## NMPSIA CUSTOMER SERVICE TELEPHONE NUMBERS & WEBSITES

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<td>Presbyterian</td>
<td>1-888-275-7737</td>
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<td>Express Scripts</td>
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<td><strong>DENTAL</strong></td>
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<td>United Concordia</td>
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<td>Davis Vision</td>
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<td><strong>LONG-TERM DISABILITY CLAIMS</strong></td>
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<td><strong>LIFE CLAIMS</strong></td>
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New Mexico Public Schools Insurance Authority
410 Old Taos Highway • Santa Fe, NM 87501
1-800-548-3724 • 505-988-2736 • 505-983-8670 fax • nmpsia.com

NMPSIA ELIGIBILITY ADMINISTRATIVE OFFICE
1-800-233-3164 Customer Service
View your information by logging into https://nmpsiaonline.nmpsia.com
Greetings from the Executive Director

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

As a participant in NMPSIA, you may be entitled to FREE Basic Life Insurance if you work at least 15 hours per week. In most districts, you may buy additional life insurance at your own cost.

You and your employer share the cost for the medical, dental, vision, and disability plans. Your payroll deduction represents only about one-third of the total cost to fund the plans.

Our medical plans are self-insured. This means NMPSIA is responsible for the design of the plan and the setting of contributions. We set the contribution rates to be adequate to pay for the claims we all incur. When our claims exceed the contributions, the contribution rates have to go up. We pay less than 6% of the contribution towards the medical plan administration (claims payment, customer service, provider networking, ID cards, booklets). The balance pays for the cost of our medical care.

Our plan now has a calendar year deductible of $300 per person which must be met before most services will be covered. We continue to offer free coverage for in-network routine physicals and screenings. Other services are covered at an 80% coinsurance, which means the plan will cover 80% of allowable expenses and you will be responsible for 20% of the cost. Most services will also have a copay.

The medical plans have an out-of-pocket limit, which is the cap on the total expenses you pay in copays, deductibles, and coinsurance. It is important to know that these plans, while requiring more member cost-sharing in their medical care, still provide invaluable protection from catastrophic medical expenses.

Please don’t miss the opportunity to enroll for insurance. If you delay enrolling, there are only certain times you may have the chance to enroll again, and it may be too late.

Sincerely,

Sammy J. Quintana, Esq.
Executive Director
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## Employer Plan Matrix

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## Employer Plan Matrix

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<td>Silver City Consolidated Schools</td>
<td>$50,000</td>
<td>BCBS, Presbyterian</td>
<td>YES</td>
<td>YES</td>
<td>60 days</td>
<td>YES</td>
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<tr>
<td>Socorro Consolidated Schools</td>
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<td>BCBS, Presbyterian</td>
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<tr>
<td>South Valley Academy</td>
<td>$50,000</td>
<td>BCBS, Presbyterian</td>
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<td>YES</td>
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<tr>
<td>SW Aeronautics, Mathematics &amp; Science Academy</td>
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<td>Southwest Intermediate Learning Center</td>
<td>$50,000</td>
<td>BCBS, Presbyterian</td>
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<tr>
<td>Southwest Primary Learning Center</td>
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<td>Southwest Secondary Learning Center</td>
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<td>Springer Municipal Schools</td>
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<td>BCBS, Presbyterian</td>
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<tr>
<td>Taos Academy Charter School</td>
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<td>BCBS, Presbyterian</td>
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<td>YES</td>
<td>60 days</td>
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<tr>
<td>Taos Charter School</td>
<td>$50,000</td>
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<td>YES</td>
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<tr>
<td>Taos Integrated School of the Arts</td>
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<td>BCBS, Presbyterian</td>
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<tr>
<td>Taos International School</td>
<td>$50,000</td>
<td>BCBS, Presbyterian</td>
<td>YES</td>
<td>YES</td>
<td>30 days</td>
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</tbody>
</table>
### Employer Plan Matrix

<table>
<thead>
<tr>
<th>EMPLOYER</th>
<th>Basic Life</th>
<th>Medical Plan Choices</th>
<th>Dental</th>
<th>Vision</th>
<th>Disability Plan</th>
<th>Add. Life</th>
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<tbody>
<tr>
<td>Taos Municipal Schools</td>
<td>$50,000</td>
<td>BCBS, Presbyterian</td>
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<td>YES</td>
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<td>Tatum Municipal Schools</td>
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<td>BCBS, Presbyterian</td>
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<td>Texico Municipal Schools</td>
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<td>The Great Academy</td>
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<td>The International School</td>
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<td>BCBS, Presbyterian</td>
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<td>YES</td>
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<td>YES</td>
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<td>The Masters Program</td>
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<td>The New America - Las Cruces</td>
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<td>BCBS, Presbyterian</td>
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<td>YES</td>
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<tr>
<td>The New America School</td>
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<td>BCBS, Presbyterian</td>
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<td>YES</td>
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<tr>
<td>The New Mexico International School</td>
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<td>BCBS, Presbyterian</td>
<td>YES</td>
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<td>Tierra Adentro of New Mexico</td>
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<td>BCBS, Presbyterian</td>
<td>YES</td>
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<td>Tierra Encantada Charter High School</td>
<td>$50,000</td>
<td>BCBS, Presbyterian</td>
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<td>YES</td>
<td>90 days</td>
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<td>Truth Or Consequences Municipal Schools</td>
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<td>BCBS, Presbyterian</td>
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<tr>
<td>Tucumcari Public Schools</td>
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<td>YES</td>
<td>30 days</td>
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<td>Tularosa Municipal Schools</td>
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<td>BCBS, Presbyterian</td>
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<td>Turquoise Trail Charter School</td>
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<td>BCBS, Presbyterian</td>
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<td>Twenty First Century Public Academy</td>
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<td>60 days</td>
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<tr>
<td>Uplift Community School</td>
<td>$50,000</td>
<td>BCBS, Presbyterian</td>
<td>YES</td>
<td>YES</td>
<td>30 days</td>
<td>YES</td>
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<td>Vaughn Municipal Schools</td>
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<td>BCBS, Presbyterian</td>
<td>YES</td>
<td>YES</td>
<td>30 days</td>
<td>YES</td>
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<tr>
<td>Village Academy</td>
<td>$50,000</td>
<td>BCBS, Presbyterian</td>
<td>YES</td>
<td>YES</td>
<td>30 days</td>
<td>YES</td>
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<tr>
<td>Vista Grande High School</td>
<td>$50,000</td>
<td>BCBS, Presbyterian</td>
<td>YES</td>
<td>YES</td>
<td>30 days</td>
<td>YES</td>
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<tr>
<td>Wagon Mound Public Schools</td>
<td>$25,000</td>
<td>BCBS, Presbyterian</td>
<td>YES</td>
<td>YES</td>
<td>n/a</td>
<td>YES</td>
</tr>
<tr>
<td>Walatowa Charter High School</td>
<td>$50,000</td>
<td>BCBS, Presbyterian</td>
<td>YES</td>
<td>YES</td>
<td>90 days</td>
<td>YES</td>
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<tr>
<td>West Las Vegas Public Schools</td>
<td>$25,000</td>
<td>BCBS, Presbyterian</td>
<td>YES</td>
<td>YES</td>
<td>30 days</td>
<td>YES</td>
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<tr>
<td>Western NM University</td>
<td>$50,000</td>
<td>BCBS, Presbyterian</td>
<td>YES</td>
<td>YES</td>
<td>30 days</td>
<td>YES</td>
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<tr>
<td>William W. &amp; Josephine Dorn Charter School</td>
<td>$50,000</td>
<td>BCBS, Presbyterian</td>
<td>YES</td>
<td>YES</td>
<td>30 days</td>
<td>YES</td>
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<tr>
<td>Zuni Public Schools</td>
<td>$50,000</td>
<td>BCBS, Presbyterian</td>
<td>YES</td>
<td>YES</td>
<td>90 days</td>
<td>YES</td>
</tr>
</tbody>
</table>

**Active Board Member Options:** Subject to health plans offered by the school district. Additional Life amount is equal to the Basic Life amount available to the school district. Basic Life and Disability coverage not available.
**ELIGIBLE EMPLOYEE**

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

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

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

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

In most cases, all other lines of NMPSIA coverage will become effective on the first day of the month following the day you apply provided you are actively at work on your effective date of coverage (and your premium is withheld and/or adjusted from your payroll check). Your effective date of coverage is determined by your employer based on your payroll deductions, but this coverage can never go into effect retroactively and never any sooner than the first day of the month FOLLOWING your first day actively at work.

**BOARD MEMBER**

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

**ELIGIBLE DEPENDENTS**

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

As a new hire, you are granted 31 days from the day your coverage goes into effect to provide the appropriate supportive documentation proving that your dependents are eligible for NMPSIA coverage. In cases of changes in status, you are granted 31 days from the qualifying event to provide the appropriate supportive documentation. In either case, coverage for your dependents will go into effect the first day of the month following the day you turn in the appropriate supportive documentation to your employer’s benefits office (provided you applied timely and meet the 31-day timeline for supportive documentation). The effective date of coverage for your dependents will not be made retroactive to your effective date of coverage, except for newborns and adopted children who are enrolled timely. See details:
NEWBORN

You are granted 31 days from the first of the month following your newborn’s birth to provide appropriate supportive documentation to your employer’s benefits office.

Coverage for a newborn begins on the newborn’s date of birth, provided that you are enrolled in NMPSIA family medical coverage. Any claims associated with your newborn, cannot be processed until you apply to enroll your newborn.

If you are not enrolled in NMPSIA family medical coverage, your newborn will not be automatically covered from date of birth. You must apply to enroll your newborn within 31 days from the newborn’s date of birth. If you miss this 31-day enrollment period, your newborn will not be eligible for coverage until January 1.

CHILDREN PLACED FOR ADOPTION OR ADOPTED

You are granted 31 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 an adopted child begins on date of placement or adoption (whichever comes first) provided that you are enrolled in NMPSIA family medical coverage. Any claims associated with your adopted child, or child placed for adoption cannot be processed until you apply to enroll your child.

If you are not enrolled in NMPSIA family medical coverage, your adopted child or child placed for adoption will not be automatically covered from date of adoption or placement. You must apply to enroll your child within 31 days from date of placement or adoption (whichever comes first) in order for your child’s coverage to be effective from date of placement or adoption. If you miss this 31-day enrollment period, your child will not be eligible for coverage until January 1.

