General Services Department
Risk Management Division

Employee Benefits Bureau
Administrative Guide

For State, LPB and Self-Pay Group Benefits Plan Participants

Updated January 2015

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I. INTRODUCTION

The success of the State's Group Benefits Plan depends on employees/participants understanding their options and their ability to make the right choices.

This Administrative Guide provides information for benefit participation and for effective administration of the State of New Mexico's Group Benefits Plan Package. Guide users are Plan participants, the State Benefits Third Party Administrator, all Group HR Representatives and/or Payroll Clerks in the various State of New Mexico departments/agencies/bureaus/commissions, and the Local Public Bodies (LPBs) covered by the State's Group Benefits Plan. To ensure consistent and effective plan administration, users should be familiar with the information provided in this manual and use it as a reference.

Within each entity, consistent and effective procedures should be established for enrolling employees and their dependents in the employee benefits plans during employment/eligibility processing (new hire, qualifying event, Open/Switch Enrollment). Each newly eligible employee should be given the Employee Benefits Instruction Sheet, which should be printed from:
https://www.mybenefitsnm.com/documents/Employee%20Benefit%20Instructions%20Hand-Out%20(revised).PDF
Each newly eligible employee should also be directed to the benefits website at www.mybenefitsnm.com, at the time of the employment/eligibility (please see New Employee Checklist page for details). The website is where plan descriptions, premium costs, carrier contact information, online benefits enrollment, and other details are located.

STATE EMPLOYEES: The State's Third Party Administrator (Erisa) will promptly enter all enrollments into SHARE to ensure appropriate benefits and payroll deductions go into effect when the participant's waiting period has ended.
LPB EMPLOYEES: enrollments will be entered into the Third Party Administrator's (Erisa) proprietary database for accurate tracking.

The rules for the State's Group Benefits Plan are based on requirements established by the General Services Department, Risk Management Division (RMD). This manual and the benefits website (www.mybenefitsnm.com) are your primary references for all rules and administrative procedures for the State's Group Benefits Plan package.

Levels of coverage vary from one plan to another. However, the rules regarding such topics as eligibility, enrollment, change of status, and notifications are governed by the State.

Answers to claim filing procedures and claim payment questions are subject to individual insurance plan rules and can be found in specific Summary Plan Descriptions (SPD) or separate administrative guides provided by each individual carrier.

We hope that this manual will be a helpful and frequently used resource. Feel free to contact Erisa with any questions:

Erisa Administrative Services, Inc.
1200 San Pedro NE
Albuquerque, New Mexico 87110

Phone: (505) 244-6000 Fax: (505) 244-6009
Toll Free: 1-855-618-1800
Email: SONM@easitpa.com

II. EMPLOYEE BENEFITS BUREAU FUNCTION

The State of New Mexico's Employee Benefits Bureau (EBB) of the Risk Management Division (RMD), General Services Department (GSD), is solely responsible for the procurement, implementation, and management of all benefits of those participating in the State's Group Benefits Plan.

Procurement

The Healthcare Purchasing Act, NMSA § 13-7-2, was enacted to ensure public employees, public school employees and retirees of public employment and public schools access to more affordable and enhanced quality of health insurance through cost containment and savings affected by procedures for consolidating the purchasing of publicly financed health insurance.

- The IBAC (Interagency Benefit Advisory Committee), composed of the State's Group Benefits Plan, NM Retiree Health Insurance Association, NM Public Schools Insurance Association, and Albuquerque Public Schools, go out to bid together
- The IBAC works together when posting Request for Proposals
- The IBAC analyzes them together, looking for lowest costs, best customer service and benefits
- Each IBAC member group does not necessarily purchase coverage through the same carrier(s) or have identical plan types since needs differ between IBAC agencies

Local Public Bodies (LPBs) may petition EBB to include their employees under the State's Group Benefits Plan. There are specific eligibility requirements for LPBs. EBB routinely handles these requests and the Risk Management Division Director approves admissions into the Plan.

Implementation

- After benefit plan contracts are awarded and signed, EBB works with the vendors to set up communication materials, file exchanges and any system updates to accommodate the new vendor. Billing and payment requirements are also part of the implementation.

Administration

- After go-live with a new carrier/vendor, EBB monitors performance by evaluating specific measurements to ensure all contractual goals are met.
- RMD and Erisa will communicate with participants about the various plans through written materials and details on the benefits website at www.mybenefitsnm.com. Erisa manages State employees, LPBs, Legislators, COBRA (for employees who have separated employment and any dependents ceasing eligibility), Short & Long Term Disability, and Flexible Spending Accounts.
- Other responsibilities of EBB include coordinating with the insurance carriers on communication materials, training classes for administrators, preparing news articles for the Round the Roundhouse newspaper, Open/Switch Enrollment activities, and other special event newsletters for employees.
- **STATE EMPLOYEES**: Employees or HR Representatives who need information and support that cannot be found or clearly understood from reading this Administrative Guide are encouraged to call Erisa at 505-244-6000 or 1-855-618-1800. Any questions that Erisa is unable to answer will be forwarded to RMD by Erisa; once answers are obtained, Erisa will call back the employee or HR Rep.
- **LPB EMPLOYEES**: Please contact your LPB HR Representative if information cannot be found or clearly understood from reading the Administrative Guide.
- EBB is the point of contact for premium refund requests (see Refund Request section).
- EBB is the contact for 3rd level appeals (see Appeals/Grievance Information section)
- EBB oversees the State Benefits Fund, budget projections, and benefit plan design responsibilities.

