of-Network Provider	EPO Benefits Member's Share of Covered Charges Preferred Provider
2022 Calendar Year 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)*	No Charge *(deductible waived)*
Acupuncture, Chiropractic (Spinal Manipulation), Massage Therapy (If medically necessary) **Naprapathy and Rolfing**	25% (combined max. benefit of 30 visits per calendar year) $60 copay *(deductible waived)* ; (Limit $500 per year)	50% Naprapathy and Rolfing Not Covered	$35 copay *(deductible waived);* (combined max. benefit of 30 visits/calendar year)
2021 Calendar Year Ambulance Service: Ground and Emergency Air Transport	25% coinsurance after deductible		$25 *(deductible waived)*
2022 Calendar Year Ambulance Service: Ground and Emergency Air Transport	25% coinsurance after deductible		$25 *(deductible waived)*
Ambulance Services: Inter-facility Transport	$0 *(deductible waived)*		$0 *(deductible waived)*
2021 Calendar Year Autism Spectrum Disorder Up to 90 visits per member per year (in & out-of-network combined) PCP copay for Applied Behavioral Analysis (ABA). Specialist includes outpatient physical therapy, occupational therapy & speech therapy.	PCP $35 copay Specialist $60 copay *(deductible waived)*	50%	PCP $25 copay Specialist $35 copay *(deductible waived)*
2022 Calendar Year Autism Spectrum Disorder Up to 90 visits per member per year (in & out-of-network combined) PCP copay for Applied Behavioral Analysis (ABA). Specialist includes outpatient physical therapy, occupational therapy & speech therapy.	PCP $30 copay Specialist $60 copay *(deductible waived)*	50%	PCP $25 copay Specialist $35 copay *(deductible waived)*
2021 Calendar Year Biofeedback (For specified medical conditions only)	25%	50%	$35 copay *(deductible waived)*
2022 Calendar Year Biofeedback (For specified medical conditions only)	25%	50%	$35 copay *(deductible waived)*
2021 Calendar Year Cardiac and Pulmonary Rehabilitation (Office/Outpatient)	25%	50%	$35 copay *(deductible waived)*
2022 Calendar Year Cardiac and Pulmonary Rehabilitation (Office/Outpatient)	25%	50%	$35 copay *(deductible waived)*
2021 Calendar Year Dental/Facial Accident, Oral Surgery & TMJ/CMJ Services	25%	50%	Varies by Services
2022 Calendar Year Dental/Facial Accident, Oral Surgery & TMJ/CMJ Services	25%	50%	Varies by Services
2021 Calendar Year Emergency Room Treatment Physician and other professional provider charges	$150 copay plus 25% coinsurance after deducible		$150 copay plus 20% coinsurance after deducible
2022 Calendar Year Emergency Room Treatment Physician and other professional provider charges	$450 copay after deductible		$150 copay plus 20% coinsurance after deducible
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: 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		Hearing Aids: No Charge up to $2,200 per hearing impaired ear; thereafter you pay 90% coinsurance in any 36-month period

LOW AND EPO OPTION - SUMMARY OF BENEFITS

This is only a summary that lists the member cost-sharing amounts and provides a brief description of NMPSIA Low and EPO Option Health Plan medical benefits.
The Low Option Plan is available under BlueCross BlueShield of New Mexico (BCBSNM), Cigna Health and Presbyterian Health Plan.
The Exclusive Provider Organization (EPO) is only offered by BlueCross BlueShield of New Mexico.
The Summary Plan Description supersedes any information outlined in this summary.

NOTE: 2021 and 2022 Benefit Summaries are both displayed here

NMPSIA Low and EPO Option Health Plan Benefits There is no overall lifetime maximum benefit. However, certain services have maximum annual limits. (Deductible applies unless specified as "deductible waived") See below:	Low Option PPO Benefits Member's Share of Covered Charges In-Network Provider	 Out-Of-Network Provider	EPO Benefits Member's Share of Covered Charges Preferred Provider
2021 Calendar Year Home Health Care/Home I.V. Services Limitations	25% Unlimited	50% 120 visits per calendar year	20% Unlimited
2022 Calendar Year Home Health Care/Home I.V. Services Limitations	25% Unlimited	50% 120 visits per calendar year	20% Unlimited
2021 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%	No charge *(deductible waived)*
2022 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%	No charge *(deductible waived)*
2021 Calendar Year Infertility: Diagnosis Only - No Treatment	Varies by services	50%	Varies by services
2022 Calendar Year Infertility: Diagnosis Only - No Treatment	Varies by services	50%	Varies by services
2021 Calendar Year 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%	$25 copay or actual allowable amount, whichever is less per day *(deductible waived)*
2022 Calendar Year 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%	$25 copay or actual allowable amount, whichever is less per day *(deductible waived)*
2021 Calendar Year 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%	$50 copay or actual allowable amount, whichever is less per day *(deductible waived)*
2022 Calendar Year 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%	$50 copay or actual allowable amount, whichever is less per day *(deductible waived)*
2021 Calendar Year High Tech Imaging: **MRI, MRA, CT Scan, PET Scan**	$700 copay or 25%, whichever is less per day *(deductible waived)*	50%	$500 copay or 20%, whichever is less per day *(deductible waived)*
2022 Calendar Year High Tech Imaging: **MRI, MRA, CT Scan, PET Scan**	$700 copay or 25%, whichever is less per day *(deductible waived)*	50%	$500 copay or 20%, whichever is less per day *(deductible waived)*
2021 Calendar Year Prothrombin Time Test	$10 copay *(deductible waived)*	50%	$10 copay *(deductible waived)*
2022 Calendar Year Prothrombin Time Test	$10 copay *(deductible waived)*	50%	$10 copay *(deductible waived)*
2021 Calendar Year Sleep Study	25%	50%	20%
2022 Calendar Year Sleep Study	25%	50%	20%

LOW AND EPO OPTION - SUMMARY OF BENEFITS

This is only a summary that lists the member cost-sharing amounts and provides a brief description of NMPSIA Low and EPO Option Health Plan medical benefits.
The Low Option Plan is available under BlueCross BlueShield of New Mexico (BCBSNM), Cigna Health and Presbyterian Health Plan.
The Exclusive Provider Organization (EPO) is only offered by BlueCross BlueShield of New Mexico.
The Summary Plan Description supersedes any information outlined in this summary.