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

<table>
<thead>
<tr>
<th>ELIGIBLE DEPENDENT</th>
<th>SUPPORTIVE DOCUMENTATION REQUIRED</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Legal Spouse</td>
<td>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)</td>
</tr>
<tr>
<td>• Domestic Partner (Only if Employer has elected this option)</td>
<td>Notarized affidavit of domestic partnership</td>
</tr>
<tr>
<td>• Child under the age of 26 as follows:</td>
<td>Original official state publicly filed birth certificate from the Bureau of Vital Statistics (hospital birth registration form is also acceptable)</td>
</tr>
<tr>
<td>o Natural Child</td>
<td>Evidence of placement by a state licensed agency, governmental agency or a court order/decree (notarized statement and power of attorney are not acceptable)</td>
</tr>
<tr>
<td>o Stepchild primarily dependent on the eligible employee for maintenance and support</td>
<td>Legal Guardianship Document (notarized statement and power of attorney documents are not acceptable)</td>
</tr>
<tr>
<td>o Legally adopted child or a child for whom the eligible employee is the legal guardian and who is primarily dependent on the eligible employee for maintenance and support</td>
<td></td>
</tr>
<tr>
<td>o Child for whom you have legal guardianship</td>
<td></td>
</tr>
</tbody>
</table>

NEWBORN

You are granted 31 days from the first of the month following your newborn’s birth to provide appropriate supportive documentation to your employer’s benefits office.

Coverage for a newborn begins on the newborn’s date of birth, provided that you are enrolled in NMPSIA family medical coverage. Any claims associated with your newborn, cannot be processed until you apply to enroll your newborn.

If you are not enrolled in NMPSIA family medical coverage, your newborn will not be automatically covered from date of birth. You must apply to enroll your newborn within 31 days from the newborn’s date of birth. If you miss this 31-day enrollment period, your newborn will not be eligible for coverage until January 1.

CHILDREN PLACED FOR ADOPTION OR ADOPTED

You are granted 31 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 an adopted child begins on date of placement or adoption (whichever comes first) provided that you are enrolled in NMPSIA family medical coverage. Any claims associated with your adopted child, or child placed for adoption cannot be processed until you apply to enroll your child.

If you are not enrolled in NMPSIA family medical coverage, your adopted child or child placed for adoption will not be automatically covered from date of adoption or placement. You must apply to enroll your child within 31 days from date of placement or adoption (whichever comes first) in order for your child’s coverage to be effective from date of placement or adoption. If you miss this 31-day enrollment period, your child will not be eligible for coverage until January 1.

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

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<tr>
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<td>Notarized affidavit of domestic partnership</td>
</tr>
<tr>
<td>• Child under the age of 26 as follows:</td>
<td>Original official state publicly filed birth certificate from the Bureau of Vital Statistics (hospital birth registration form is also acceptable)</td>
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<tr>
<td>o Natural Child</td>
<td>Evidence of placement by a state licensed agency, governmental agency or a court order/decree (notarized statement and power of attorney are not acceptable)</td>
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<tr>
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<td>Legal Guardianship Document (notarized statement and power of attorney documents are not acceptable)</td>
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<tr>
<td>o Legally adopted child or a child for whom the eligible employee is the legal guardian and who is primarily dependent on the eligible employee for maintenance and support</td>
<td></td>
</tr>
<tr>
<td>o Child for whom you have legal guardianship</td>
<td></td>
</tr>
</tbody>
</table>
INELIGIBLE DEPENDENTS
The following ARE NOT ELIGIBLE for NMPSIA Group Coverage:

- Ex-spouses (even if stipulated in a final divorce decree)
- Common law relationships of the same or opposite sex which are not recognized by New Mexico Law unless domestic partner benefits are offered by your employer
- Dependents while in active military service
- Children left in the care of an eligible employee without evidence of legal guardianship
- Parents, aunts, uncles, brothers, sisters, or any other person not defined as eligible dependent under NMPSIA Rules
- Domestic partners unless your employer has elected this option

ENROLLMENT REQUIREMENTS
You are required to provide Social Security numbers for you and your dependents to enroll in the NMPSIA Group Plan. If you are in the process of applying for a social security number, you may turn in this proof to your employer’s benefits office.

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

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

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

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

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

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

• **Medical/Prescription Coverage** – You may apply during the established open enrollment period in the fall, and your coverage will go into effect January 1 (coverage may begin sooner if you have a qualifying or special event occur and you apply with proof within 31 days from the event).

• **Dental Coverage** – You may apply during the established open enrollment period in the fall, and your coverage will go into effect January 1 (coverage may begin sooner if you have a qualifying event occur and you apply with proof within 31 days from the event).

• **Vision Coverage** – You may apply during the established open enrollment period in the fall, and your coverage will go into effect January 1 (coverage may begin sooner if you have a qualifying event occur and you apply with proof within 31 days from the event).

• **Long Term Disability Coverage (LTD) and/or Additional Life Coverage (LTD)** – There is no open enrollment for these coverages. You may apply for ADL and LTD coverage (or increase your ADL coverage) through the evidence of insurability process (children are exempt from going through evidence of insurability). The Life and LTD Insurance Carrier will review your health statement and may request medical records in order to make a final decision on your application.

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

CHANGE OF STATUS

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

Qualifying Events:

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

- Involuntary loss of group or individual coverage through no fault of the person having the group or individual insurance coverage. (This may include an involuntary loss of medical insurance, dental insurance, vision insurance, Medicaid, exhaustion of COBRA, etc. IMPORTANT: You will be required to provide your employer’s benefits office with a loss of coverage letter specifying who lost coverage, what type of coverage was lost, what day coverage was lost, and why coverage was lost. If the letter does not address each of these factors, we cannot determine the loss of coverage to be an involuntary loss of coverage and your enrollment may not be accepted.)

- Loss of employment (including retirement)

- Establishment of termination through affidavit terminating domestic partnership

- Death

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

If you meet eligibility requirements and are not enrolled in the NMPSIA Medical Plan, you may enroll yourself and any of your eligible dependents for NMPSIA medical coverage within 31 days from the occurrence of the following special events:

- You suffer an involuntary loss of coverage because coverage of your spouse (or domestic partner if your employer allows domestic partner enrollment) or child under another plan is terminated as a result of divorce, death, termination of employment, reduction in hours, legal separation, or termination of employer contributions

- You get married or you establish domestic partnership by affidavit (if your employer participates in offering domestic partnership coverage)

- A child is born to you or your spouse

- You adopt a child or a child is placed for adoption in your family

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

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

Example #1: You divorce on July 12th; this causes your ex-spouse to become ineligible effective July 31st. You should immediately visit your employee benefits office to drop your ex-spouse (and any enrolled step-children, if applicable) from the NMPSIA Group Plan (provide this office with a copy of your divorce decree and a “signed” record change card). Your ex-spouse may apply for COBRA continuation coverage provided that you report this change of status within the timeframe listed above. (REMEMBER: Review your beneficiary designation and make any changes you wish. Life insurance proceeds may not be payable to an ex-spouse unless the ex-spouse is redesignated as beneficiary after the divorce was final.)
When you are electing NMPSIA Group coverage, you will be required to complete, sign, and turn in the appropriate application, or you and your employer may enter your enrollment and upload the supportive documentation on the NMPSIA online benefit system at https://nmpsiaonline.nmpsia.com. In the event of a dependent enrollment, your employer’s benefits office is required to view the supportive documentation you have presented. Without the appropriate supportive documentation, your dependent’s effective date of coverage will be delayed. If supportive documentation is not provided by the established deadline (31 days from your effective date or 31 days from the qualifying event), your dependent will not be eligible for coverage until January 1.

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

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

TERMINATION OF COVERAGE EFFECTIVE DATES
Coverage terminates for NMPSIA Group participation as follows:

- **Employees** – Coverage terminates at the end of the period for which deductions are made from your payroll check. This termination date is determined by your employer.

- **Actively Serving Board Members** – Coverage terminates on the last day of the month in which the board member’s term expires.

- **Dependents (spouse and dependent child)** – Coverage terminates on the last day of the month in which the eligible dependent becomes ineligible (i.e., coverage for an ex-spouse terminates on the last day of the month in which the divorce becomes final).

- **Employees on an extended leave of absence** – Your employer determines when your coverage ends under the active plan. Your employer’s policy may allow you to remain on the active plan for up to one year from the date your extended leave of absence was approved. Your employer will inform you about premium payment requirements.

GENERAL INFORMATION

- **The Two Year Vision Rule** – Once enrolled in vision, you may not drop vision until you and each of your covered dependents have been enrolled two years.

- **Open Enrollment** – NMPSIA offers open enrollment each fall for medical, dental, and vision coverage. Once you apply (prior to January 1), the change becomes effective on January 1.

- **Switch Enrollment** – NMPSIA offers switch enrollment each fall for medical coverage and for dental coverage. Once you apply (prior to January 1) to switch plans, the change becomes effective on January 1.

- **The No NMPSIA Double Coverage Rule** – If both of you and your spouse work for a NMPSIA employer, you and your spouse may not enroll each other as a spouse, nor may you both cover your children. If your child is also an employee of a NMPSIA participating entity and enrolled for employee coverage, you may not cover your child as a dependent for the lines of coverage your child is enrolled as an employee. Double coverage outside of the NMPSIA Group Plan is allowed.

- **Confirmation of Enrollment** –
  - The NMPSIA Eligibility Administrative Office will mail or email you a Confirmation of Enrollment (or a Notice of
Incomplete Enrollment if you are missing information or documentation. Review these notices carefully and report any discrepancies to your Employee Benefits office. Failure to act may cause coverage to be postponed or denied.

- Check your enrollment online at [https://nmpsiaonline.nmpsia.com](https://nmpsiaonline.nmpsia.com).

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

**IF YOU HAVE ANY QUESTIONS ABOUT THE NMPSIA ELIGIBILITY RULES, CONTACT YOUR EMPLOYER’S BENEFITS OFFICE OR NMPSIA at 1-800-548-3724, or you may contact the NMPSIA ELIGIBILITY ADMINISTRATIVE OFFICE at 1-800-233-3164. You may also log on to [nmpsia.com](http://nmpsia.com) to view the entire set of NMPSIA Rules and State Statutes, or to find the links to contact NMPSIA staff.**
FREQUENTLY ASKED QUESTIONS

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

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

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

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

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

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

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

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

A. Yes, NMPSIA offers switch enrollment for medical and for dental coverage each fall with an effective date of January 1. Visit your Benefits Office during the established switch enrollment period in the fall to apply to switch plans.

Q. If I enroll in the NMPSIA Vision Plan, may I drop it at any time?

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

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

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

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

A. We will initially cover you and the one child for whom you have provided a birth certificate. We will cover your spouse and your other child effective on the first day of the month following the date you provide this missing documentation to your employer’s Benefits Office. (We will not cover these dependents retroactive to your initial effective date.) You will have 31 days from your date of hire or qualifying event to provide these missing documents. If you do not meet this deadline, your dependents will be considered late and ineligible for coverage until January 1. You will have an opportunity apply to enroll them during the established open enrollment period in the fall, and their medical, dental, or vision coverage will go into effect January 1.”