IV. APPEALS/GRIEVANCE INFORMATION

If you have a grievance about a decision made by one of the State's medical, dental, and vision carriers (they denied, reduced, or terminated a requested healthcare service on the grounds that it was either not a covered benefit or it was not medically necessary), the grievance will be subject to the utilization management review procedure. Any grievance may be submitted orally or in writing. If you make an oral grievance, the carriers have a Customer Service Center that will assist you in completing the required forms. Please be advised that our carriers shall not take any retaliatory action against you for filing a complaint.

You may request a copy and detailed written explanation of the grievance procedures by calling your particular health plan, dental or vision carrier.

Members have 180 days from the date of the initial denial to file an appeal with the carrier.

1. Adverse Determination Appeal Review Procedures

Within 72 hours where circumstances require expedited review, or within 24 working days for all other cases, the carrier shall determine whether the requested healthcare service is covered by your health benefits plan and is medically necessary. If the carrier's initial review results in a denial, reduction or termination of the requested healthcare service, they will notify you of the determination and of your right to request an internal review.

Please refer to your respective medical/health carrier's Summary Plan Description book under Member's Rights, Appeals and Grievances for address and phone information.

Internal Adverse Determination appeal review procedures require an initial review by a plan medical director and then, if necessary, a second review by a medical panel. Both reviews must be completed within 72 hours when the circumstances require expedited review or within 20 working days for all other cases. If the medical director decides to uphold the denial, reduction or termination of the requested healthcare service, the carrier will notify you of the medical director's decision by telephone and mail and will ask you whether you want a second review by a medical panel selected by the healthcare insurer.

If you indicate that you want a second review of your appeal by a medical panel, the carrier will notify you of the date, time and location of the medical panel review and of your rights to participate in the review.

Risk Management External Grievance Review Procedures: If any party to the original appeal declines to accept the decision of the medical panel, that party has 30 days in which to file a formal complaint with the State of New Mexico, General Services Department, Risk Management Division. Upon receipt of the formal complaint, the State of New Mexico General Services Department, Risk Management Division will review the case and respond to the parties involved within 30 days. If the formal complaint is due to an emergency situation, a response will be given within 48 hours of receipt of such formal complaint. Contact Risk Management at:

General Services Department, Risk Management Division, Employee Benefits Bureau
1100 St Francis Drive, Room 2073
Santa Fe, NM 87505-0110

PHONE: *1st level appeal, call the carrier directly*
2nd level appeal, carrier medical panel
3rd level appeal, call RMD at 505-827-0450

V. STATE HUMAN RESOURCES REPRESENTATIVE RESPONSIBILITIES

State HR Reps have view-only access to SHARE benefit modules. HR responsibilities (*related to benefits*) are such things as:

- Managing employees' PERA forms, Retirement, Deferred Compensation enrollments;
- Maintaining accuracy of employee demographic information in SHARE;
- Managing employees' FMLA/LWOP, including determining & obtaining premium payments from an employee if leave hours are not sufficient to cover premium costs, and maintaining accurate tracking & copies of payments in employees' personnel files. Notify Erisa at 505-244-6000 or 1-855-618-1800 so that they can stop benefits if an employee fails to self-pay premiums;
- Entering employees' job termination dates into SHARE job data and faxing to Erisa, at 505-244-6009, COBRA Notification Forms when employees retire/leave employment (this does not include transfers to another State agency). A COBRA Notification Form also needs to be faxed to Erisa with a job status change that reduces work hours below 20 hours/week resulting in loss of benefit eligibility;
- Providing new hires, or employees with qualifying events, the Employee Benefits Instruction Sheet (which can be printed from https://www.mybenefitsnm.com/bene-instruction.htm). Ask employees to read/sign Instruction Sheet, give them a copy, and keep signed original in respective personnel files (required at time of hire and any Qualifying Event). Any employee benefit questions, please refer employees to Erisa;
- Providing employees with COBRA rights information, as well as HIPAA Privacy notices (found at the end of the Forms section in this Admin Guide). Ask employees to read/sign HIPAA notice, and keep signed original in respective personnel files (only required at time of hire);
- Preparing refund and payroll deduction requests, including all required documentation (instructions included in Refund and Forms sections in this Guide);
- Keeping on file the original signed life insurance beneficiary designation forms (this is the one benefit-related document that will be maintained in Agency files instead of Erisa);
- Assisting employees with any life insurance claim requests. If needed, obtain from Erisa the life carrier's required documentation for life claims (call Erisa at 505-244-6000 or 1-855-618-1800);
- Informing employees of their obligation to fax marriage certificates, domestic partner affidavits, and/or birth certificates directly to Erisa at 505-244-6009;
- Directing employees to Erisa and the new **www.mybenefitsnm.com** website for benefit-related questions;
- Life Insurance: Upon an employee's termination/retirement, direct the employee to the Life carrier website to access the Request for Group Life Conversion Materials form at (https://web1.lifebenefits.com/sites/lbwem/sonm.html). The employee will use this form to apply to convert his/her life insurance to an individual policy. Portability of Insurance is also an option under the plan. The form is available at the Securian/Minnesota LifeBenefits website at https://web1.lifebenefits.com/sites/lbwem/sonm.html. Please refer to the Employee Certificate of Insurance for eligibility requirements for Conversion or Portability also found at this website under Documents.

VI. Premium Only Plan (POP)

The State's Premium Only Plan (POP) allows you to have *your share* of the contribution on the cost of medical, dental and/or vision coverage(s) subtracted from your gross pay *before* taxes are calculated, thereby increasing your net pay. If an employee wants these premiums deducted *after* taxes, a Waiver of POP must be signed and faxed to Erisa at 505-244-6009 on the same day the enrollment form is submitted online to Erisa. POP Waivers must be completed each year to maintain the post-tax status.