NOTE: 2021 and 2022 Benefit Summaries are both displayed here

NMPSIA Low and EPO Option Health Plan Benefits There is no overall lifetime maximum benefit. However, certain services have maximum annual limits. (Deductible applies unless specified as "deductible waived") See below:	Low Option PPO Benefits Member's Share of Covered Charges In-Network Provider	 Out-Of-Network Provider	EPO Benefits Member's Share of Covered Charges Preferred Provider
Inpatient Hospital/Facility Services (High Option copays are waived if you are re-admitted for the same condition within 15 days of discharge or transferred to a rehab or skilled nursing facility within 15 days of discharge from an acute care facility			
2021 Calendar Year 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%	$500 facility copay/admission plus 20%
2022 Calendar Year 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%	$500 facility copay/admission plus 20%
2021 Calendar Year Observation Stay including Related Professional Charges	25%	50%	$100 facility copay plus 20%
2022 Calendar Year Observation Stay including Related Professional Charges	25%	50%	$100 facility copay plus 20%
Maternity Services			
2021 Calendar Year Physicians Midwife Services (Delivery, pre- and post-natal care, including lab, diagnostic testing, and pre-natal genetic testing, if medically necessary)	25%	50%	$25 Office Visit Copay/Initial Visit
2022 Calendar Year Physicians Midwife Services (Delivery, pre- and post-natal care, including lab, diagnostic testing, and pre-natal genetic testing, if medically necessary)	25%	50%	$25 Office Visit Copay/Initial Visit
2021 Calendar Year Hospital Admission (Including routine newborn nursery charges)	25%	50%	$500 copay per pregnancy plus 20%
2022 Calendar Year Hospital Admission (Including routine newborn nursery charges)	25%	50%	$500 copay per pregnancy plus 20%
2021 Calendar Year Extended Stay (non-routine) Charges for covered Newborn	25%	50%	$500 facility copay/admission plus 20%
2022 Calendar Year Extended Stay (non-routine) Charges for covered Newborn	25%	50%	$500 facility copay/admission plus 20%
2021 Calendar Year Home Birth	25%	50%	20%
2022 Calendar Year Home Birth	25%	50%	20%
Mental Health Services			
2021 Calendar Year Office, Home, Outpatient Facility/Physician	$35 copay *(deductible waived)*	50%	$25 copay *(deductible waived)*
2022 Calendar Year Office, Home, Outpatient Facility/Physician	No Charge	No Charge	No Charge
2021 Calendar Year Inpatient	25%	50%	$500 copay plus 20%
2022 Calendar Year Inpatient	No Charge	No Charge	No Charge
2021 Calendar Year Partial Hospitalization	25%	50%	$250 copay plus 20%
2022 Calendar Year Partial Hospitalization	No Charge	No Charge	No Charge
2021 Calendar Year Facility-Based Intensive Outpatient Programs (IOP)	25%	50%	$125 copay plus 20%

LOW AND EPO OPTION - SUMMARY OF BENEFITS

This is only a summary that lists the member cost-sharing amounts and provides a brief description of NMPSIA Low and EPO Option Health Plan medical benefits.
The Low Option Plan is available under BlueCross BlueShield of New Mexico (BCBSNM), Cigna Health and Presbyterian Health Plan.
The Exclusive Provider Organization (EPO) is only offered by BlueCross BlueShield of New Mexico.
The Summary Plan Description supersedes any information outlined in this summary.

NOTE: 2021 and 2022 Benefit Summaries are both displayed here

NMPSIA Low and EPO Option Health Plan Benefits There is no overall lifetime maximum benefit. However, certain services have maximum annual limits. (Deductible applies unless specified as "deductible waived") See below:	Low Option PPO Benefits Member's Share of Covered Charges In-Network Provider	Low Option PPO Benefits Member's Share of Covered Charges Out-Of-Network Provider	EPO Benefits Member's Share of Covered Charges Preferred Provider
2022 Calendar Year Facility-Based Intensive Outpatient Programs (IOP)	No Charge	No Charge	No Charge
Substance Abuse Rehabilitation (Lifetime-no limit on number of courses of treatment for all services combined)			
2021 Calendar Year Office, Home, Outpatient Facility/Physician (No limit on number of days/calendar year)	$35 copay *(deductible waived)*	50%	$25 copay *(deductible waived)*
2022 Calendar Year Office, Home, Outpatient Facility/Physician (No limit on number of days/calendar year)	No Charge	No Charge	No Charge
2021 Calendar Year Inpatient (No limit on number of days/calendar year)	25%	50%	$500 copay plus 20%
2022 Calendar Year Inpatient (No limit on number of days/calendar year)	No Charge	No Charge	No Charge
2021 Calendar Year Partial Hospitalization (No limit on number of days/calendar year combined with Inpatient)	25%	50%	$250 copay plus 20%
2022 Calendar Year Partial Hospitalization (No limit on number of days/calendar year combined with Inpatient)	No Charge	No Charge	No Charge
2021 Calendar Year Facility-Based Intensive Outpatient Programs (IOP)	25%	50%	$125 copay plus 20%
2022 Calendar Year Facility-Based Intensive Outpatient Programs (IOP)	No Charge	No Charge	No Charge
2021 Calendar Year Outpatient Hospital/Facility/Ambulatory Surgery Facility (Including Related Professional Charges)	25%	50%	$150 copay plus 20%
2022 Calendar Year Outpatient Hospital/Facility/Ambulatory Surgery Facility (Including Related Professional Charges)	25%	50%	$150 copay plus 20%
2021 Calendar Year Residential Treatment Center (RTC): (For adults age 18 & older only) (No limit on number of days/calendar year and no limit on days/admit)	25%	50%	$250 copay plus 20%
2022 Calendar Year 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	No Charge	No Charge
2021 Calendar Year Short-Term Rehabilitation, Outpatient and Office: Occupational, Physical & Speech Therapy Services	25%	50%	$35 copay *(deductible waived)* up to $350; thereafter No Charge for the remaining calendar year
2022 Calendar Year Short-Term Rehabilitation, Outpatient and Office: Occupational, Physical & Speech Therapy Services	25%	50%	$35 copay *(deductible waived)* up to $350; thereafter No Charge for the remaining calendar year
Smoking/Tobacco Use Cessation (Includes medication, hypnotherapy, acupuncture, related tests, and any counseling programs not eligible under 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	No Charge For Prescription Drugs, see your Express Scripts Plan for details
2021 Calendar Year 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%	20%
2022 Calendar Year 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%	20%

LOW AND EPO OPTION - SUMMARY OF BENEFITS

This is only a summary that lists the member cost-sharing amounts and provides a brief description of NMPSIA Low and EPO Option Health Plan medical benefits.
The Low Option Plan is available under BlueCross BlueShield of New Mexico (BCBSNM), Cigna Health and Presbyterian Health Plan.
The Exclusive Provider Organization (EPO) is only offered by BlueCross BlueShield of New Mexico.
The Summary Plan Description supersedes any information outlined in this summary.