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

A. No, NMPSIA Rules do not permit double coverage within the NMPSIA Group Plan. You can have double coverage outside of the NMPSIA Group Plan.
Basic Term Life Insurance and Accidental Death and Dismemberment (AD&D)

Insured by Standard Insurance Company

Employee Coverage

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

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

The Accelerated Benefit option allows for payment of up to 75% of your insurance (Basic and Additional combined) if you are terminally ill with a life expectancy of 12 months or less. The maximum Accelerated Benefit amount is $450,000.

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

1. Life Threatening Cancer
2. Myocardial Infarction (Heart Attack)
3. Coronary Artery Bypass Procedure
4. Renal Failure
5. Stroke
6. Major Organ Transplant
7. Acquired Immune Deficiency Syndrome (AIDS)

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

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

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

AD&D benefits may be paid in addition to Basic Life benefits. In the event of a covered accidental death, your AD&D benefit is equal to your Basic Life amount. Lesser amounts are paid for other specific accidental losses. (See page 17 and your certificate for details.)

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

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

Employee Coverage

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

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

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

The Accelerated Benefit option allows for payment of up to 75% of your insurance (Basic and Additional combined) if you are terminally ill with a life expectancy of 12 months or less. The maximum Accelerated Benefit amount is $450,000. Your death benefit will be reduced by the amount you elect under this provision.

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

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

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

Dependent Term Life Insurance

Spouse Coverage

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

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

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

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

Spouse coverage will end upon termination of your Additional Life insurance; however, insurance may be converted to an individual policy with The Standard. In some cases, portable group insurance is also available.
Suicide Exclusion Additional and Dependent Spouse Life Insurance - If death results from suicide or other intentionally self-inflicted injury, while sane or insane, the amount payable will exclude the amount of Life Insurance which is subject to this suicide exclusion and which has not been continuously in effect for at least 2 years on the date of death. In computing the 2-year period, we will include time insured under the Prior Plan. We will refund all premiums paid for that portion of Life Insurance which is excluded from payment under this suicide exclusion.

**Child Coverage**

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

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

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

*See page 47 for premium calculation or go to nmpsia.com and use “Calculate LTD and ALF Premiums”.*

**Basic and Additional Life AD&D**

*Insured by Standard Insurance Company*

**Employee Only Coverage**

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

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

<table>
<thead>
<tr>
<th>Loss</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life</td>
<td>100%</td>
</tr>
<tr>
<td>Sight in both eyes</td>
<td>100%</td>
</tr>
<tr>
<td>Both hands or both feet</td>
<td>100%</td>
</tr>
<tr>
<td>One hand and one foot</td>
<td>100%</td>
</tr>
<tr>
<td>One hand or one foot and sight in one eye</td>
<td>100%</td>
</tr>
<tr>
<td>Speech and hearing in both ears</td>
<td>100%</td>
</tr>
<tr>
<td>Quadriplegia</td>
<td>100%</td>
</tr>
<tr>
<td>Paraplegia</td>
<td>75%</td>
</tr>
<tr>
<td>Hemiplegia</td>
<td>50%</td>
</tr>
<tr>
<td>One hand or one foot</td>
<td>50%</td>
</tr>
<tr>
<td>Sight in one eye</td>
<td>50%</td>
</tr>
<tr>
<td>Speech</td>
<td>50%</td>
</tr>
<tr>
<td>Hearing in both ears</td>
<td>50%</td>
</tr>
<tr>
<td>Thumb &amp; index finger on the same hand</td>
<td>25%</td>
</tr>
</tbody>
</table>

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

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

**Additional AD&D Benefits:**

- Exposure and Disappearance Benefit
- Coma Benefit
- Occupational Assault Benefit
- Career Adjustment Benefit (for your spouse)
- Higher Education Benefit (for your children)
- Child Care Benefit
AD&D exclusions – No AD&D insurance benefit is payable if the accident or loss is caused or contributed to by war or act of war; suicide or other intentionally self-inflicted injury while sane or insane; committing or attempting to commit an assault or felony; actively participating in a violent disorder or riot; voluntary use or consumption of any poison, chemical compound, alcohol or drug, unless used or consumed according to the directions of a physician; sickness or pregnancy existing at the time of the accident; heart attack or stroke; or medical or surgical treatment for any of the above.

Additional Benefits – Basic and Additional Life
Insured by Standard Insurance Company

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

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

MEDEX® Travel Assist: For the covered employee and covered dependents.

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

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

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

Insured by Standard Insurance Company

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

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

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

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

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

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

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

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

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

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

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

Insured by Standard Insurance Company

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

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

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

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

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

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

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

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

Premiums: Please see page 47 or go to nmpsia.com and use “Calculate LTD and ALF Premiums”. Your employer shares the cost of this benefit based on your contracted annual salary.

Your employer’s share is:
- 60% if you earn $25,000 or more
- 65% if you earn between $20,000 and $25,000
- 70% if you earn between $15,000 and $20,000
- 75% if you earn less than $15,000

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

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

The New Mexico Public Schools Insurance Authority (NMPSIA) is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this Notice or if you want more information about the privacy practices at NMPSIA, please contact the Administrative Office located at 410 Old Taos Highway, Santa Fe, NM 87501, or by telephone at 1-800-548-3724.

How NMPSIA May Use or Disclose Your Health Information

The following categories describe the ways that NMPSIA may use and disclose your health information. For each category of uses and disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all the ways we are permitted to use and disclose information will fall within one of the categories.

1. **Payment Functions.** We may use or disclose health information about you to determine eligibility for plan benefits, obtain premiums, facilitate payment for the treatment and services you receive from health care providers, determine plan responsibility for benefits, and to coordinate benefits. For example, payment functions may include reviewing the medical necessity of health care services, determining whether a particular treatment is experimental or investigational, or determining whether a treatment is covered under your plan.

2. **Health Care Operations.** We may use and disclose health information about you to carry out necessary insurance-related activities. For example, such activities may include underwriting, premium rating and other activities relating to plan coverage; conducting quality assessment and improvement 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.

3. **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.

4. **Public Health.** As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child 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.

5. **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.

6. **Judicial and Administrative Proceedings.** We may disclose your health information in the course of any administrative or judicial proceeding.

7. **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.

8. **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.

9. **Organ and Tissue Donation.** We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues, as necessary.
NOTICE OF PRIVACY PRACTICES

10. 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.

11. National Security. We may disclose your health information for military, national security, prisoner and government benefits purposes.

12. Worker’s Compensation. We may disclose your health information as necessary to comply with worker’s compensation or similar laws.

13. Marketing. We may contact you to give you information about health-related benefits and services that may be of interest to you.

14. Disclosures to Plan Sponsors. We may disclose your health information to the sponsor of your group health plan, for purposes of administering benefits under the plan.

When NMPSIA May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, we will not use or disclose your health information without written authorization from you. If you do authorize us to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time. If you revoke your authorization, we will no longer be able to use or disclose health information about you for the reasons covered by your written authorization, though we will be unable to take back any disclosures we have already made with your permission.

Statement of Your Health Information Rights

1. Right to Request Restrictions. You have the right to request restrictions on certain uses and disclosures of your health information. NMPSIA 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 the Administrative Office, 410 Old Taos Highway, Santa Fe, NM 87501.

2. Right to Request Confidential Communications. You have the right to receive your health information through a reasonable alternative means or at an alternative location. To request confidential communications, you must submit your request in writing to the 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 copy health information about you that may be used to make decisions about your plan benefits. To inspect and copy such information, you must submit your request in writing to the Administrative Office, 410 Old Taos Highway, Santa Fe, NM 87501. If you request a copy of the information, we may charge you a reasonable fee to cover expenses associated with your request.

4. Right to Request Amendment. You have a right to request that NMPSIA 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 the 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 the 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. NMPSIA will provide one list per 12 month period free of charge; we may charge you for additional lists.
NOTICE OF PRIVACY PRACTICES

6. **Right to Paper Copy.** You have a right to receive a paper copy of this Notice of Privacy Practices at any time. To obtain a paper copy of this Notice, send your written request to the Administrative Office, 410 Old Taos Highway, Santa Fe, NM 87501.

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 the Administrative Office, 410 Old Taos Highway, Santa Fe, NM 87501, or by telephone at 1-800-548-3724.

NMPSIA 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, NMPSIA is required by law to comply with the current version of this Notice.

**Complaints**

Complaints about this Notice of Privacy Practices or about how we handle your health information should be directed to the Administrative Office, 410 Old Taos Highway, Santa Fe, NM 87501. NMPSIA will not retaliate against you in any way for filing a complaint. All complaints to NMPSIA must be submitted in writing. If you believe your privacy rights have been violated, you may file a complaint with the Secretary of the Department of Health and Human Services.

**Effective Date of This Notice:** April 14, 2003
NMPSIA’s Medical Plans
Offering you two plans—High-Option and Low-Option—to meet your health care needs.

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

Choose the High-Option or Low-Option Plan

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

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.
Dual-Option PPO Plan

Extensive statewide provider network
Choose from more than 23,000 quality health care providers in our statewide Preferred Provider network. The BCBSNM network includes the only Gamma Knife technology center in New Mexico for treatment of neurological brain diseases, the only women’s hospital in the state, and award-winning cancer treatment and cardiology programs.

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

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

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

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

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

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

Special Beginnings* for prenatal health
The first step to a healthy pregnancy and delivery is knowing all you can about your health. BCBSNM offers Special Beginnings to help you manage your pregnancy. This program is voluntary, confidential, and available at no extra cost to you. Special Beginnings can help you from early pregnancy until six weeks after delivery through:

- Identifying your pregnancy risk factors
- Offering videos that cover topics such as eating habits, exercise, stress, and more
- Personal telephone contact with specially trained maternity nurses who can address your needs and concerns and coordinate care with your doctor
- Helping you manage high-risk conditions such as gestational diabetes and pre eclampsia

To help ensure the best health for you and your baby, it’s best to enroll in Special Beginnings as soon as you find out you are pregnant.
Presbyterian Health Plan membership has its benefits.

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

- Look up your health plan’s benefits
- Estimate out-of-pocket costs for common medical procedures with our Treatment Cost Calculator
- Pay a physician or hospital bill
- View your medical claims and explanation of benefits
- Request replacement ID cards

**Talk to a nurse 24/7.** Members can call 1-866-221-9679 to speak with a registered nurse for medical guidance 24 hours a day, 365 days a year.

**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 600 doctors in 40 specialties and eight hospitals across New Mexico, Presbyterian offers specialized healthcare in the areas of women’s health, pediatric services, heart wellness, cancer care and more.