NOTE:

- If using POP, all medical, dental and vision coverage must be pre-tax. An employee cannot pick & choose which of these are pre vs. post-tax.
- All **State** employees are automatically enrolled in POP. If the desire is to have the medical, dental and vision premiums taken post-tax, a POP waiver form must be completed and faxed to Erisa at 505-244-6009 within 31 days of hire and annually thereafter during Open/Switch Enrollment. Employees can also change their POP option within 31 days of an eligible Qualifying Event (see Enrollment Section in this Guide for list of Qualifying Events).
  (form found at https://www.mybenefitsnm.com/Documents/POP%20Waiver_CY15.PDF)

COMMONLY ASKED QUESTIONS

AS I PARTICIPATE IN *POP*, CAN I USE MY MEDICAL, DENTAL, AND/OR VISION PREMIUMS AS A DEDUCTION ON MY INDIVIDUAL INCOME TAXES?

No. You will already have received your tax savings by participating in this plan.

WHEN WILL THE EFFECT OF *POP* SHOW UP ON MY PAYCHECK

Your pre-tax premium payment will appear on the 1st or 2nd paycheck where benefit premiums are withheld. New employees will see the effects of the program when the first premium for medical, dental and/or vision insurance is deducted from the paycheck.

CAN I HAVE JUST PART OF MY PREMIUM PAID THROUGH *POP*?

No. Only your full eligible premiums can be paid through this plan.

WHAT EFFECT WILL *POP* HAVE ON MY RETIREMENT BENEFITS?

None. PERA will continue to be calculated on original gross salary before the reduction for premium payment.

WHEN CAN I CHANGE MY *POP* ENROLLMENT?

POP can be changed when enrolling for benefits for the first time (cannot have any existing medical, dental, or vision coverage), during the annual open/switch enrollment at the start of each plan year, or within 31 days after your family status has changed. This includes marriage, divorce, birth of a child, the death of your spouse or a dependent, your spouse's ending or beginning employment, when you or your spouse switch from part-time to full-time employment or full-time to part-time, or when you or your spouse take an unpaid leave of absence which impacts your medical, dental, and/or vision enrollment.

WHAT IF I WANT TO CHANGE OR DISCONTINUE MY INSURANCE COVERAGE DURING THE YEAR AND HAVE NOT HAD A CHANGE IN FAMILY STATUS?

According to IRS guidelines, once you are enrolled in POP you may <u>not</u> change your deduction until the end of the POP plan year.

WITH *POP*, INSURANCE PREMIUMS ARE DEDUCTED FROM YOUR PAY BEFORE TAXES ARE TAKEN. THE RESULT IS A SMALLER TAX BITE AND MORE MONEY IN YOUR POCKET; IT'S THAT EASY.

State Employees: Automatically set up as pre-tax (POP) with POP-allowed benefits.
LPB Employees: Please check with respective LPB HR Representatives/Payroll Offices.

PROCEDURE

If you do not wish to participate in pre-tax deductions, sign and fax the waiver letter to Erisa at 505-244-6009 on the same day you submit your online enrollment/change form.
STATE EMPLOYEES: Erisa will provide EBB with a copy of this form to ensure your deductions are changed from pre-tax to post-tax.
LPB EMPLOYEES: Erisa will provide your LPB agency with a copy of this form to ensure your deductions are post-tax.

WHAT'S THE CATCH?

There really is no "catch." The State's POP is a fully legal form of "Cafeteria Plan," a mechanism for offering group benefit plans which is regulated by Section 125 of the Internal Revenue Code. There are three situations why POP may not be advantageous:

A lower FICA base may affect your Social Security retirement benefit **slightly** depending on how far in the future retirement begins. Because your Social Security base is reduced, the final average used in determining your Social Security pension may be affected. However the impact on Social Security Benefits described above is so minimal that POP should be beneficial to nearly 100% of State employees.

Current tax laws allow employees who itemize deductions to deduct insurance premiums on their federal income tax forms. However, medical expenses - including insurance premiums - are deductible only if out-of-pocket medical expenses for the year exceed 7.5% of income. Therefore, very few people are able to take this IRS deduction, so POP is generally more advantageous. If you participate in POP, you will not be able to deduct insurance premiums.

There are rules for tax credits for people with young children covered by employee paid health plans, which make it advantageous to pay premiums with post-tax dollars. This tax credit is not as beneficial to many people when compared to the exclusion from income offered by POP. These rules, however, are complex and you should consult your tax advisor if this might apply to you.

VII. ORIENTATION OF NEW EMPLOYEES

If the employee wishes, Erisa will provide ***general*** benefit discussions and explanations for plan participants. New hires (State employees) will receive an Employee Benefits Instruction sheet from their HR Representatives with benefits contact information. LPB employees: please talk directly with your HR Representatives. ***Detailed*** benefit information will be provided by the Summary of Benefit Coverage and your Summary Plan Description books found on benefit carriers' websites (may be accessed via www.mybenefitsnm.com or directly from carrier websites). In addition to Erisa talking with State employees, the HR Representative should schedule an orientation meeting or group presentation with all new employees to distribute the Employee Benefits Instruction Sheet (employees complete/sign form, keep a copy for themselves, and return to HR Rep for personnel file), the Basic Life beneficiary form (employees complete/sign form and return to HR Rep for personnel file), review HIPAA/privacy practices and guidelines (employees complete/sign privacy acknowledgement form and return to HR Rep for personnel file), and Employee Assistance Program (EAP) for State employees only. Please refer to and use the New Employee Orientation Checklist which is in this Administrative Guide for your convenience.