NOTE: 2021 and 2022 Benefit Summaries are both displayed here

NMPSIA Low and EPO Option Health Plan Benefits There is no overall lifetime maximum benefit. However, certain services have maximum annual limits. (Deductible applies unless specified as "deductible waived") See below:	Low Option PPO Benefits Member's Share of Covered Charges In-Network Provider	 Out-Of-Network Provider	EPO Benefits Member's Share of Covered Charges Preferred Provider
2021 Calendar Year Insulin Pump Supplies (Insertion sets, reservoirs)	No Charge *(deductible waived)*	50%	No Charge *(deductible waived)*
2022 Calendar Year Insulin Pump Supplies (Insertion sets, reservoirs)	No Charge *(deductible waived)*	50%	No Charge *(deductible waived)*
2021 Calendar Year Therapy: Chemotherapy and Radiation Therapy	25%	50%	No Charge *(deductible waived)*
2022 Calendar Year Therapy: Chemotherapy and Radiation Therapy	25%	50%	No Charge *(deductible waived)*
2021 Calendar Year Therapy: Dialysis	25%	50%	20%
2022 Calendar Year Therapy: Dialysis	25%	50%	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	Not Covered	Applicable copays based on place and type of service
2021 Calendar Year Urgent Care (Includes all services and supplies such as x-ray/labs/ physician fees)	$60 copay *(deductible waived)*	50%	$45 copay *(deductible waived)*
2022 Calendar Year Urgent Care (Includes all services and supplies such as x-ray/labs/ physician fees)	$60 copay *(deductible waived)*	50%	$45 copay *(deductible waived)*

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

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

	LOCAL PARTICIPATING RETAIL PHARMACY	HOME DELIVERY PHARMACY
Maximum day's supply per copay	**30 days**	**90 days**
Generic drugs	**$10 copay**	**$22 copay**
Preventative Products Under the Patient Protection & Afford- able Care Act. *(Prescription required. To confirm products covered, contact Member Services at 1-800-498-4904.)*	**$0 copay**	**$0 copay**
Diabetic supplies, Generic & preferred-brand insulin	**$0 copay**	**$0 copay**
Generic & preferred-brand oral diabetes medications	**$10 copay**	**$22 copay**
Non-preferred diabetes medications and supplies	**70% copay**	**70% copay**
Preferred brand-name drugs	**30% of the discounted cost; minimum payment of $30 and maximum payment of $60**	**$60 copay**
Non-preferred drugs	**70% copay** **Visit www.express-scripts.com to price a medication, view drug coverage notes and find less costly alternatives for your doctor's review.**	**70% copay** **Visit www.express-scripts.com to view the current formulary, obtain copay cost estimates, and find less costly alternatives for your doctor's review.**
Specialty drugs **These drugs must be filled via the contracted specialty pharmacy, (Accredo) at Express Scripts.** *(Call 1-800-803-2523)*	**30 day supply (if 90-day supply is approved, copay will multiply x 3):** • **Generic $55 copay** • **Preferred brand-name $80 copay** • **Non-preferred drugs $130 copay** Please Note: Any specialty medication not obtained through the Accredo Specialty Pharmacy will be rejected.	
Immunizations administered by certified pharmacists *(See definitions in this Section.)*	**$0 copay** **To locate a certified pharmacist, visit https://nmpsia.com/ExpressScripts.html or Contact Member Services at 1-800-498-4904.**	**Not covered at mail order.** **Only available from local, certified pharmacist. Visit https://nmpsia.com/ExpressScripts.html or contact Member Services at 1-800-498-4904.**
Out of pocket Maximum *(specialty/non-specialty combined; $3,100/individual, $6,200/family)* **Effective 1/1/2022** *(specialty/non-specialty combined; $3,000/individual, $6,000/family)*	**If you choose to take a brand name drug when a generic is available, you will still pay the difference in cost between the brand and the generic even after your out-of-pocket has been met.**	

EXPRESS SCRIPTS®

DEFINITIONS

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

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

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

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

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

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

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

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

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

DEFINITIONS (cont.)

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

Specialty medications. Accredo, Express Scripts' specialty pharmacy, is the provider of specialty medications. Specialty medications are used to treat complex conditions, such as Cancer, Growth Hormone Deficiency, Hemophilia, Hepatitis C, Immune Deficiency, Multiple Sclerosis, and Rheumatoid Arthritis. Your plan participates in a specialty pharmacy co-pay assistance program through SaveonSP. Certain specialty pharmacy medications (Program drugs) in this program are considered Non-Essential Health Benefits under the plan and the cost of such drugs will NOT be applied toward satisfying the patient out of pocket maximum. Although the cost of the Program drugs will not be applied towards satisfying the patient out of pocket maximum, once enrolled, the cost of the Program drugs will be reimbursed by the manufacturer at no cost to the patient. To find out more about your specialty prescription drug benefit, visit www.express-scripts.com or call Accredo at **1-800-803-2523.**

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

MEMBERS WITH DIABETES

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

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

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

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

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

TAKE THE OPPORTUNITY TO TAKE CONTROL OF YOUR PRESCRIPTION PLAN

TAKE THINGS ONLINE

Create an account on express-scripts.com or the Express Scripts® mobile app.

Manage your prescription plan anytime and anywhere with an online account.
It's simple and easy to get started.

1. **Visit express-scripts.com** and select Register OR download the Express Scripts mobile app for free from your phone's app store and select Register
2. **Enter the requested information,** including your member ID or Social Security number, and create your user name and password
3. **Click or tap Register Now**

Once your account is created, you can:

- Check your order status
- View and print member ID cards
- Enroll in home delivery
- Refill and renew prescriptions
- Enroll eligible prescriptions in automatic refill
- Find your nearest preferred pharmacy
- Set reminders to take your medication

TAKE A SHORTER TRIP TO GET YOUR MEDS

Enroll in home delivery to get your 90-day prescriptions shipped right to your door.

Requesting to get your medications delivered to your home from Express Scripts Pharmacy® is simple and convenient.
First, log in to express-scripts.com (if you haven't already registered, make sure to have your member ID or SSN).