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

PRESBYTERIAN
Health Plan, Inc.
Peace of mind is part of the plan.

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

Choosing the best health coverage for you and your family can be confusing, but we can help make it simple. 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.

Wherever you go, we’ve got you covered.

- **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 more than 10,000 providers and facilities throughout New Mexico and border communities. Visit phs.org/directory for the most current list.

- **National Coverage.** You also receive in-network benefits outside of New Mexico with nearly 900,000 providers through our partnership with the national MultiPlan/PHCS network. Specific providers are listed at multiplan.com/presbyterian.

As the provider of healthcare benefits to more than 425,000 New Mexicans, Presbyterian Health Plan offers the coverage you need to live the life you want through New Mexico’s most preferred health plan.*

*According to 2013 Research and Polling Brand Preference Study

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

**PRESBYTERIAN**
Health Plan, Inc.
## High Option
### Summary of Benefits

Summary only – lists the deductible, out-of-pocket limits, copayment amounts, member coinsurance percentage amounts, and provides a brief description of NM Public Schools Insurance Authority’s Health Care Plan benefits.

### NMPsIA High Option PPO Benefits

<table>
<thead>
<tr>
<th>NMPsIA High Option PPO Benefits</th>
<th>Member’s Share of Covered Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Preferred Provider</td>
</tr>
<tr>
<td><strong>Calendar Year Deductible</strong></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$300</td>
</tr>
<tr>
<td>Family (aggregate of three times the individual amount)</td>
<td></td>
</tr>
<tr>
<td><strong>Annual Out-of-Pocket Limit</strong></td>
<td>$2,800</td>
</tr>
<tr>
<td>Individual</td>
<td>$8,400</td>
</tr>
<tr>
<td>Family (aggregate of three times the individual amount)</td>
<td></td>
</tr>
<tr>
<td><strong>Office Visit/Exam Charge</strong></td>
<td></td>
</tr>
<tr>
<td>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.)</td>
<td>Office Visit Copay</td>
</tr>
<tr>
<td>Primary Preferred Provider (PPP)</td>
<td>$20</td>
</tr>
<tr>
<td>Specialist Office/Home Visit</td>
<td>$30</td>
</tr>
<tr>
<td>Office Surgery (including casts, splints, and dressings)</td>
<td>20%</td>
</tr>
<tr>
<td>Family Planning (including devices, insertion, etc.)</td>
<td>Office Visit Copay</td>
</tr>
<tr>
<td>Allergy Injections (only), Extract Preparation</td>
<td>No Charge (deductible waived)</td>
</tr>
<tr>
<td>Therapeutic Injections: Allergy Testing</td>
<td>Office Visit Copay</td>
</tr>
<tr>
<td><strong>Routine/Preventive Services</strong></td>
<td></td>
</tr>
<tr>
<td>Routine Adult Physicals and Gynecological Exams, Well-Child Care; Routine Vision or Hearing Screenings, Related Testing (includes routine Pap tests, cholesterol tests, urinalysis, etc.), Routine Colonoscopies (outpatient/office), Smoking/Tobacco Cessation Counseling, and Immunizations</td>
<td>No Charge (deductible waived)</td>
</tr>
<tr>
<td><strong>OTHER SERVICES</strong></td>
<td></td>
</tr>
<tr>
<td>Acupuncture, Spinal Manipulation, Massage Therapy, and Rolffing (combined max. benefit of 30 visits/calendar year)</td>
<td>$30 (deductible waived)</td>
</tr>
<tr>
<td>Ambulance Services: Ground and Emergency Air Transport</td>
<td>$30 (deductible waived)</td>
</tr>
<tr>
<td>Ambulance Services: Nonemergency Transfer/Medically Necessary</td>
<td>$30 (deductible waived)</td>
</tr>
<tr>
<td>Biofeedback (for specified medical conditions only)</td>
<td>$30 (deductible waived)</td>
</tr>
<tr>
<td>Cardiac and Pulmonary Rehabilitation (office/outpatient)</td>
<td>$30 (deductible waived)</td>
</tr>
<tr>
<td>Dental/Facial Accident, Oral Surgery, and TMJ/CMJ Services</td>
<td>Varies by services</td>
</tr>
<tr>
<td>Emergency Room Treatment</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Physician and Other Professional Provider Charges</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Hearing Aids and Related Services (Age 21 and older, hearing aids limited to $500 per member in any 3-year period; routine exams/testing not covered. )</td>
<td>Plan pays 100% up to $500; thereafter you pay 90%</td>
</tr>
<tr>
<td>Hearing Aids and Related Services (Under age 21, hearing aids paid at 100% of covered charges up to $2,200 per ear in any 3-year period; exam/testing subject to usual cost-sharing.)</td>
<td>Plan pays 100% up to $2,200; thereafter you pay 90%</td>
</tr>
<tr>
<td>Home Health Care/Home I.V. Services</td>
<td>20%</td>
</tr>
<tr>
<td>Limitations</td>
<td>Unlimited</td>
</tr>
<tr>
<td>Hospice Services including respite care (limited to 10 days for each 6-month period) and bereavement counseling (limited to 3 sessions during the hospice benefit period)</td>
<td>No charge (deductible waived)</td>
</tr>
<tr>
<td>Lab, X-Ray, and Other Basic Diagnostic Tests (nonroutine)</td>
<td></td>
</tr>
<tr>
<td>MRI, CT Scans, PET Scans; Sleep Studies; Other Lab, X-Ray, diagnostic tests (Office/Outpatient)</td>
<td>20%</td>
</tr>
</tbody>
</table>

* A Primary Preferred Provider is a physician or other professional provider in one of the following categories of practice: Family or General Practice, Internal Medicine, Pediatrics, Obstetrics and Gynecology, and Gynecology Only. A "PPP" is a Primary Preferred Provider in the preferred provider network.*

NMPSIA High Option PPO 01/01/14
<table>
<thead>
<tr>
<th>NMPSIA High Option PPO Benefits – There is no lifetime maximum benefit. However, certain services have maximum annual limits. See below.</th>
<th>Member’s Share of Covered Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient Hospital/Facility Services</strong> <em>(High Option copays are waived if you are re-admitted for the same condition within 15 days of discharge or transferred to a rehab or skilled nursing facility within 15 days of discharge from acute care facility.)</em></td>
<td><strong>Preferred Provider</strong></td>
</tr>
<tr>
<td>Medical/Surgical Acute Care, and Maternity-Related Room and Board, Covered Ancillaries, Related Professional charges</td>
<td>$500 facility copay/admission plus 20%</td>
</tr>
<tr>
<td>Skilled Nursing Facility (max. 60 days/calendar year)</td>
<td></td>
</tr>
<tr>
<td>Inpatient Physical Rehabilitation</td>
<td></td>
</tr>
<tr>
<td>Observation Stay including Related Professional Charges</td>
<td>$100 facility copay plus 20%</td>
</tr>
<tr>
<td><strong>Maternity Services</strong></td>
<td><strong>Office Visit Copay/Initial visit</strong></td>
</tr>
<tr>
<td>Physician/Midwife Services (delivery, pre- and post-natal care)</td>
<td>Office Visit Copay/Initial visit</td>
</tr>
<tr>
<td>Hospital Admission (including routine newborn nursery charges)</td>
<td>$500 per pregnancy plus 20%</td>
</tr>
<tr>
<td>Extended Stay (Nonroutine) Charges for covered Newborn</td>
<td>$500 facility copay/admission plus 20%</td>
</tr>
<tr>
<td><strong>Mental Health Services</strong></td>
<td></td>
</tr>
<tr>
<td>Office, Home, Outpatient Facility/Physician</td>
<td>$30 (deductible waived)</td>
</tr>
<tr>
<td>Inpatient</td>
<td>$500 copay plus 20%</td>
</tr>
<tr>
<td>Partial Hospitalization</td>
<td>$250 copay plus 20%</td>
</tr>
<tr>
<td>Facility-Based Intensive Outpatient Programs (IOP)</td>
<td>$125 copay plus 20%</td>
</tr>
<tr>
<td><strong>Outpatient Hospital/Facility/Ambulatory Surgery Facility</strong> (including Related Professional Charges)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$150 plus 20%</td>
</tr>
<tr>
<td><strong>Short-Term Rehabilitation, Outpatient and Office: Occupational, Physical, and Speech Therapy Services</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$30 (deductible waived)</td>
</tr>
<tr>
<td><strong>Smoking/Tobacco Use Cessation</strong> <em>(lifetime max. benefit payment of $500 includes medication, hypnotherapy, acupuncture, related tests, and any counseling programs not eligible under Preventive)</em></td>
<td></td>
</tr>
<tr>
<td><strong>Substance Abuse Rehabilitation</strong></td>
<td></td>
</tr>
<tr>
<td>Office, Home, Outpatient Facility/Physician</td>
<td>$30 (deductible waived)</td>
</tr>
<tr>
<td>Inpatient</td>
<td>$500 copay plus 20%</td>
</tr>
<tr>
<td>Partial Hospitalization</td>
<td>$250 copay plus 20%</td>
</tr>
<tr>
<td>Facility-Based Intensive Outpatient Programs (IOP)</td>
<td>$125 copay plus 20%</td>
</tr>
<tr>
<td>Residential Treatment Center (For adults age 18 and older only. Max. 60 days/calendar year and 30 days per admission)</td>
<td>$500 copay plus 20%</td>
</tr>
<tr>
<td><strong>Supplies, Durable Medical Equipment, Prosthetics, and Functional Orthotics</strong> <em>(Support hose limited to 6 pair (or 12 hose) per calendar year. Mastectomy bras limited to three/calendar year)</em></td>
<td></td>
</tr>
<tr>
<td>Insulin Pump Supplies (insertion sets, reservoirs)</td>
<td>No Charge (deductible waived)</td>
</tr>
<tr>
<td>Therapy: Chemotherapy and Radiation Therapy</td>
<td>No Charge (deductible waived)</td>
</tr>
<tr>
<td>Therapy: Dialysis</td>
<td>20%</td>
</tr>
<tr>
<td><strong>Transplant Services</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Applicable copays based on place and type of service</td>
</tr>
<tr>
<td><strong>Urgent Care Facility</strong></td>
<td></td>
</tr>
</tbody>
</table>

NMPSIA High Option PPO_01/01/14
### LOW OPTION SUMMARY OF BENEFITS

**Summary only** – lists the deductible, out-of-pocket limits, copayment amounts, member coinsurance percentage amounts, and provides a brief description of NM Public Schools Insurance Authority’s Health Care Plan benefits.