The Plan participant is responsible for completing and submitting the online enrollment form within the required timeframe (within 31 days of new hire/qualifying event, or by due date if it's an annual open/switch enrollment) and faxing proof of dependency documentation to Erisa at 505-244-6009 on the same day as enrollment submission (copy of marriage certificate/domestic partner affidavit, dependents' birth certificates, if applicable). **Dependents will not be enrolled for benefits unless the required proof of dependency is submitted at the time of enrollment.** Plan participants are also responsible to always check their pay advices for benefit deduction accuracy. Notify Erisa of any discrepancies related to health (medical, dental, vision), Disability, Flexible Spending Accounts, and/or life benefit deductions.

1. EMPLOYEE COMMUNICATIONS

Benefit options have become more complex than ever before. Employees now have a broad array of benefits and coverage to choose from. Each coverage option has its own guidelines which employees may find confusing. **The success of our benefit plans depends on employees understanding their options and their ability to make the right health care choices. It is the efforts of Erisa, the plan carriers, and the Risk Management Division in providing ongoing employee communications that help ensure that success.**

Sharing knowledge and expertise during and beyond the orientation stage helps employees understand the value of their benefits and how to use them correctly. **If you do not have certain information and cannot find it on www.mybenefitsnm.com or in the *Summary of Benefits* or *Administrative Manuals*, please call the appropriate carrier for details.**

VIII. INSURANCE PLAN RULES

1. COVERAGE OPTIONS

State of New Mexico employees, and those employed by Local Public Bodies (LPBs) covered by the State's Group Benefits Plan, have a range of coverage options from which to choose. The available plans include the Premium Only Plan (POP), Medical, Prescription/Pharmacy, Dental, Vision, Basic Life/Accidental Death and Dismemberment (AD&D), Dependent Life, Additional (Supplemental) Life/AD&D coverage based on salary through the Group Life carrier, and Short & Long Term Disability. State employees also have plan options for the Employee Assistance Program (EAP), and the Flexible Spending Accounts (FSA).

Legislators are eligible to participate in the State's Group Benefits Plan ***except*** Disability and EAP. Legislators are responsible to pay 100% of all premiums.

Elected officials serving LPBs are eligible to choose any coverage option that the LPB offers its employees. Elected officials must pay 100% of all premiums or otherwise follow statutes pertaining to the specific LPB.

COBRA participants should check with Erisa for available coverage options.

All of the State's plans are available to eligible employees, regardless of where they live; **however**, if both an employee and their spouse/domestic partner work for the State or participating Local Public Body (LPB), they *cannot* enroll each other as a spouse/domestic partner in medical, dental, or vision, nor can they both cover their children. The only exception is dependent life for employee/spouse/domestic partner. Employees can, individually, elect Additional (Supplemental) Life, and can elect to cover the spouse/Domestic Partner under Dependent Life. They can**not** both cover children under Dependent Life.

All newly hired State employees and most LPB employees who meet the eligibility requirements shall be automatically insured for Basic Life. Basic Life premium for the employee is paid 100% by the employer for both State and LPB employees. The Disability program is a voluntary benefit available to employees only – not dependents. The Disability premium is paid 100% by the employee, **post**-tax. Employees can choose the Life and/or Disability without medical coverage.

Covered employees who are terminated may be eligible for continued coverage under COBRA. See Administrative Guide section titled "COBRA Administration" for more information. Those insured for Life may also have the option to apply for Portability or convert to individual coverage, and Dependent Life may have the option to convert to individual coverage. Please see website maintained by The Securian/Minnesota Life if you have questions: https://web1.lifebenefits.com/sites/lbwem/sonm/contact-us

IX. ELIGIBILITY AND EFFECTIVE DATES

Carefully study the eligibility rules listed below and the applicable coverage information. The State's Group Benefits Plan cannot allow employees to enroll who are not eligible.

Plan rules regarding eligibility apply to all State benefit plans including Medical/Prescription/Pharmacy, Dental, Vision, Basic (Term) Life/AD&D, Dependent Life, Additional (Supplemental) Life/AD&D, Disability, Employee Assistance Program (EAP) and Flexible Spending Accounts (FSA).

NOTE: If enrolled in the **Premium Only Plan (POP)**, an employee may *not* cancel medical, dental or vision coverage unless a qualifying event has occurred (see POP guidelines for those events). POP participants cannot drop pre-tax status until the next annual POP enrollment or a Qualifying Event.

Non-POP participants can drop the coverage at any time. Remember, POP is regulated by the Internal Revenue Service (IRS) and not by the State of New Mexico. You can find additional POP information at the end of this guide. Since Domestic Partner premiums are after-tax, they may change coverage at any time.

Since Disability premiums are paid 100% by employees *after-tax*, an employee is able to add or drop Disability coverage at any time. IMPORTANT NOTE to employees who drop Disability and then start coverage again at a later time: to be eligible to make an initial Disability claim, an active employee must have paid Disability premiums for at least twelve (12) consecutive months.

1. EMPLOYEE ELIGIBILITY

- An eligible employee includes anyone hired as classified, Governor-exempt, probationary, temporary, term or hourly, if the employee works an average of at least 20 hours per week over the course of a pay period and whose length of employment, when hired, is for at least six months. Elected Officials, if part of the State or a participating LPB, are considered eligible and do not need to meet the work schedule of at least 20 hours per week. Independent contractors are *not* eligible under the State benefit plan.
    - NOTE: Annualized salary is based upon a 40-hour work week and should be calculated on *base* pay (do not include multiple components of pay). This must be used to determine insurance premiums for those hired as temporary, term, or hourly even if they are scheduled to work less than 40 hours per week.