If you are enrolling a new prescription…

- **Contact your doctor** and ask them to e-prescribe a 90-day prescription directly to Express Scripts
- **OR send a request** by selecting "Forms" or "Forms & Cards" from the "Benefits" menu, print a mail order form and follow the mailing instructions
- **OR call us** at the Member Services number on your card and we'll contact your doctor for you

If you are enrolling a current prescription…

Transfer retail prescriptions to home delivery by **clicking "Add to Cart"** for eligible prescriptions and check out.
You can also **refill and renew** prescriptions.
We'll contact your doctor and take care of the rest.

Check **Order Status** to track the shipping of your prescriptions. After we receive your prescription from your doctor, you will receive your medication within 7 days.[1]

TAKE A BREAK FROM BRAND NAMES

Ask about switching to a generic medication to save money on your prescriptions.

By not looking for the best deal on your prescription drugs, you may end up paying more than you should for your medications.

The easiest—and safest—way to save money on prescriptions is to ask for a generic, which typically costs less because the manufacturer did not have to conduct the initial research or studies that the branded drug did.

Generics fall into two categories:

Direct chemical equivalent – a drug that has the same active ingredient as its brand-name counterpart

Therapeutic alternative – a drug that may not be chemically equivalent to the brand, but has the same therapeutic or treatment effect

Direct chemical equivalents are practically identical to the branded drug, while therapeutic alternatives are part of the same family.

Is there a generic for your medication? You can ask…

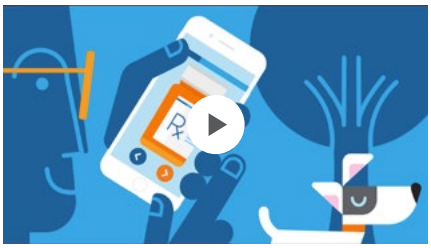
Your health care provider. Check with your doctor or nurse if there's a generic for any medication you're prescribed.

Your pharmacist. Before getting a prescription filled, refilled or renewed, ask your pharmacist if there's a generic alternative.

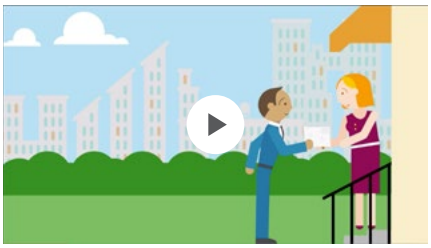
Express Scripts. You can review your prescriptions and specific generics savings opportunities at **express-scripts.com**.

DID YOU KNOW

All generics must adhere to strict guidelines before the FDA will approve their use and are the same as a brand-name medication in dosage, safety, effectiveness, strength, stability and quality.



Watch to learn more about managing your prescription plan online.



Watch to learn just what's so great about home delivery.

For additional information on how to take control of your prescription plan or any other questions about your account or coverage, visit **express-scripts.com**, **download the Express Scripts mobile app** or **call the Member Services number** on the back of your member ID card.

EXPRESS SCRIPTS®

1 Over 85% of members receive their medications within 7 days. Longer delivery times may be due to additional correspondence needed with prescribers, medication availability and/or delivery times from the shipping vendor.

Every mind deserves better

You and your dependents can now access discrete, personalized mental health support and care. It's what you deserve.

Check your benefit materials for more information.

1 Substance Abuse and Mental Health Services Administration. Key Substance Use and Mental Health Indicators in the United States: Results from the National Survey on Drug Use and Health. Published 2018.

Photo is for representative purposes only and does not depict an actual patient.

EXPRESS SCRIPTS®

CHAMPIONS FOR BETTER™

Relax with 90-day supplies.*

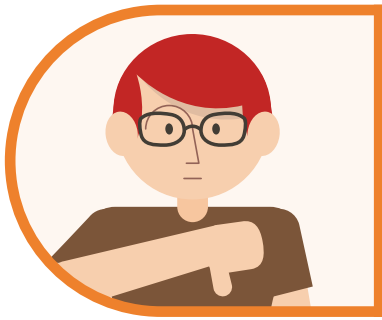
EXPRESS SCRIPTS® CHAMPIONS FOR BETTER℠

Meet Kyle and Nick – two Express Scripts members who take medications on a daily basis. But there's one big difference...

Kyle

gets 90-day supplies of his daily medication through home delivery from Express Scripts Pharmacy® or from a participating retail pharmacy.

That's why Kyle gets to ...



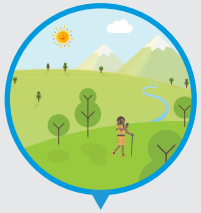
Nick

gets his prescriptions filled ... every ... single ... month.

That's why Nick gets to ...

... **spend his time at film festivals** and not pharmacy counters!

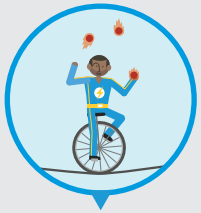
... **keep on track with his medicine** which helps him stay healthier!



... **take long hikes** without worrying that his medicine will run out!

... **grab dinner with friends** with all the money he's saving!

... **kick back by the pool** instead of making that monthly pharmacy trip!

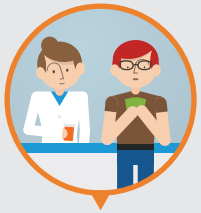


... and **focus on other fun hobbies** instead of annoying errands!

... make time in his schedule to **drive to the pharmacy month after month!**

... miss a dose because **he forgot this month's refill!**

... **wait in line** over and over again!



... **possibly pay more** than he needs to for his medicine!

The bottom line:

Be like Kyle – order 90-day supplies of your daily medication through home delivery or go online to find a participating retail pharmacy!

Here's how your plan works:

1. Choose where you want to fill 90-day supplies to take advantage of your savings opportunities.
2. We can deliver them straight to your door with home delivery from Express Scripts Pharmacy.
3. Or you can pick up your 90-day supplies from a participating retail pharmacy.

Make the switch from a 30-day to a 90-day supply at express-scripts.com/3month

*Relaxation levels may vary.