<table>
<thead>
<tr>
<th>NMPSIA Low Option PPO Benefits</th>
<th>Member’s Share of Covered Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Preferred Provider</td>
</tr>
<tr>
<td><strong>Calendar Year Deductible</strong></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td></td>
</tr>
<tr>
<td>Family (aggregate of three times the individual amount)</td>
<td>$1,500</td>
</tr>
<tr>
<td><strong>Annual Out-of-Pocket Limit</strong></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td></td>
</tr>
<tr>
<td>Family (aggregate of three times the individual amount)</td>
<td>$3,500</td>
</tr>
<tr>
<td><strong>Office Visit/Exam Charge</strong></td>
<td></td>
</tr>
<tr>
<td>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.)</td>
<td>(Deductible Waived)</td>
</tr>
<tr>
<td>Primary Preferred Provider (PPP) Office/Home Visit</td>
<td>$25</td>
</tr>
<tr>
<td>Specialist Office/Home Visit</td>
<td>$35</td>
</tr>
<tr>
<td>Office Surgery (including casts, splints, and dressings)</td>
<td>25%</td>
</tr>
<tr>
<td>Family Planning (including devices, insertion, etc.)</td>
<td>25%</td>
</tr>
<tr>
<td>Allergy Injections (only), Extract Preparation</td>
<td>25%</td>
</tr>
<tr>
<td>Therapeutic Injections: Allergy Testing</td>
<td>25%</td>
</tr>
<tr>
<td><strong>Routine/Preventive Services</strong></td>
<td></td>
</tr>
<tr>
<td>Routine Adult Physicals and Gynecological Exams, Well-Child Care, Routine Vision or Hearing Screenings, Related Testing (includes routine Pap tests, cholesterol tests, urinalysis, etc.), Routine Colonoscopies (outpatient/office), Smoking/Tobacco Cessation Counseling, and Immunizations</td>
<td>No Charge</td>
</tr>
</tbody>
</table>

### OTHER SERVICES

- **Acupuncture, Spinal Manipulation, Massage Therapy, and Rolffing** (combined max. benefit of 30 visits/calendar year) 25% | 50%
- **Ambulance Services: Ground and Emergency Air Transport** 25% | 25%
- **Ambulance Services: Nonemergency Transfer/Medically Necessary** 25% | 25%
- **Biofeedback** (for specified medical conditions only) 25% | 50%
- **Cardiac and Pulmonary Rehabilitation** 25% | 50%
- **Dental/Facial Accident, Oral Surgery, and TMJ/CMJ Services** 25% | 50%
- **Emergency Room Treatment** 25% after deductible
- **Physician and Other Professional Provider Charges** 25% after deductible

- **Hearing Aids and Related Services** (Age 21 and older, hearing aids limited to $500 per member in any 3-year period; routine exams/testing not covered) Plan pays 100% up to $500; thereafter you pay 90%

- **Hearing Aids and Related Services** (Under age 21, hearing aids paid at 100% of covered charges up to $2,200 per ear in any 3-year period; exam/testing subject to usual cost-sharing.) Plan pays 100% up to $2,200; thereafter you pay 90%

- **Home Health Care/Home I.V. Services** 25% | 50%

- **Hospice Services** including respite care (limited to 10 days for each 6-month period) and bereavement counseling (limited to 3 sessions during the hospice benefit period) 25% | 50%

- **Lab, X-Ray, and Other Basic Diagnostic Tests** (nonroutine) 25% | 50%

- **MRI, CT Scans, PET Scans; Sleep Studies; Other Lab, X-Ray, diagnostic tests (Office/Outpatient)** 25% | 50%

* A Primary Preferred Provider is a physician or other professional provider in one of the following categories of practice: Family or General Practice, Internal Medicine, Pediatrics, Obstetrics and Gynecology, and Gynecology Only. A "PPP" is a Primary Preferred Provider in the preferred provider network.
### NMPSIA Low Option PPO Benefits

- **There is no lifetime maximum benefit. However, certain services have maximum annual limits. See below.**

#### Inpatient Hospital/Facility Services
*High Option copays are waived if you are re-admitted for the same condition within 15 days of discharge or transferred to a rehab or skilled nursing facility within 15 days of discharge from acute care facility.*

<table>
<thead>
<tr>
<th>Service</th>
<th>Preferred Provider</th>
<th>Nonpreferred Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical/Surgical Acute Care, and Maternity-Related Room and Board, Covered Ancillaries, Related Professional charges</td>
<td>25%</td>
<td>50%</td>
</tr>
<tr>
<td>Skilled Nursing Facility (max. 60 days/calendar year)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Physical Rehabilitation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Observation Stay including Related Professional Charges</td>
<td>25%</td>
<td>50%</td>
</tr>
</tbody>
</table>

#### Maternity Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Preferred Provider</th>
<th>Nonpreferred Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician/Midwife Services (delivery, pre- and post-natal care)</td>
<td>25%</td>
<td></td>
</tr>
<tr>
<td>Hospital Admission (including routine newborn nursery charges)</td>
<td>25%</td>
<td>50%</td>
</tr>
<tr>
<td>Extended Stay (Nonroutine) Charges for covered Newborn</td>
<td>25%</td>
<td></td>
</tr>
</tbody>
</table>

#### Mental Health Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Preferred Provider</th>
<th>Nonpreferred Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office, Home, Outpatient Facility/Physician</td>
<td>25%</td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>25%</td>
<td>50%</td>
</tr>
<tr>
<td>Partial Hospitalization</td>
<td>25%</td>
<td></td>
</tr>
<tr>
<td>Facility-Based Intensive Outpatient Programs (IOP)</td>
<td>25%</td>
<td></td>
</tr>
</tbody>
</table>

#### Outpatient Hospital/Facility/Ambulatory Surgery Facility
*Including Related Professional Charges*

- **Short-Term Rehabilitation, Outpatient and Office:** Occupational, Physical, and Speech Therapy Services

- **Smoking/Tobacco Use Cessation** *(lifetime max. benefit payment of $500 includes medication, hypnotherapy, acupuncture, related tests, and any counseling programs not eligible under Preventive)*

#### Substance Abuse Rehabilitation

<table>
<thead>
<tr>
<th>Service</th>
<th>Preferred Provider</th>
<th>Nonpreferred Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office, Home, Outpatient Facility/Physician</td>
<td>25%</td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>25%</td>
<td>50%</td>
</tr>
<tr>
<td>Partial Hospitalization</td>
<td>25%</td>
<td></td>
</tr>
<tr>
<td>Facility-Based Intensive Outpatient Programs (IOP)</td>
<td>25%</td>
<td></td>
</tr>
</tbody>
</table>

#### Residential Treatment Center *(For adults age 18 and older only. Max. 60 days/calendar year and 30 days per admission)*

<table>
<thead>
<tr>
<th>Service</th>
<th>Preferred Provider</th>
<th>Nonpreferred Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supplies, Durable Medical Equipment, Prosthetics, and Functional Orthotics</td>
<td>25%</td>
<td>50%</td>
</tr>
<tr>
<td>Insulin Pump Supplies <em>(insertion sets, reservoirs)</em></td>
<td>No Charge (deductible waived)</td>
<td>50%</td>
</tr>
<tr>
<td>Therapy: Chemotherapy and Radiation Therapy</td>
<td>25%</td>
<td>50%</td>
</tr>
<tr>
<td>Therapy: Dialysis</td>
<td>25%</td>
<td>50%</td>
</tr>
</tbody>
</table>

#### Transplant Services

- Maximums apply to donor charges and travel and lodging. Must be received at a facility that contracts with BCBSNM or with the national BCBS transplant network. See Section 3.

<table>
<thead>
<tr>
<th>Service</th>
<th>Preferred Provider</th>
<th>Nonpreferred Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent Care Facility</td>
<td>$50 (deductible waived)</td>
<td>50%</td>
</tr>
</tbody>
</table>

### Prescription Drugs, Insulin, Diabetic Supplies, Nutritional Products, Smoking/tobacco Cessation Products

EXCLUSIONS AND LIMITATIONS

THESE PLAN EXCLUSION AND LIMITATION CATEGORIES APPLY TO ALL NMPSIA MEDICAL PLANS:


The above are highlights of areas which may be excluded or limited. Please refer to the booklet for complete details of exclusions and limitations or call the medical plan’s customer service unit at the telephone number listed on the back cover of this guide.
# PRESCRIPTION DRUG BENEFIT SUMMARY

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

Effective Date of Coverage: July 1, 2014

<table>
<thead>
<tr>
<th>Local Participating Pharmacy (EXCLUDES ALL WALGREENS PHARMACIES)</th>
<th>Mail-Order Pharmacy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Maximum days’ supply per copay</strong></td>
<td><strong>90 days</strong></td>
</tr>
<tr>
<td>30 days</td>
<td></td>
</tr>
<tr>
<td>Generic drugs (includes OTC Claritin®, Allegra, Alavert®, and Prilosec OTC®. (Prescription required.)</td>
<td>$7.50 copay</td>
</tr>
<tr>
<td>$3 copay</td>
<td></td>
</tr>
<tr>
<td>Preventative products under the Patient Protection &amp; Affordable Care Act. (Prescription required. To confirm products covered, contact Member Services at 1-800-498-4904.)</td>
<td>$0 copay</td>
</tr>
<tr>
<td>$0 copay</td>
<td></td>
</tr>
<tr>
<td>Preferred diabetes medications and supplies</td>
<td>To confirm copay or coverage of insulin or diabetes supplies, visit <a href="http://www.express-scripts.com">www.express-scripts.com</a> or contact Member Services at 1-800-498-4904.</td>
</tr>
<tr>
<td>To confirm copay or coverage of insulin or diabetes supplies, visit <a href="http://www.express-scripts.com">www.express-scripts.com</a> or contact Member Services at 1-800-498-4904.</td>
<td></td>
</tr>
<tr>
<td>Preferred brand-name drugs</td>
<td>$45 copay</td>
</tr>
<tr>
<td>30% of the discounted cost; minimum payment of $18 and maximum payment of $50</td>
<td></td>
</tr>
<tr>
<td>Nonpreferred drugs</td>
<td>70% copay</td>
</tr>
<tr>
<td>70% copay</td>
<td></td>
</tr>
<tr>
<td>Visit <a href="http://www.express-scripts.com">www.express-scripts.com</a> to view the current formulary, obtain copay cost estimates, and find less costly alternatives for your doctor's review.</td>
<td></td>
</tr>
<tr>
<td>Specialty drugs</td>
<td>Specialty drugs are obtained via the contracted specialty pharmacy after the second fill at retail.</td>
</tr>
<tr>
<td>$75 copay for a 30-day supply. After specialty copays add up to $750, copays are reduced for the remainder of the calendar year. ($7.50 generic, $45 preferred, 70% nonpreferred).</td>
<td></td>
</tr>
<tr>
<td>Immunizations administered by certified pharmacists. (See definitions in this Section.)</td>
<td>Not covered at mail order.</td>
</tr>
<tr>
<td>$0 copay</td>
<td></td>
</tr>
<tr>
<td>To locate a certified pharmacist, visit <a href="https://nmpsia.com/ExpressScripts.html">https://nmpsia.com/ExpressScripts.html</a> or contact Member Services at 1-800-498-4904.</td>
<td></td>
</tr>
<tr>
<td>Out of pocket Maximum: $3000 (combined)</td>
<td></td>
</tr>
</tbody>
</table>

Maximum days’ supply per copay:

- **Generic drugs (includes OTC Claritin®, Allegra, Alavert®, and Prilosec OTC®. (Prescription required.)**
  - $3 copay
  - $7.50 copay

Preventative products under the Patient Protection & Affordable Care Act. (Prescription required. To confirm products covered, contact Member Services at 1-800-498-4904.)