    - Temporary employees whose original term of employment was to be less than six months, but it is later determined will be longer than 6 months, may be eligible for coverage if they are scheduled to work at least 20 hours per week. Employees will be eligible for benefits, as long as the employee has met the required eligibility waiting period, upon the offer of extended employment (the two pay period wait is not required for State employees).

- Dual coverage is <u>not</u> allowed. If both an employee and their spouse/domestic partner are eligible employees, they *cannot* enroll each other as a spouse/domestic partner, nor can they both cover their children. The only exception is dependent life for employee/spouse/domestic partner. If both eligible employees seek to enroll their spouse/domestic partner and/or dependents, the enrollment will be rejected and forms returned for proper election.

2. DEPENDENT ELIGIBILITY

Family members eligible for benefit coverage are:

- Spouse. Same sex marriage certificates from states that legally recognize same sex spouses shall be treated as an employee & spouse, with the option of pre-tax premiums
- Common-law marriages are *not* recognized under New Mexico statute; however, common-law marriages from states which *do* recognize them will also be recognized for benefit eligibility purposes
- Domestic Partner (DP), and partner's children upon submission of an executed Affidavit of Domestic Partnership (note: according to Federal IRS Guidelines, premiums for Domestic Partners cannot be taken on a pre-tax basis). Please see Domestic Partner section and Domestic Partner Guide for further information
- Children under age 26, including legally adopted children, stepchildren, and recognized natural (born out of wedlock) children, regardless of dependents' marital status, residence, student status or tax filing. Foster children are included if they live with you in a regular parent-child relationship. Coverage terminates at the end of the last day of the month in which the dependent turns 26
- A newborn can be added on to benefits with the hospital proof of birth; *however*, if the employee does *not* submit an official birth certificate within 3 months of the date of birth, the baby will be retro-termed and the employee will be responsible to pay all incurred birth/baby-related expenses and claims. The result: because the baby was never covered (due to the retro-term), the baby is NOT eligible for COBRA. At future Open/Switch Enrollments, the baby can be added if an official birth certificate is provided
- A child age 26 or over who is incapable of self-support because of a mental or physical disability that existed *before* age 26 is eligible for enrollment in medical, dental, or vision. Disabled dependent *life* coverage is only available if the disabled dependent had *life* coverage prior to turning 26 years of age. To apply for continued coverage, disabled dependents must complete and file required forms with their medical and life carriers (forms found at https://www.mybenefitsnm.com/FGP.htm under "Disabled Dependent Forms").
- A court order directing that an employee and/or employee's dependent provide insurance for someone else does not require the State to grant eligibility. Individual coverage may need to be purchased separately. NOTE: A "Power Of Attorney" is not considered a court order to establish State Plan eligibility or otherwise extend coverage under the State Plan.
- If an employee's spouse has step-children from a previous marriage, and neither the employee nor spouse has adopted them or obtained legal guardianship, the step-children are *not* eligible for coverage.
- Dual coverage is *not* allowed. An eligible dependent cannot be covered by more than one employee participating in the Plan. If a dependent is also an employee of the State, the dependent cannot be covered under their own coverage and as a dependent under another state employee.
- Dependents' benefits coverage cannot begin until the required Proof of Dependency/ Supporting Documentation is faxed to Erisa at 505-244-6009. These documents (marriage certificate/domestic partner affidavit, birth certificates, legal adoption/guardianship/Foster placement papers) must be faxed **at the same time** the enrollment/change form is submitted to Erisa. If an employee is able to clearly document that they are in process of obtaining the required document(s), such as a letter or email from a Vital Records agency, an extension of 3 months may be granted.

NOTE: For Dependent Life coverage of stepchildren, foster children and/or children of a Spouse, these children must be living in the same household as the employee.

3. EFFECTIVE DATES

- For eligible dependents enrolled at the same time as the employee, coverage becomes effective the date the employee's coverage becomes effective.

STATE EMPLOYEES:

For eligible employees paid on a bi-weekly basis, medical, dental and vision insurance coverage will be effective on the first day of the third pay period following their date of employment. Pay periods begin on Saturday.

The effective date of life insurance is determined by the language in the Certificate posted on the Securian/Minnesota LifeBenefits Website: https://web1.lifebenefits.com/sites/lbwem/sonm

LOCAL PUBLIC BODY (LPB) EMPLOYEES:

PLEASE NOTE: *There are exceptions with some LPBs.* Please check with your HR Representative for effective date timelines.

Typically, for eligible employees paid on a monthly basis, medical, dental and vision insurance coverage will be effective on the first day of the month coinciding with or following one month of employment.

Typically, eligible employees paid on the first or fifteenth day of the month will be effective on the first or fifteenth day of the month coinciding with or following one full month of employment.

The effective date of life insurance is determined by the language in the Certificate posted on the website maintained by Securian/Minnesota LifeBenefits Website: https://web1.lifebenefits.com/sites/lbwem/sonm.

STATE EMPLOYEES

Timeline for State employees to submit enrollment changes/additions, via online enrollment, **along with faxing** proof of dependency/supporting documentation to Erisa at 505-244-6009:

- New hires: within 31 days of the date of hire
- Qualifying events: within 31 days of the date of the qualifying event
- Annual Open/Switch Enrollment: no later than the last day of the enrollment period

Access to online enrollment (no paper enrollment forms are allowed) is found at www.mybenefitsnm.com.