DELTA DENTAL®

Your Local Choice in Dental

To change 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**, please call the **Delta Dental/NMPSIA Customer Service Open Enrollment Hot-Line** at:

(844) 356-6345

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

NOW 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. 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 (fax, voice, or email), 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	Low Option Plan		High Option 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 Appleseed
- 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

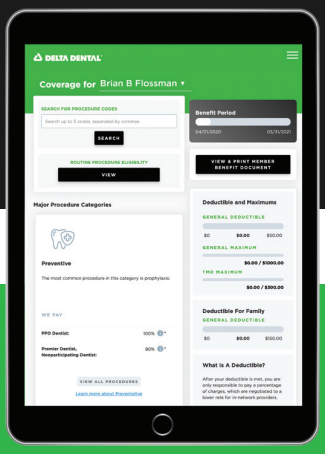
As shown below, your lowest out-of-pocket costs result from going to either a Delta Dental PPO™ or Delta Dental Premier® dentist.

		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®

Delta Dental mobile app

Manage your benefits anytime, anywhere

Your oral health is important to Delta Dental — and to your overall health! We've designed our mobile app to make it easy for you to make the most of your dental benefits. Maximize your health, wherever you are! Search for a dentist near you, check claims and coverage, view ID cards and more, right on your mobile device.

Getting started

SCAN TO DOWNLOAD DELTA DENTAL MOBILE

Delta Dental's mobile app is optimized for iOS (Apple) and Android devices. To download our app on your device, visit the App Store (Apple) or Google Play (Android) and search for Delta Dental. Or, scan the QR code at right. You will need an internet connection in order to download and use most features of our free app.

Using the mobile app without logging in

Anyone can use the Delta Dental mobile app without logging in to search for a dentist near you, access our toothbrush timer, LifeSmile Score risk assessment and Cost Estimator.

Logging in to view benefits

Delta Dental subscribers can log in using the username and password they use to log in to our website. If you haven't registered for an account yet, you can do that within the app. If you've forgotten your username or password, you can also retrieve these via the Delta Dental mobile app.

UNITED CONCORDIA® DENTAL
Protecting More Than Just Your Smile®

Welcome to United Concordia!

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

With your United Concordia dental plan, you will experience:

- Access to quality dentists through our **Alliance** network with more than 3,000 access points in New Mexico
- Online and personal service
  - Access your benefit information when you need it, where you need it through **UnitedConcordia.com** and our mobile app—download today to get started
  - Create a ***MyDental****Benefits* account for fast, secure access to claim details, payment information, procedure history, printable ID cards and more
  - Speak to a knowledgeable, US-based representative by calling **1-888-898-0370** who can resolve problems and give on-the-spot solutions

Why use a United Concordia network dentist?

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

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

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

Your plan includes Smile for Health®–Wellness

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

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

Enhanced Benefits with Smile for Health®–Wellness

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

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

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

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 more than 400 participating private colleges and universities.

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

UNITED CONCORDIA® DENTAL
Protecting More Than Just Your Smile®

HIGH OPTION

Concordia Preferred Comprehensive Plan

Benefit Category	Alliance Network		Non-Network	
	Plan Pays[1]	You Pay[1]	Plan Pays[4]	You Pay
Diagnostic & Preventive Services ■ Routine Oral Exams (twice every 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-0143-0720

UNITED CONCORDIA® DENTAL
Protecting More Than Just Your Smile®

LOW OPTION

Concordia Preferred Basic Plan

Benefit Category	Alliance Network		Non-Network	
	Plan Pays[1]	You Pay[1]	Plan Pays[4]	You Pay
Diagnostic & Preventive Services ■ Routine Oral Exams (twice every 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-0143-0720

UNITED CONCORDIA® DENTAL
Protecting More Than Just Your Smile®

Frequently Asked Questions

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

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

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

A. An orthodontic treatment plan must be submitted by the treating provider to determine the remaining benefit that you may be entitled. (Orthodontic benefit is paid on a prorated basis. Payments are made quarterly. If coverage ends before the treatment plan is completed, the full benefit may not be paid.)

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

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

Q. Does United Concordia require predetermination of benefits?

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

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

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

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

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

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

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

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

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

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

DavisVision®

NEW MEXICO PUBLIC SCHOOLS INSURANCE AUTHORITY

Premier Vision Plan

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

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

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

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

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

How to locate a Network Provider...

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

Order eyewear online

You have multiple options for ordering eyewear online! The following websites are available to you as in-network retailers, providing a similar benefit experience as though you were shopping in person.

- 1800Contacts.com
- Glasses.com
- Visionworks.com
- Befitting.com

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

IN-NETWORK BENEFITS	
Eye Examination[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 & Follow Up Care	Every 12 months, Collection Contacts: **Covered in full** OR Non Collection Contacts: 15% discount[3]
Contact Lenses	Every 12 months, **Covered in full** Any contact lenses from Davis Vision's Contact Lens Collection[1] OR $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 & COATINGS		
MOST POPULAR OPTIONS Savings based on in-network usage and average retail values.	Without Davis Vision	With Davis Vision
Scratch-Resistant Coating	$45	$0
Polycarbonate Lenses	$64	$0[2]-$30
Standard Anti-Reflective (AR) Coating	$62	$35
Standard Progressives (no-line bifocal)	$154	$50
Plastic Photosensitive (Transitions®[4])	$123	$65

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

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

Savings up to: ***$358***

[1] *The Davis Vision Collection is available at most participating independent provider locations. Collection is subject to change. Collection is inclusive of select toric and multifocal contacts.*
[2] *For dependent children, monocular patients and patients with prescriptions of 6.00 diopters or greater.*
[3] *Additional discounts not applicable at Walmart, 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.*

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

CD00450 7/17/20

Here's what we have to offer...

Value for our Members

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

Convenient Network Locations

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

Freedom of Choice

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

Value-Added Features:

- Mail Order Contact Lenses Replacement contacts (after initial benefit) through DavisVisionContacts.com mail-order service ensures easy, convenient, purchasing online and quick, direct shipping to your door. Log on to our member Web site for details.
- Davis Vision provides you and your eligible dependents with the opportunity to receive discounted laser vision correction, often referred to as LASIK. For more information, visit www.davisvision.com.
- You also have access to Your Hearing Network for a savings of up to 40% off national average selling prices for brand name hearing aids.