- $0 copay

Preferred diabetes medications and supplies

- To confirm copay or coverage of insulin or diabetes supplies, visit [www.express-scripts.com](http://www.express-scripts.com) or contact Member Services at 1-800-498-4904.

Preferred brand-name drugs

- 30% of the discounted cost; minimum payment of $18 and maximum payment of $50
- $45 copay

Nonpreferred drugs

- 70% copay
  - Visit [www.express-scripts.com](http://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

- $75 copay for a 30-day supply. After specialty copays add up to $750, copays are reduced for the remainder of the calendar year. ($7.50 generic, $45 preferred, 70% nonpreferred).

Immunizations administered by certified pharmacists. (See definitions in this Section.)

- $0 copay
  - To locate a certified pharmacist, visit [https://nmpsia.com/ExpressScripts.html](https://nmpsia.com/ExpressScripts.html) or contact Member Services at 1-800-498-4904.

Out of pocket Maximum: $3000 (combined)
# Prescription Drug Benefit Summary

Administered by Express Scripts
Toll-free: 1-800-498-4904
Effective Date of Coverage: July 1, 2014

<table>
<thead>
<tr>
<th>Maximum days’ supply per copay</th>
<th>30 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic drugs (includes OTC Claritin®, Allegra, Alavert®, and Prilosec OTC®. (Prescription required.)</td>
<td>$8 copay</td>
</tr>
<tr>
<td>Preventative products under the Patient Protection and Affordable Care Act. (Prescription required. To confirm products covered, contact Member Services at 1-800-498-4904.)</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Preferred diabetes medications and supplies</td>
<td>Not eligible for copay waiver at Walgreens. Customary copays apply.</td>
</tr>
<tr>
<td>Preferred brand-name drugs</td>
<td>30% of the discounted cost; minimum payment of $23 and maximum payment of $55</td>
</tr>
<tr>
<td>Nonpreferred drugs</td>
<td>70% copay</td>
</tr>
<tr>
<td>Visit <a href="http://www.express-scripts.com">www.express-scripts.com</a> to view the current formulary, obtain copay cost estimates, and find less costly alternatives for your doctor’s review.</td>
<td></td>
</tr>
<tr>
<td>Specialty drugs</td>
<td>$75 copay for a 30-day supply.</td>
</tr>
<tr>
<td>After specialty copays add up to $750, copays are reduced for the remainder of the calendar year. ($7.50 generic, $45 preferred, 70% nonpreferred).</td>
<td></td>
</tr>
<tr>
<td>Specialty drugs are obtained via the contracted specialty pharmacy after the second fill at retail.</td>
<td></td>
</tr>
<tr>
<td>Immunizations administered by certified pharmacists</td>
<td>To locate a certified pharmacist, visit <a href="https://nmpsia.com/ExpressScripts.html">https://nmpsia.com/ExpressScripts.html</a> or contact Member Services at 1-800-498-4904</td>
</tr>
<tr>
<td>Out of pocket Maximum: $3000 (combined)</td>
<td></td>
</tr>
</tbody>
</table>
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’ll be charged the brand copay, plus the difference in cost between the brand and the generic.

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, 6:00 a.m. to 7:00 p.m., 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. Accredro, Express Scripts’ specialty pharmacy, is the preferred 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. To find out more about your specialty prescription drug benefit, visit www.express-scripts.com or call Accredro at 1-800-501-7210.

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

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

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

Not covered: Drugs for cosmetic purposes only. Over-the-counter (OTC) medications except for Prilosec OTC®, Claritin®, Allegra, Alavert®, and Loratadine, and certain preventative products under the Patient Protection and Affordable Care Act. Prescription drugs for which an equivalent is available without a prescription. 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.
NOTICE OF CREDITABLE COVERAGE

To People Eligible for Medicare:
Important Notice from NMPSIA About
Your Prescription Drug Coverage and 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 NMPSIA and about your options under Medicare’s prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. NMPSIA has determined that the prescription drug coverage we offer through all of our Plans is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered Creditable Coverage.

Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep NMPSIA coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

You can join a Medicare drug plan when you first become eligible for Medicare and each year from November 15th through December 31st. This may mean that you may have to wait to join a Medicare drug plan and that you may pay a higher premium (a penalty) if you join later. You may pay that higher premium (a penalty) as long as you have Medicare prescription drug coverage. However, if you lose creditable prescription drug coverage, through no fault of your own, you will be eligible for a sixty (60) day Special Enrollment Period (SEP) because you lost creditable coverage to join a Part D plan. In addition, if you lose or decide to leave employer/union sponsored coverage; you will be eligible to join a Part D plan at that time using an Employer Group Special Enrollment Period. You should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area.

If you decide to join a Medicare drug plan, your NMPSIA coverage will not be affected. You may keep this coverage in addition to Part D and the NMPSIA plan will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your NMPSIA medical and prescription drug coverage, be aware that you and your dependents will be able to re-enroll under NMPSIA as a late enrollee.

You should also know that if you drop or lose your coverage with NMPSIA and don’t join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without prescription drug coverage that’s at least as good as Medicare’s prescription drug coverage, your monthly premium may go up by at least 1% of the base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without...
coverage, your premium may consistently be at least 19% higher than the base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For more information about this notice or your current prescription drug coverage...

Contact the NMPSIA office for further information at 1-800-548-3724. NOTE: You’ll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through NMPSIA changes. You also may request a copy from NMPSIA by contacting the Benefits Department.

For more information about your options under Medicare prescription drug coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the “Medicare & You” handbook. You’ll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of 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.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage 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 whether or not you are required to pay a higher premium (a penalty).
Experience the Dental Difference with United Concordia

With more than 40 years of dental experience, United Concordia is one of the nation’s largest and most respected dental insurers. We proudly serve the dental health needs of NMPSIA, as well as the needs of more than 6 million Americans worldwide.

With dental benefits administered through United Concordia, all members can:

- Access United Concordia’s national Advantage Plus network of dentists, with more than 79,000 providers nationwide and more than 1,500 access points in New Mexico
- Receive dental ID cards
- Register to use My Dental Benefits at www.UnitedConcordia.com for secure access to eligibility, claim details, payment information, procedure history, printable ID cards and more
- Call 1-888-898-0370 to speak with a dedicated customer service representative or find out claim and benefit information through an automated system, 24/7

Why visit a United Concordia network dentist?

While you can visit any dentist or specialist without a referral, maximize your benefits by visiting a United Concordia Advantage Plus network dentist. Visiting a network dentist …

- **Saves you money**—Because network dentists accept United Concordia’s negotiated fees, or maximum allowable charges (MACs), as payment-in-full for covered services, there’s no balance-billing and you save more out-of-pocket! And, many of our dentists accept our MACs for non-covered services as well. Just look for the black box next to these dentists’ names in Find a Dentist.
- **Saves you time**—Network providers agree to file claims, so it’s one less thing to worry about.
- **Stretches your benefit dollars**—Paying less for care from a network dentist lets you receive more covered services before reaching your annual maximum.

We recommend you verify that your current dentist is a participating provider. You can do this by visiting www.UnitedConcordia.com and selecting Find a Dentist from the homepage.

Remember your plan has the Smile for Health® Enhanced Dental Benefit, which enhances your current coverage by providing additional diagnostic, preventive and periodontal services and by increasing the amount your plan will pay to 100%. The services offered help treat periodontal disease, which has been linked to diabetes, heart disease, stroke and respiratory disease. Look for the Smile for Health logo next to the benefits in your plan to see where you’ll get additional coverage—and savings.

For more information, visit www.nmpsia.com.

Welcome to United Concordia!
Q. How do I find out if my dentist participates with United Concordia?
A. You can access provider directory information online at www.UnitedConcordia.com by clicking on Find a Dentist and then searching for an Advantage Plus dentist. Many of our dentists offer network discounts on non-covered services, in addition to the services covered under your plan. These dentists have a black box next to their name. You can also call the toll-free customer service line at 1-888-898-0370.

Q. What does “maximum allowable charge” mean?
A. The maximum allowable charge (MAC) is the discounted amount that network dentists agree to charge for a covered service. United Concordia network dentists accept this amount as payment-in-full for covered services (most of our dentists accept this for non-covered services, as well), collect only the applicable coinsurance from the member and cannot bill members for any amount over the maximum allowable charge.

Q. Do I have to complete a claim form for each dental visit?
A. If you receive care from a United Concordia network dentist, you do not need to worry about claim forms—your dentist will take care of all the paperwork. If, however, 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 going online at the Members section of www.UnitedConcordia.com, calling Customer Service or contacting your Benefits Office.

Q. How will orthodontic benefits be paid if I am currently undergoing orthodontic treatment?
A. An orthodontic treatment plan must be submitted by the treating provider to determine the remaining benefit that you may be entitled.

Q. How can 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. Or, ask the dental office to provide a list of procedures to be performed and their corresponding fees. You can then call Customer Service or go to My Dental Benefits on www.UnitedConcordia.com to determine how much your plan will cover for these procedures. For more exact cost information, 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 how much you can expect to pay out-of-pocket.

Q. Are there frequency limitations for certain services?
A. Yes. For example, you can receive a 2 routine cleaning once in a 12 month period. This is not calendar year; this is a rolling 12 month period.

<table>
<thead>
<tr>
<th>1st Cleaning</th>
<th>2nd Cleaning</th>
<th>3rd Cleaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td>Covered?</td>
<td>Date</td>
</tr>
<tr>
<td>10/04/13</td>
<td>Yes</td>
<td>05/01/14</td>
</tr>
</tbody>
</table>

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

Q. What is an Alternate Benefit Provision?
A. An Alternate Benefit Provision is a limitation on all covered benefits. Frequently, several alternate methods exist to treat a dental condition. United Concordia will make payment based on the allowance for the less expensive procedure provided that the less expensive procedure meets accepted standards of dental treatment. For example, a dentist may recommend putting a composite (tooth-colored) filling on one of your back (posterior) teeth. The plan will pay for an amalgam (silver) filling only. If you elect to have the composite filling, you will be responsible for the difference between the allowance for an amalgam filling and the cost of the composite filling.