LPB EMPLOYEES

Timeline for LPB employees to submit **to their HR Reps** their benefit enrollment forms and proof of dependency/supporting documentation:

- New hires: within 31 days of the date of hire (there may be exceptions based on LPB eligibility requirements; however, the benefit effective date must be no later than 90 days from date of hire)
- Qualifying events: within 31 days of the date of the qualifying event
- Annual Open/Switch Enrollment: no later than the last day of the enrollment period

LPB agencies must submit all required documents **to Erisa within 15 days from the date the enrollment is signed and dated**.

LEGISLATORS

Timeline for Legislators to submit **to Erisa** their benefit enrollment forms and proof of dependency/supporting documentation:

- New Legislators: within 31 days of being sworn in to office
- Qualifying events: within 31 days of the date of the qualifying event
- Annual Open/Switch Enrollment: no later than the last day of the enrollment period

EFFECTIVE DATES TO BE USED FOR QUALIFYING EVENTS

Qualifying Event	**Effective Date**
Birth, adoption, legal guardianship, marriage, cessation of domestic partnership	Date is the day the event occurs
Domestic Partnership Affidavits	Date it is notarized
Divorce	Date the Final Decree is filed
Dependent losing coverage due to turning 26 years of age	Benefits will terminate at the end of the last day of the month in which the dependent turns 26
Change in job status (reduction of hours or termination)	Date is the day following the event
Gain of other coverage	Date is the day prior to new coverage effective date
Death of employee	Date is the day reflected on Death Certificate Coverage for dependents ends the last day of the pay period in which the death occurred
Death of dependent	Date is day reflected on Death Certificate

X. ENROLLMENT

STATE EMPLOYEES

State employees enroll for benefits *online* at www.mybenefitsnm.com. At the top of the home page is an orange/yellow section; click on the 2nd tab marked "Enrollment." Once the enrollment form is complete, you must be sure to click on "Submit" to send it to Erisa for benefit enrollment into SHARE and to start your premium payroll deductions. If you wish to enroll dependents, Proof of Dependency/Supporting Documents must be faxed to Erisa at 505-244-6009 *on the same day* as you submit your online enrollment form. Dependents will *not* be covered without submitting the required marriage certificate/domestic partner affidavit, birth certificates and/or legal adoption/guardianship/Foster placement papers.

LPB EMPLOYEES and LEGISLATORS

At the top of the home page of www.mybenefitsnm.com is an orange/yellow section; click on the 2nd tab marked "Enrollment." Then, on the left menu, click on the Legislators, Local Public Bodies which will take you to an online Enrollment/Change Form that must be completed for enrollment (exception: NMSU employees who must complete a specific NMSU form). Please open the online form(s), type in all information in all boxes, print off the form (it cannot be saved), sign it give it to your HR Representative, along with the required Proof of Dependency/Supporting Documentation. Legislators, please complete the form, sign it, and fax it to Erisa (505-244-6009), along with the required Proof of Dependency/Supporting Documentation. HR Representatives from participating Local Public Bodies should keep originals and either fax or mail these enrollment forms to Erisa. **New hires' enrollment/change forms and supporting documentation must be submitted to Erisa within 15 days from the date of execution on the enrollment form.** If an employee wishes to add a spouse/domestic partner or dependent during an Open/Switch Enrollment Period, the required supporting documents must be provided to Erisa PRIOR to the Open/Switch Enrollment Period.

Legislators are eligible to participate in the State's Group Benefits Plan ***except*** Disability and EAP. Legislators are responsible to pay 100% of all premiums.

Elected officials serving LPBs are eligible to choose any coverage option that the LPB offers its employees. Elected officials must pay 100% of all premiums or otherwise follow statutes pertaining to the specific LPB.

Enrollment in Employee Assistance Program (EAP):

STATE EMPLOYEES: All eligible State employees and their dependents are eligible to participate in the Employee Assistance Program (EAP). No enrollment is necessary and employees do not pay the premiums for the EAP coverage.

LPB EMPLOYEES: Please contact your HR Representative to see if your employer participates in the EAP.

Enrollment in Basic Life Insurance:

STATE EMPLOYEES: All State employee eligible for benefits are automatically enrolled in basic life coverage. The State pays 100% of the premiums.

LPB EMPLOYEES: Most LPBs that offer life coverage through the State's Plan will pay 100% of Basic Life premiums for their benefit-eligible employees. Please contact your HR Representative to see if your employer participates in Life coverage.

Basic Life (LPB employee only):

To become insured for guaranteed-issue basic life coverage, an LPB new hire must enroll within the first thirty-one (31) days of becoming eligible. An LPB employee who does not enroll in basic life within 31 days of becoming eligible must submit "proof of insurability" by completing the Medical History Statement (Evidence of Insurability – EOI). A physical exam and/or physician statement may be required. The application is subject to approval. Do ***not*** start payroll withhold or set up benefit election until approval has been received from the life carrier.

PROCEDURE FOR OBTAINING ADDITIONAL (SUPPLEMENTAL) LIFE COVERAGE

FOR BOTH STATE & PARTICIPATING LPB EMPLOYEES

Upon becoming eligible for coverage, as a new hire, employees may elect Additional Employee Life, Spouse/ Domestic Partner and Child Life coverage within 31 days of becoming benefit eligible. Premiums for Additional (Supplemental) Life and Dependent Life are paid 100% by the employee.
Payment for these premiums are direct billed to the employee.