Contact Info

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

COPAYS FOR OPTIONS AND UPGRADES	
FRAMES	
Fashion Frame (from the Davis Vision Collection)	$0
Designer Frame (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[1/] 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	$70
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 Flitering	$15
Scratch Protection Plan (Single vision | Multifocal lenses)	$20 | $40

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

Out-of-Network Benefits

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

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

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

MONTHLY CONTRIBUTIONS EFFECTIVE OCTOBER 1, 2021

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	**$811.68**	**$1,543.68**	**$2,061.76**
Blue Cross Blue Shield New Mexico – Low Option	**$578.02**	**$1,099.34**	**$1,468.36**
Blue Cross Blue Shield New Mexico – Exclusive Provider Organization (EPO) Option*	**$730.50**	**$1,389.28**	**$1,855.56**
Cigna – High Option	**$775.04**	**$1,496.14**	**$2,005.34**
Cigna – Low Option	**$554.52**	**$1,070.44**	**$1,434.76**
Presbyterian – High Option	**$656.38**	**$1,378.32**	**$1,837.90**
Presbyterian – Low Option	**$467.50**	**$981.60**	**$1,308.86**
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; 3.6% increase on Low medical plan options)

Date prepared: 03.05.2021

CONTRIBUTIONS EFFECTIVE OCTOBER 1, 2021 *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)**	**$202.92**	**$243.50**	**$284.08**	**$324.68**
BCBS	Single (district/employer contribution)	$608.76	$568.18	$527.60	$487.00
High Option	**Two-Party (employee deduction)**	**$385.92**	**$463.10**	**$540.28**	**$617.48**
	Two-Party (district/employer contribution)	$1,157.76	$1,080.58	$1,003.40	$926.20
	Family (employee deduction)	**$515.44**	**$618.52**	**$721.62**	**$824.70**
	Family (district/employer contribution	$1,546.32	$1,443.24	$1,340.14	$1,237.06
BCBS	**Single (employee deduction)**	**$144.50**	**$173.40**	**$202.30**	**$231.20**
Low Option	Single (district/employer contribution)	$433.52	$404.62	$375.72	$346.82
	Two-Party (employee deduction)	**$274.84**	**$329.80**	**$384.76**	**$439.74**
	Two-Party (district/employer contribution)	$824.50	$769.54	$714.58	$659.60
	Family (employee deduction)	**$367.10**	**$440.50**	**$513.92**	**$587.34**
	Family (district/employer contribution	$1,101.26	$1,027.86	$954.44	$881.02
BCBS	**Single (employee deduction)**	**$182.62**	**$219.16**	**$255.68**	**$292.20**
EPO Option	Single (district/employer contribution)	$547.88	$511.34	$474.82	$438.30
	Two-Party (employee deduction)	**$347.32**	**$416.78**	**$486.24**	**$555.72**
	Two-Party (district/employer contribution)	$1,041.96	$972.50	$903.04	$833.56
	Family (employee deduction)	**$463.90**	**$556.66**	**$649.44**	**$742.22**
	Family (district/employer contribution	$1,391.66	$1,298.90	$1,206.12	$1,113.34
Cigna	**Single (employee deduction)**	**$193.76**	**$232.52**	**$271.26**	**$310.02**
High Option	Single (district/employer contribution)	$581.28	$542.52	$503.78	$465.02
	Two-Party (employee deduction)	**$374.04**	**$448.84**	**$523.64**	**$598.46**
	Two-Party (district/employer contribution)	$1,122.10	$1,047.30	$972.50	$897.68
	Family (employee deduction)	**$501.34**	**$601.60**	**$701.86**	**$802.14**
	Family (district/employer contribution	$1,504.00	$1,403.74	$1,303.48	$1,203.20
Cigna	**Single (employee deduction)**	**$138.64**	**$166.36**	**$194.08**	**$221.80**
Low Option	Single (district/employer contribution)	$415.88	$388.16	$360.44	$332.72
	Two-Party (employee deduction)	**$267.62**	**$321.14**	**$374.66**	**$428.18**
	Two-Party (district/employer contribution)	$802.82	$749.30	$695.78	$642.26
	Family (employee deduction)	**$358.70**	**$430.42**	**$502.16**	**$573.90**
	Family (district/employer contribution	$1,076.06	$1,004.34	$932.60	$860.86
Presbyterian	**Single (employee deduction)**	**$164.10**	**$196.92**	**$229.74**	**$262.56**
High Option	Single (district/employer contribution)	$492.28	$459.46	$426.64	$393.82
	Two-Party (employee deduction)	**$344.58**	**$413.50**	**$482.42**	**$551.32**
	Two-Party (district/employer contribution)	$1,033.74	$964.82	$895.90	$827.00
	Family (employee deduction)	**$459.48**	**$551.38**	**$643.26**	**$735.16**
	Family (district/employer contribution	$1,378.42	$1,286.52	$1,194.64	$1,102.74
Presbyterian	**Single (employee deduction)**	**$116.88**	**$140.26**	**$163.62**	**$187.00**
Low Option	Single (district/employer contribution)	$350.62	$327.24	$303.88	$280.50
	Two-Party (employee deduction)	**$245.40**	**$294.48**	**$343.56**	**$392.64**
	Two-Party (district/employer contribution)	$736.20	$687.12	$638.04	$588.96
	Family (employee deduction)	**$327.22**	**$392.66**	**$458.10**	**$523.54**
	Family (district/employer contribution	$981.64	$916.20	$850.76	$785.32
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;
3.6% increase on Low medical plan options)

THE STANDARD ADDITIONAL LIFE Employee pays 100% of the premium. (*page 19) 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 *(page 22)*

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 June 2021

This document contains important employee benefit program notices of interest to you and your family. Please share this information with your family members. Some of the notices in this document are required by law and other notices contain helpful information. These notices are updated from time-to-time and some of the federal notices are updated each year. Be sure you 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 2021/2022 NMPSIA plan year beginning on July 1, 2021 through June 30, 2022. The election may be renewed for subsequent plan years.

For the 2021/2022 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 2021) 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 web site, we will prominently post the revised Notice on that web site by the effective date of the material change to the Notice. We will also provide the revised notice, or information about the material change and how to obtain the revised Notice, in our next annual mailing to individuals covered by the Plan.

When the Plan May Use or Disclose Your Health Information

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

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

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

The Plan 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, 2021.**

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, 2021. Contact your State for more information on eligibility –

ALABAMA – Medicaid	COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Website: http://myalhipp.com/ Phone: 1-855-692-5447	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

ALASKA – Medicaid	FLORIDA – Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
ARKANSAS – Medicaid	**GEORGIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
CALIFORNIA – Medicaid	**INDIANA – Medicaid**
Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Email: hipp@dhcs.ca.gov	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**MONTANA – 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://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KANSAS – Medicaid	**NEBRASKA – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
KENTUCKY – Medicaid	**NEVADA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900

LOUISIANA – Medicaid	NEW HAMPSHIRE – 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)	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
MAINE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
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	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
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK – Medicaid**
Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa Phone: 1-800-862-4840	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp 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	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**UTAH – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
OREGON – Medicaid	**VERMONT– Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
RHODE ISLAND – Medicaid and CHIP	**WASHINGTON – Medicaid**

Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA - Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	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, 2021, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

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

Glossary of Health Coverage and Medical Terms

- This glossary defines many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan or health insurance policy. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)
- Underlined text indicates a term defined in this Glossary.
- See page 6 for an example showing how deductibles, coinsurance and out-of-pocket limits work together in a real life situation.