Q. Can I receive care from a dentist that is not in United Concordia’s network?
A. Yes, you can 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 in and above United Concordia’s allowed amount for covered services. Network dentists accept United Concordia’s maximum allowable charge as payment-in-full for covered services, which means you are responsible only for the applicable deductible and coinsurance amount.
## HIGH OPTION

### Concordia Preferred Comprehensive Plan

<table>
<thead>
<tr>
<th>Benefit Category</th>
<th>Advantage Plus Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Plan Pays*</td>
<td>You Pay*</td>
</tr>
<tr>
<td>Diagnostic &amp; Preventive Services</td>
<td>100%</td>
<td>0%</td>
</tr>
<tr>
<td>- Fluoride Treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Nonsurgical Periodontics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Routine Cleaning for pregnant women</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basic Services</td>
<td>80%</td>
<td>20%</td>
</tr>
<tr>
<td>- Basic Restorative (amalgam allowance for posterior teeth)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Simple Extractions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Endodontics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Repair of Denture and Bridgework</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- General Anesthesia &amp; IV Sedation (covered only in conjunction with dental surgery)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Complex Oral Surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Surgical Periodontics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Major Services</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>- Removable Partial or Complete Dentures and Fixed Bridges (to replace teeth lost while insured under this contract)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Inlays, Onlays &amp; Crowns (when teeth cannot be restored to normal form and function with amalgam, composite resin or plastic fillings)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Implant Coverage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orthodontic Services</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>- Diagnostic, Active, Retention Treatment Adult and Child</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calendar Year Deductible (per person/per family)</td>
<td>$50/$150</td>
<td>$50/$150</td>
</tr>
<tr>
<td>Calendar Year Maximum (per person) **</td>
<td>$1,250</td>
<td>$50/$150</td>
</tr>
<tr>
<td>Lifetime Orthodontic Maximum (per person)</td>
<td>$1,500</td>
<td>$1,000</td>
</tr>
</tbody>
</table>

* Network providers agree to accept United Concordia’s maximum allowable charge as payment-in-full.

** Network and non-network maximums cannot be combined.

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.
## Concordia Preferred Basic Plan

<table>
<thead>
<tr>
<th>Benefit Category</th>
<th>Advantage Plus Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Plan Pays*</td>
<td>Plan Pays</td>
</tr>
<tr>
<td></td>
<td>You Pay*</td>
<td>(of Allowed Amount)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>+ Any charges in excess of the allowed amount</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(No Deductible)</td>
</tr>
<tr>
<td>Diagnostic &amp; Preventive Services</td>
<td>100%</td>
<td>75% (of Allowed Amount) + Any charges in excess of the allowed amount (No Deductible)</td>
</tr>
<tr>
<td>■ Routine Oral Exams (twice every 12 months)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>■ Routine Cleanings (twice every 12 months)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>■ X-rays—complete mouth (once every 5 years); bitewings (twice every 12 months through age 13, once every 12 months thereafter)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>■ Sealants (through age 15), permanent first and second molars only</td>
<td></td>
<td></td>
</tr>
<tr>
<td>■ Emergency Treatment for Relief of Pain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>■ Fluoride Treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>■ Nonsurgical Periodontics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>■ Routine Cleaning for pregnant women</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basic Services</td>
<td>80%</td>
<td>75% (of Allowed Amount) + Any charges in excess of the allowed amount (Deductible Applies)</td>
</tr>
<tr>
<td>■ Basic Restorative (amalgam allowance for posterior teeth)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>■ Simple Extractions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>■ Endodontics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>■ Repair of Denture and Bridgework</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Major Services</td>
<td></td>
<td>Not Covered</td>
</tr>
<tr>
<td>■ Complex Oral Surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>■ Surgical Periodontics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>■ Removable Partial or Complete Dentures and Fixed Bridges</td>
<td></td>
<td></td>
</tr>
<tr>
<td>■ Inlays, Onlays &amp; Crowns (when teeth cannot be restored to normal form and function with amalgam, composite resin or plastic fillings)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orthodontic Services</td>
<td></td>
<td>Not Covered</td>
</tr>
<tr>
<td>■ Diagnostic, Active, Retention Treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calendar Year Deductible (per person/per family)</td>
<td>$50/$150</td>
<td></td>
</tr>
<tr>
<td>Calendar Year Maximum (per person) **</td>
<td>$1,250</td>
<td></td>
</tr>
<tr>
<td>Lifetime Orthodontic Maximum (per person)</td>
<td></td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

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** Network and non-network maximums cannot be combined.

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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.4

Contact Lens Collection: Select from the most popular contact lenses on the market today with Davis Vision’s Contact Lens Collection.6

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

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

<table>
<thead>
<tr>
<th>Service</th>
<th>Benefit Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eye Examination</td>
<td>Every 12 months. Covered in full after $10 copayment</td>
</tr>
<tr>
<td>Spectacle Lenses</td>
<td>Every 12 months. Covered in full</td>
</tr>
<tr>
<td></td>
<td>For standard single-vision, lined bifocal, or trifocal</td>
</tr>
<tr>
<td></td>
<td>lenses after $15 copayment</td>
</tr>
<tr>
<td>Frames</td>
<td>Every 24 months. Covered in full</td>
</tr>
<tr>
<td></td>
<td>Any Fashion, Designer or Premier frame from Davis</td>
</tr>
<tr>
<td></td>
<td>Vision’s Collection6 (value up to $225)</td>
</tr>
<tr>
<td></td>
<td>OR</td>
</tr>
<tr>
<td></td>
<td>$40 wholesale allowance toward any other frame from</td>
</tr>
<tr>
<td></td>
<td>provider</td>
</tr>
<tr>
<td>Contact Lenses (in lieu of eyeglasses)</td>
<td>Every 12 months, Collection Contacts: Covered in full</td>
</tr>
<tr>
<td></td>
<td>OR</td>
</tr>
<tr>
<td></td>
<td>Non Collection Contacts: 15% discount6</td>
</tr>
<tr>
<td>Contact Lenses</td>
<td>Every 12 months. Covered in full</td>
</tr>
<tr>
<td></td>
<td>Any contact lenses from Davis Vision’s Contact Lens</td>
</tr>
<tr>
<td></td>
<td>Collection6</td>
</tr>
<tr>
<td></td>
<td>OR</td>
</tr>
<tr>
<td></td>
<td>$110 retail allowance toward provider supplied contact</td>
</tr>
<tr>
<td></td>
<td>lenses, plus 15% off balance6</td>
</tr>
<tr>
<td></td>
<td>OR</td>
</tr>
<tr>
<td></td>
<td>Medically necessary contacts covered in full with prior</td>
</tr>
<tr>
<td></td>
<td>approval</td>
</tr>
</tbody>
</table>

ADDITIONAL DISCOUNTED LENS OPTIONS & COATINGS

<table>
<thead>
<tr>
<th>Lens Option</th>
<th>Without Davis Vision</th>
<th>With Davis Vision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scratch-Resistant Coating</td>
<td>$45</td>
<td>$0</td>
</tr>
<tr>
<td>Polycarbonate Lenses</td>
<td>$54</td>
<td>$0</td>
</tr>
<tr>
<td>Standard Anti-Reflective (AR) Coat</td>
<td>$92</td>
<td>$35</td>
</tr>
<tr>
<td>Standard Progressives (no-line bifocal)</td>
<td>$154</td>
<td>$50</td>
</tr>
<tr>
<td>Plastic PhotoSensitive (Transitions6)</td>
<td>$123</td>
<td>$65</td>
</tr>
</tbody>
</table>

Lower costs and more benefits! See the savings!

<table>
<thead>
<tr>
<th>Service</th>
<th>Without Davis Vision</th>
<th>With Davis Vision</th>
<th>Savings up to</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eye Examination</td>
<td>$100</td>
<td>$10</td>
<td>$358</td>
</tr>
<tr>
<td>Lenses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bilifocals</td>
<td>$50</td>
<td>$15</td>
<td></td>
</tr>
<tr>
<td>Scratch-Resistant Coating</td>
<td>$45</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>Transitions6</td>
<td>$123</td>
<td>$65</td>
<td></td>
</tr>
<tr>
<td>Frame</td>
<td>$100</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>$448</td>
<td>$90</td>
<td></td>
</tr>
</tbody>
</table>
Davis Vision plans offer...

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

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

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

Value-Added Features:
- Replacement contacts through LENS123® mail-order contact lens replacement service, saving both time and money.
- Laser Vision Correction discounts of up to 25% off the provider's Usual & Customary fees, or 5% off advertised specials, whichever is lower.

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

<table>
<thead>
<tr>
<th>ADDITIONAL LENS OPTIONS</th>
<th>WITHOUT DAVIS VISION</th>
<th>WITH DAVIS VISION</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Ranges of Prescriptions and Sizes</td>
<td>$90</td>
<td>$0</td>
</tr>
<tr>
<td>Plastic Lenses</td>
<td>$33</td>
<td>$0</td>
</tr>
<tr>
<td>Oversized Lenses</td>
<td>$20</td>
<td>$0</td>
</tr>
<tr>
<td>Tinting of Plastic Lenses</td>
<td>$20</td>
<td>$0</td>
</tr>
<tr>
<td>Scratch-Resistant Coating</td>
<td>$45</td>
<td>$0</td>
</tr>
<tr>
<td>Polycarbonate Lenses</td>
<td>$64</td>
<td>$0* or $30</td>
</tr>
<tr>
<td>Ultraviolet Coating</td>
<td>$28</td>
<td>$12</td>
</tr>
<tr>
<td>Standard Anti-Reflective (AR) Coating</td>
<td>$62</td>
<td>$35</td>
</tr>
<tr>
<td>Premium AR Coating</td>
<td>$80</td>
<td>$48</td>
</tr>
<tr>
<td>Ultra AR Coating</td>
<td>$113</td>
<td>$60</td>
</tr>
<tr>
<td>Intermediate-Vision Lenses</td>
<td>$150</td>
<td>$30</td>
</tr>
<tr>
<td>Standard Progressive Addition Lenses</td>
<td>$154</td>
<td>$80</td>
</tr>
<tr>
<td>Select Progressive Addition Lenses</td>
<td>$248</td>
<td>$70</td>
</tr>
<tr>
<td>Premium Progressives (Varilux®, etc.)</td>
<td>$248</td>
<td>$90</td>
</tr>
<tr>
<td>Ultra Progressive Addition Lenses</td>
<td>$462</td>
<td>$195</td>
</tr>
<tr>
<td>High-Index Lenses</td>
<td>$120</td>
<td>$55</td>
</tr>
<tr>
<td>Plastic Photosensitive Lenses</td>
<td>$123</td>
<td>$65</td>
</tr>
<tr>
<td>Scratch Protection Plan (Single vision</td>
<td>Multifocal lenses)</td>
<td>$20</td>
</tr>
</tbody>
</table>