Employees may elect from the following options to obtain coverage on a guaranteed basis, without providing proof of good health known as evidence of insurability (EOI):

Class 2: Employee and Class 1: Legislator - All coverage is guaranteed up to a maximum of $150,000,
Spouse/Domestic Partner Coverage - All coverage is guaranteed up to a maximum of$30,000, and
Child Coverage - All coverage is guaranteed up to a maximum amount of coverage; $15, 000

Employees can elect coverage beyond the guaranteed issue amount, but will be required to provide evidence of insurability (EOI). The maximum amount of coverage available is:

Class 2: Employee - An amount elected by the employee in increments of $10,000 subject to a maximum amount of $500,000

Class 1: Legislator - An amount elected by the legislator, in increments of $10,000 subject to a maximum amount of $400,000

Spouse/Domestic Partner Coverage - An amount elected by the employee for spouse/domestic partner, in increments of $10,000 subject to a maximum amount of $250,000

NOTE: employees must be active/at work (not on leave of any kind) to be eligible to apply for additional levels of Additional Employee Life or Spouse/Domestic Partner Life coverage.

If the employee 1) does not elect Additional Employee Life or Dependent Life insurance at time of hire, or 2) but later wishes to increase level coverage, evidence of insurability (EOI) is required to obtain approval. Applications can be accepted at any time for Additional Employee Life, Spouse/ Domestic Partner or Dependent Life. Minnesota Life will correspond directly with employees about any health-related issues or further information required.

To calculate an estimated premium for Additional Employee and/or Dependent Spousal/Domestic Partner Life coverage, go to the following website http://www.lifebenefits.com/plandesign/sonm and click Determine the Cost Link located in the middle of the page.

DEPENDENT LIFE COVERAGE (Spouse/Domestic Partner)

Evidence of Insurability (EOI) requirement

A Medical History Statement is required for:

- A spouse/domestic partner enrolling outside of a new hire or new marriage/new Affidavit of Domestic Partnership
- Loss of coverage of spouse/domestic partner without proof of prior life coverage

ELIGIBLE CHILD DEPENDENT(S):

1. If elected, the dependent life insurance coverage for child(ren) will become effective when the employee is approved for life coverage. Coverage for dependent children does not require Evidence of Insurability (EOI).
2. To continue dependent coverage on disabled children after they turn 26 years of age, a Disabled Dependent Life application must be submitted and approved by the Life Insurance carrier prior to the dependent turning 26.

   NOTE: For Dependent Life coverage of stepchildren, foster children and/or children of a Spouse, these children must be living in the same household as the employee.

For questions or guidance, please contact:

Minnesota Life Insurance Company
A Securian Company
400 Robert Street North
St. Paul, MN 55101

Hours of Operation:
7:00 a.m. – 6:00 p.m. (Central Time)

Customer Service Center
855-750-2051

Once on Minnesota Life's website employees can:
- Enroll for coverage
- Complete Evidence of Insurability if necessary
- Manage beneficiary designations

1. STARTING PAYROLL DEDUCTIONS

- As soon as an employee has enrolled and the effective date of coverage has been determined, Erisa will process the enrollment to begin appropriate payroll deductions for the correct pay period. *LPB's: Please refer to your Employee Pay Period Calendar for appropriate pay period deduction dates, as procedures may vary with LPB's.*

- Each year, RMD provides a Contribution Schedule showing the gross premiums and both the employer and employee contributions. It is the employees' responsibility to review their pay advice to ensure that all benefit deductions are being taken correctly.

  State employees: Erisa ensures accurate entry of employee elections into PeopleSoft SHARE to initiate correct payroll deductions

  LPB employees: LPB HR Representatives should follow their own guidelines to initiate payroll deductions

The Flexible Spending Account (FSA) Program is offered to State employees annually. Pledge deductions begin with the first pay period in January. Employees pay 100% of the pledged amount for this option.

LPB employees: Please check with your HR Representatives to determine if your LPB offers FSA.

NOTE:
State Employees: For Medical, Dental, Vision and Disability, enrollment/changes due to Qualifying Events within 31 days, payroll deductions must begin at the start of the pay cycle in which the *Qualifying Event* occurs. Effective date of the change is the actual date of the qualifying event; however, premiums are for the full pay period (not pro-rated).

Since Disability premiums are paid 100% by employees *after-tax*, an employee is able to add or drop Disability coverage at any time. IMPORTANT NOTE to employees who drop Disability and then start coverage again at a later time: to be eligible to make an initial Disability claim, an active employee must have paid Disability premiums for at least twelve (12) consecutive months.

LPB Employees: Check with Erisa to obtain your premium payment start dates.

2. QUALIFYING EVENTS (Change of Status)

Change of Status rules protect employees and/or their eligible dependents when a qualified change of status occurs, allowing changes to coverage as needed.

For purposes of this section, *Qualifying Events* are the following changes:

- Change in job status of spouse/domestic partner resulting in loss of group coverage or gain of other coverage from new employment.

- Change in job status of employee (such as reduction of hours due to FMLA, LWOP, and Disability).

- Marriage or a change in marital status, such as divorce or legal separation, resulting in a loss of coverage. This includes satisfying requirements for Domestic Partnership eligibility.

- Death of the employee.

- Death of a spouse or eligible dependent, resulting in a loss of group coverage.

- Birth of a child, a court approved adoption or legal guardianship.

- Any other circumstance where the individual had other coverage and loses it due to circumstances beyond their control **must be evaluated by RMD for eligibility**.

- NOTE: Loss of a provider or provider group is *not* a qualifying event to change carriers.

- If there has been a qualifying event, coverage becomes effective the day following loss of coverage, providing the enrollment is made within 31 days of the *Qualifying Event.* Payroll deductions must begin at the start of the pay cycle in which the *Qualifying Event* occurs.

- Dependents that were covered under another group plan and lose that coverage due to a qualifying event may be immediately insured under the State plan, provided adequate proof of previous group coverage is submitted to Erisa and the employer. **Enrollment of the dependents must be made within 31 days of the loss of coverage. Proof of dependency must be submitted before coverage will begin.**

A qualifying event acts like an Open/Switch Enrollment for the employee, with the exception of Life coverage.