Allowed Amount

This is the maximum payment the plan will pay for a covered health care service. May also be called "eligible expense", "payment allowance", or "negotiated rate".

Appeal

A request that your health insurer or plan review a decision that denies a benefit or payment (either in whole or in part).

Balance Billing

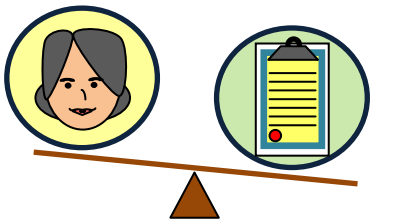
When a provider bills you for the balance remaining on the bill that your plan doesn't cover. This amount is the difference between the actual billed amount and the allowed amount. For example, if the provider's charge is $200 and the allowed amount is $110, the provider may bill you for the remaining $90. This happens most often when you see an out-of-network provider (non-preferred provider). A network provider (preferred provider) may not bill you for covered services.

Claim

A request for a benefit (including reimbursement of a health care expense) made by you or your health care provider to your health insurer or plan for items or services you think are covered.

Coinsurance

Your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the allowed amount for the service. You generally pay coinsurance ***plus*** any deductibles you owe. (For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.)



(See page 6 for a detailed example.)

Complications of Pregnancy

Conditions due to pregnancy, labor, and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section generally aren't complications of pregnancy.

Copayment

A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Cost Sharing

Your share of costs for services that a plan covers that you must pay out of your own pocket (sometimes called "out-of-pocket costs"). Some examples of cost sharing are copayments, deductibles, and coinsurance. Family cost sharing is the share of cost for deductibles and out-of-pocket costs you and your spouse and/or child(ren) must pay out of your own pocket. Other costs, including your premiums, penalties you may have to pay, or the cost of care a plan doesn't cover usually aren't considered cost sharing.

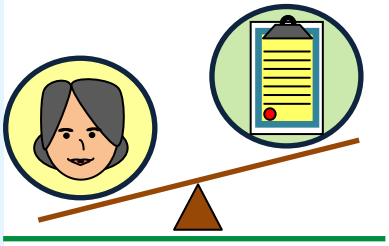
Cost-sharing Reductions

Discounts that reduce the amount you pay for certain services covered by an individual plan you buy through the Marketplace. You may get a discount if your income is below a certain level, and you choose a Silver level health plan or if you're a member of a federally-recognized tribe, which includes being a shareholder in an Alaska Native Claims Settlement Act corporation.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146

Deductible

An amount you could owe during a coverage period (usually one year) for covered health care services before your plan begins to pay. An overall deductible applies to all or almost all covered items and services. A plan with an overall deductible may also have separate deductibles that apply to specific services or groups of services. A plan may also have only separate deductibles. (For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible.)



Jane pays 100% | Her plan pays 0%

(See page 6 for a detailed example.)

Diagnostic Test

Tests to figure out what your health problem is. For example, an x-ray can be a diagnostic test to see if you have a broken bone.

Durable Medical Equipment (DME)

Equipment and supplies ordered by a health care provider for everyday or extended use. DME may include: oxygen equipment, wheelchairs, and crutches.

Emergency Medical Condition

An illness, injury, symptom (including severe pain), or condition severe enough to risk serious danger to your health if you didn't get medical attention right away. If you didn't get immediate medical attention you could reasonably expect one of the following: 1) Your health would be put in serious danger; or 2) You would have serious problems with your bodily functions; or 3) You would have serious damage to any part or organ of your body.

Emergency Medical Transportation

Ambulance services for an emergency medical condition. Types of emergency medical transportation may include transportation by air, land, or sea. Your plan may not cover all types of emergency medical transportation, or may pay less for certain types.

Emergency Room Care / Emergency Services

Services to check for an emergency medical condition and treat you to keep an emergency medical condition from getting worse. These services may be provided in a licensed hospital's emergency room or other place that provides care for emergency medical conditions.

Excluded Services

Health care services that your plan doesn't pay for or cover.

Formulary

A list of drugs your plan covers. A formulary may include how much your share of the cost is for each drug. Your plan may put drugs in different cost sharing levels or tiers. For example, a formulary may include generic drug and brand name drug tiers and different cost sharing amounts will apply to each tier.

Grievance

A complaint that you communicate to your health insurer or plan.

Habilitation Services

Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance

A contract that requires a health insurer to pay some or all of your health care costs in exchange for a premium. A health insurance contract may also be called a "policy" or "plan".

Home Health Care

Health care services and supplies you get in your home under your doctor's orders. Services may be provided by nurses, therapists, social workers, or other licensed health care providers. Home health care usually doesn't include help with non-medical tasks, such as cooking, cleaning, or driving.

Hospice Services

Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization

Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. Some plans may consider an overnight stay for observation as outpatient care instead of inpatient care.

Hospital Outpatient Care

Care in a hospital that usually doesn't require an overnight stay.

Individual Responsibility Requirement
Sometimes called the "individual mandate", the duty you may have to be enrolled in health coverage that provides minimum essential coverage. If you don't have minimum essential coverage, you may have to pay a penalty when you file your federal income tax return unless you qualify for a health coverage exemption.

In-network Coinsurance
Your share (for example, 20%) of the allowed amount for covered healthcare services. Your share is usually lower for in-network covered services.

In-network Copayment
A fixed amount (for example, $15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network copayments usually are less than out-of-network copayments.

Marketplace
A marketplace for health insurance where individuals, families and small businesses can learn about their plan options; compare plans based on costs, benefits and other important features; apply for and receive financial help with premiums and cost sharing based on income; and choose a plan and enroll in coverage. Also known as an "Exchange". The Marketplace is run by the state in some states and by the federal government in others. In some states, the Marketplace also helps eligible consumers enroll in other programs, including Medicaid and the Children's Health Insurance Program (CHIP). Available online, by phone, and in-person.

Maximum Out-of-pocket Limit
Yearly amount the federal government sets as the most each individual or family can be required to pay in cost sharing during the plan year for covered, in-network services. Applies to most types of health plans and insurance. This amount may be higher than the out-of-pocket limits stated for your plan.