1 Polyurethane lenses are covered in full for dependent children, monocular patients and patients with prescriptions 6.00 diopters or greater.
2 Varilux® is a registered trademark of Société Esilor International

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 1526
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, Medically Necessary Contacts up to $210
# MEDICAL, DENTAL, VISION MONTHLY DEDUCTIONS

## If you earn $25,000 or more, monthly payroll deductions are:

<table>
<thead>
<tr>
<th></th>
<th>Single</th>
<th>Two Party</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blue Cross Blue Shield – High Option</td>
<td>$227.00</td>
<td>$431.72</td>
<td>$576.62</td>
</tr>
<tr>
<td>Blue Cross Blue Shield – Low Option</td>
<td>$190.68</td>
<td>$362.64</td>
<td>$484.38</td>
</tr>
<tr>
<td>Presbyterian – High Option</td>
<td>$183.58</td>
<td>$385.48</td>
<td>$514.00</td>
</tr>
<tr>
<td>Presbyterian – Low Option</td>
<td>$154.20</td>
<td>$323.80</td>
<td>$431.76</td>
</tr>
<tr>
<td>Dental – High Option</td>
<td>$10.90</td>
<td>$20.74</td>
<td>$32.60</td>
</tr>
<tr>
<td>Dental – Low Option</td>
<td>$5.46</td>
<td>$10.38</td>
<td>$16.30</td>
</tr>
<tr>
<td>Vision</td>
<td>$2.50</td>
<td>$4.18</td>
<td>$5.66</td>
</tr>
</tbody>
</table>

## If you earn $20,000 but less than $25,000, monthly payroll deductions are:

<table>
<thead>
<tr>
<th></th>
<th>Single</th>
<th>Two Party</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blue Cross Blue Shield – High Option</td>
<td>$198.62</td>
<td>$377.76</td>
<td>$504.54</td>
</tr>
<tr>
<td>Blue Cross Blue Shield – Low Option</td>
<td>$166.84</td>
<td>$317.32</td>
<td>$423.84</td>
</tr>
<tr>
<td>Presbyterian – High Option</td>
<td>$160.62</td>
<td>$337.28</td>
<td>$449.76</td>
</tr>
<tr>
<td>Presbyterian – Low Option</td>
<td>$134.94</td>
<td>$283.32</td>
<td>$377.80</td>
</tr>
<tr>
<td>Dental – High Option</td>
<td>$9.54</td>
<td>$18.16</td>
<td>$28.52</td>
</tr>
<tr>
<td>Dental – Low Option</td>
<td>$4.78</td>
<td>$9.08</td>
<td>$14.26</td>
</tr>
<tr>
<td>Vision</td>
<td>$2.20</td>
<td>$3.68</td>
<td>$4.94</td>
</tr>
</tbody>
</table>

## If you earn $15,000 but less than $20,000, monthly payroll deductions are:

<table>
<thead>
<tr>
<th></th>
<th>Single</th>
<th>Two Party</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blue Cross Blue Shield – High Option</td>
<td>$170.26</td>
<td>$323.78</td>
<td>$432.46</td>
</tr>
<tr>
<td>Blue Cross Blue Shield – Low Option</td>
<td>$143.02</td>
<td>$271.98</td>
<td>$363.28</td>
</tr>
<tr>
<td>Presbyterian – High Option</td>
<td>$137.70</td>
<td>$289.10</td>
<td>$385.50</td>
</tr>
<tr>
<td>Presbyterian – Low Option</td>
<td>$115.66</td>
<td>$242.84</td>
<td>$323.82</td>
</tr>
<tr>
<td>Dental – High Option</td>
<td>$8.18</td>
<td>$15.56</td>
<td>$24.44</td>
</tr>
<tr>
<td>Dental – Low Option</td>
<td>$4.10</td>
<td>$7.78</td>
<td>$12.22</td>
</tr>
<tr>
<td>Vision</td>
<td>$1.88</td>
<td>$3.14</td>
<td>$4.24</td>
</tr>
</tbody>
</table>

## If you earn less than $15,000, monthly payroll deductions are:

<table>
<thead>
<tr>
<th></th>
<th>Single</th>
<th>Two Party</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blue Cross Blue Shield – High Option</td>
<td>$141.90</td>
<td>$269.82</td>
<td>$360.38</td>
</tr>
<tr>
<td>Blue Cross Blue Shield – Low Option</td>
<td>$119.18</td>
<td>$226.66</td>
<td>$302.74</td>
</tr>
<tr>
<td>Presbyterian – High Option</td>
<td>$114.74</td>
<td>$240.92</td>
<td>$321.26</td>
</tr>
<tr>
<td>Presbyterian – Low Option</td>
<td>$96.40</td>
<td>$202.38</td>
<td>$269.86</td>
</tr>
<tr>
<td>Dental – High Option</td>
<td>$6.82</td>
<td>$12.96</td>
<td>$20.38</td>
</tr>
<tr>
<td>Dental – Low Option</td>
<td>$3.42</td>
<td>$6.50</td>
<td>$10.18</td>
</tr>
<tr>
<td>Vision</td>
<td>$1.58</td>
<td>$2.64</td>
<td>$3.54</td>
</tr>
</tbody>
</table>

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

The contribution rates are effective **October 1, 2014** and represent the maximum contribution allowed by law. They are subject to change. Payroll deductions are made in advance for coverage (September deductions pay for October coverage). Your deductions above represent about 1/3 of the total cost; your employer pays the rest.
## The Standard Additional (Voluntary) Life

### Age of Adult

<table>
<thead>
<tr>
<th>Under 30</th>
<th>30-39</th>
<th>40-44</th>
<th>45-49</th>
<th>50-54</th>
<th>55-59</th>
<th>60-64</th>
<th>65-69</th>
<th>70+</th>
<th>Child(ren)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate per $1,000</td>
<td>$.04</td>
<td>$.06</td>
<td>$.08</td>
<td>$.12</td>
<td>$.22</td>
<td>$.34</td>
<td>$.52</td>
<td>$.78</td>
<td>$1.02</td>
</tr>
</tbody>
</table>

To calculate your Additional Life monthly payroll deduction, follow these steps:

1. Enter Annual Contracted Salary, rounded to next higher $1,000
2. Multiply by your selection (1x, 2x, or 3x) (Maximum amount $500,000 without medical underwriting; $600,000 if approved by medical underwriting)
3. Divide by 1,000 (for # of units of $1,000)
4. Multiply the rate for Employee’s age group to get the Employee Life Insurance deduction
5. If insuring Spouse, enter the lesser of:
   - (a) 50% of your Additional Life Insurance or
   - (b) 1x your Annual Contracted Salary, rounded to the next higher $1,000
6. Divide by 1,000 (for # of units of $1,000)
7. Multiply by the rate for Spouse’s age group to get the deduction for Spouse Life
8. If insuring Child(ren) for the Children’s Additional Life Coverage of $5,000, add $.24
9. Add amounts in shaded rows for your total deduction for Additional Life

### Example:

Employee Age 46 earning $34,666 choosing 3x for Employee Life Insurance and enrolling Spouse Age 36 and Children

- Enter Annual Contracted Salary: $35,000
- Multiply by selection: $35,000 x 3 = $105,000
- Divide by 1,000: $105,000 / 1,000 = 105
- Rate for ages 45-49 is $.12
- Multiply: $105 x $.12 = $12.60
- 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
- Enter Spouse’s Contracted Salary: $35,000
- Divide by 1,000: $35,000 / 1,000 = 35
- Rate for ages 30-39 is $.06
- Multiply: $35 x $.06 = $2.10
- Add: $.24
- Total deduction: $12.60 for $105,000 on Employee, $2.10 for $35,000 on Spouse, $.24 for $5,000 on Children, $14.94 per month

## The Standard Long Term Disability Plan

### Benefit Waiting Period

- 30 Day Wait
- 60 Day Wait
- 90 Day Wait

### Monthly Premium

<table>
<thead>
<tr>
<th>Plan</th>
<th>Premium per $100 payroll</th>
</tr>
</thead>
<tbody>
<tr>
<td>30 Day</td>
<td>$.58</td>
</tr>
<tr>
<td>60 Day</td>
<td>$.34</td>
</tr>
<tr>
<td>90 Day</td>
<td>$.28</td>
</tr>
</tbody>
</table>

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

1. Enter Contracted Annual Salary but not more than $90,000
2. Divide by Salary by 1200
3. Multiply by plan rate from table.
4. 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

### Example:

Employee Salary $40,000, 30 Day Benefit Waiting Period

- Enter Contracted Annual Salary: $40,000
- Divide by Salary by 1200: $40,000 / 1200 = $33.34
- Multiply by plan rate: $33.34 x $.58 = $19.34
- Your share: 40% of $19.34 = $7.74
- Sample monthly deduction at $40,000 Salary, 30 Day Benefit Waiting Period: $7.74
NMPSIA CUSTOMER SERVICE TELEPHONE NUMBERS & WEBSITES

<table>
<thead>
<tr>
<th>MEDICAL</th>
<th>TOLL FREE</th>
<th>WEBSITE</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Mexico Blue Cross and Blue Shield</td>
<td>1-888-966-7742</td>
<td>bcbsnm.com</td>
</tr>
<tr>
<td>Presbyterian</td>
<td>1-888-275-7737</td>
<td>phs.org</td>
</tr>
</tbody>
</table>

PRESCRIPTION DRUGS

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<th>PRESCRIPTION DRUGS</th>
<th>TOLL FREE</th>
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<tr>
<td>Express Scripts</td>
<td>1-800-498-4904</td>
<td>express-scripts.com</td>
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DENTAL

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<tbody>
<tr>
<td>United Concordia</td>
<td>1-888-898-0370</td>
<td>unitedconcordia.com</td>
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VISION

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<tr>
<td>Davis Vision</td>
<td>1-800-999-5431</td>
<td>davisvision.com</td>
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LONG-TERM DISABILITY CLAIMS

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<tr>
<td>The Standard</td>
<td>1-888-609-9763</td>
<td>standard.com</td>
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LIFE CLAIMS

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<tr>
<td>The Standard</td>
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</table>
New Mexico Public Schools Insurance Authority

410 Old Taos Highway
Santa Fe, NM 87501

1-800-548-3724
505-988-2736
505-983-8670 fax
nmipsia.com

NMPSIA ELIGIBILITY
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Customer Service
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https://nmpsiaonline.nmpsia.com