Medically Necessary
Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms, including habilitation, and that meet accepted standards of medicine.

Minimum Essential Coverage
Health coverage that will meet the individual responsibility requirement. Minimum essential coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage.

Minimum Value Standard
A basic standard to measure the percent of permitted costs the plan covers. If you're offered an employer plan that pays for at least 60% of the total allowed costs of benefits, the plan offers minimum value and you may not qualify for premium tax credits and cost sharing reductions to buy a plan from the Marketplace.

Network
The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Network Provider (Preferred Provider)
A provider who has a contract with your health insurer or plan who has agreed to provide services to members of a plan. You will pay less if you see a provider in the network. Also called "preferred provider" or "participating provider."

Orthotics and Prosthetics
Leg, arm, back and neck braces, artificial legs, arms, and eyes, and external breast prostheses after a mastectomy. These services include: adjustment, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition.

Out-of-network Coinsurance
Your share (for example, 40%) of the allowed amount for covered health care services to providers who don't contract with your health insurance or plan. Out-of-network coinsurance usually costs you more than in-network coinsurance.

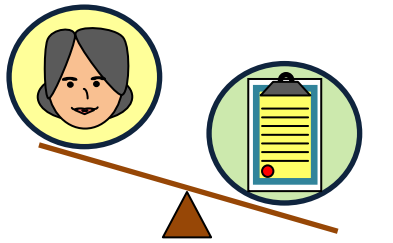
Out-of-network Copayment
A fixed amount (for example, $30) you pay for covered health care services from providers who do ***not*** contract with your health insurance or plan. Out-of-network copayments usually are more than in-network copayments.

Out-of-network Provider (Non-Preferred Provider)

A provider who doesn't have a contract with your plan to provide services. If your plan covers out-of-network services, you'll usually pay more to see an out-of-network provider than a preferred provider. Your policy will explain what those costs may be. May also be called "non-preferred" or "non-particiapting" instead of "out-of-network provider".

Out-of-pocket Limit

The most you *could* pay during a coverage period (usually one year) for your share of the costs of covered services. After you meet this limit the plan will usually pay 100% of the allowed amount. This limit helps you plan for health care costs. This limit never includes your premium, balance-billed charges or health care your plan doesn't cover. Some plans don't count all of your copayments, deductibles, coinsurance payments, out-of-network payments, or other expenses toward this limit.



(See page 6 for a detailed example.)

Physician Services

Health care services a licensed medical physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), provides or coordinates.

Plan

Health coverage issued to you directly (individual plan) or through an employer, union or other group sponsor (employer group plan) that provides coverage for certain health care costs. Also called "health insurance plan", "policy", "health insurance policy" or "health insurance".

Preauthorization

A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment (DME) is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Premium

The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly, or yearly.

Premium Tax Credits

Financial help that lowers your taxes to help you and your family pay for private health insurance. You can get this help if you get health insurance through the Marketplace and your income is below a certain level. Advance payments of the tax credit can be used right away to lower your monthly premium costs.

Prescription Drug Coverage

Coverage under a plan that helps pay for prescription drugs. If the plan's formulary uses "tiers" (levels), prescription drugs are grouped together by type or cost. The amount you'll pay in cost sharing will be different for each "tier" of covered prescription drugs.

Prescription Drugs

Drugs and medications that by law require a prescription.

Preventive Care (Preventive Service)

Routine health care, including screenings, check-ups, and patient counseling, to prevent or discover illness, disease, or other health problems.

Primary Care Physician

A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), who provides or coordinates a range of health care services for you.

Primary Care Provider

A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist, or physician assistant, as allowed under state law and the terms of the plan, who provides, coordinates, or helps you access a range of health care services.

Provider

An individual or facility that provides health care services. Some examples of a provider include a doctor, nurse, chiropractor, physician assistant, hospital, surgical center, skilled nursing facility, and rehabilitation center. The plan may require the provider to be licensed, certified, or accredited as required by state law.

Reconstructive Surgery
Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries, or medical conditions.

Referral
A written order from your primary care provider for you to see a specialist or get certain health care services. In many health maintenance organizations (HMOs), you need to get a referral before you can get health care services from anyone except your primary care provider. If you don't get a referral first, the plan may not pay for the services.

Rehabilitation Services
Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Screening
A type of preventive care that includes tests or exams to detect the presence of something, usually performed when you have no symptoms, signs, or prevailing medical history of a disease or condition.

Skilled Nursing Care
Services performed or supervised by licensed nurses in your home or in a nursing home. Skilled nursing care is ***not*** the same as "skilled care services", which are services performed by therapists or technicians (rather than licensed nurses) in your home or in a nursing home.

Specialist
A provider focusing on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

Specialty Drug
A type of prescription drug that, in general, requires special handling or ongoing monitoring and assessment by a health care professional, or is relatively difficult to dispense. Generally, specialty drugs are the most expensive drugs on a formulary.

UCR (Usual, Customary and Reasonable)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

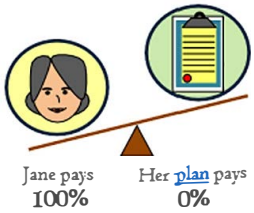
Urgent Care
Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

How You and Your Insurer Share Costs - Example

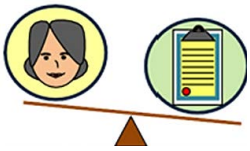
Jane's Plan Deductible: $1,500 **Coinsurance:** 20% **Out-of-Pocket Limit:** $5,000

January 1st
Beginning of Coverage Period

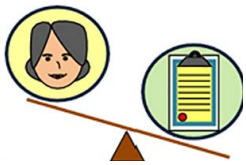
December 31st
End of Coverage Period



more costs



more costs



Jane hasn't reached her $1,500 deductible yet

Her plan doesn't pay any of the costs.

Office visit costs: $125
Jane pays: $125
Her plan pays: $0

Jane reaches her $1,500 deductible, coinsurance begins

Jane has seen a doctor several times and paid $1,500 in total, reaching her deductible. So her plan pays some of the costs for her next visit.

Office visit costs: $125
Jane pays: 20% of $125 = $25
Her plan pays: 80% of $125 = $100

Jane reaches her $5,000 out-of-pocket limit

Jane has seen the doctor often and paid $5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.

Office visit costs: $125
Jane pays: $0
Her plan pays: $125

Glossary of Health Coverage and Medical Terms (cms.gov), 2021

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 • www.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