Dropping Benefit Coverages

When employees cancel medical/dental/vision coverage, re-enrollment cannot occur until the next open/switch enrollment unless there is a new *Qualifying Event*. Since Disability and Dependent/ Supplemental Life premiums are post-tax, these coverages can be cancelled by employees at any time.

IMPORTANT: If an employee enrolls in Disability at a later date, they will have to meet the requirement of paying premiums for 12 *consecutive* months before eligible for Disability claim payments. If an employee enrolls in Dependent (Spouse/Domestic Partner) and/or Supplemental Life at a later date, it will require completing the Evidence of Insurability process.

3. SHARE DATA ENTRY REQUIREMENTS FOR REMOVING DEPENDENTS

- Employees must notify Erisa when a dependent's eligibility ceases due to the following circumstances: divorce from the employee, child marries (is under age 26 and chooses to elect coverage elsewhere), or otherwise fails to meet eligibility guidelines. The dependent must be waived from benefits. NEVER delete any spouse/domestic partner/child(ren) from the system.

a. Coverage for dependent children turning 26 terminates at the end of the last day of the month in which they turn 26.

b. Coverage for a spouse becoming non-eligible due to divorce ***must*** be terminated on the date of the Divorce Decree.

c. Domestic Partners must also be terminated from coverage on the date of termination of domestic partnership.

d. Medical, Dental and Vision coverage for deceased employees or dependents terminates on the last day of the pay period for which deductions/payments were made. The actual date of an employee's death should be recorded, in SHARE, in the employee's Biographical Details tab at the "Modify a Person" module.

e. If the ineligible dependent is the employee's last or only dependent, Erisa will **change the payroll coverage from family to couple or single.** If there are other covered dependents, the coverage type and premium may not change.

f. If a Non-POP employee chooses to waive any dependents for any reason other than ceasing to meet eligibility requirements, obtain a signed and dated form documenting the employee's intent to cancel coverage. **Coverage will terminate on the last day of the pay period in which the application is signed and a deduction has been taken.**

4. TRANSFERS

State Employees who transfer from one State agency to another State agency or covered LPB*, with no break from employment, may transfer their employee benefits coverage without the waiting period that applies to new employees. Benefits must remain the same and will be effective the first day of employment at the new agency with no break in coverage.

** LPB's: please check with the agency for hiring requirements, and check with HR Representatives for mandatory waiting period requirements.*

Employees who transfer must keep the same coverage(s) they previously had. They cannot add or delete coverage(s) at the time of transfer. If the employee chooses to add a benefit not previously enrolled in, they will need to be treated as a new hire, with appropriate eligibility waiting periods.

It is recommended that employees only transfer at the beginning of a pay period.

NOTE: With any break in service followed by a rehire (even for 1 day), the employee is considered a *new hire*. Reinstatements are only considered with a court order and review/approval by the Employee Benefits Bureau.

XI. TERMINATION OF EMPLOYMENT

LPBs have their own termination processes.

Following are the steps when a **STATE** employee terminates employment:

1. The HR Reps update the terminated employees' personnel files and enter the date of termination in SHARE job data.

2. HR Reps immediately notify Erisa of the termination by faxing them (505-244-6009) a COBRA Notice of Termination form. Erisa will then mail a COBRA information packet to the employee or dependent(s). Federal Law requires that the information packet be sent out by Erisa within 14 days of receipt of notice of the qualifying event, so it is imperative that the HR Rep notify Erisa immediately with any termination/retirement.

3. Benefit coverage and premium deductions are automatically stopped in SHARE upon entering the termination in job data. Medical, dental, vision and Disability coverage ends on the last day of the pay period for which deductions/payments were made. **Deceased employee/dependents medical, dental and vision coverage ends on the last day of the pay period for which deductions/payments were made.**

   Life insurance coverage ends on the date employment terminates, but in the event of an employee's death, dependent coverage extends per the terms of the Certificate posted on the website maintained by Securian/Minnesota: https://web1.lifebenefits.com/sites/lbwem/sonm

4. Carriers are notified of the employee's termination and/or dependents' loss of coverage via the weekly eligibility file.

5. Life Insurance: HR Representatives should direct the employee to the Life carrier website to access the Request for Group Life Conversion forms. The employee will use this form to apply to convert his/her life insurance to an individual policy. Portability of Insurance is also an option under the plan and the form is available at https://web1.lifebenefits.com/sites/lbwem/sonm. Please refer to the Certificate of Insurance for eligibility requirements for Conversion or Portability.

6. Any termination with a retro-active date must be coordinated through the Employee Benefits Bureau to ensure data accuracy and compliance with COBRA and the Patient Protection and Affordable Care Act (PPACA) requirements.

XII. LEAVE FOR ACTIVE MILITARY DUTY

STATE EMPLOYEES

When an employee is pressed into active military service, all benefits are provided by the federal government (including employees' dependents). Upon submission of military Activation Orders to Human Resources, State HR Representatives must immediately notify Erisa. The HR Rep must enter a job status change of Leave of Absence/Military (LOA/MIL) to stop all benefit/life coverage and premiums. DO NOT USE THIS for 2-week summer trainings for the National Guard.

LPB EMPLOYEES

LPB HR Representatives must fax copies of Activation Orders to Erisa (505-244-6009) for inactivation of employees/dependent benefits. An enrollment/change form must accompany the active order when faxed to Erisa.

BOTH STATE & LPB EMPLOYEES

Upon timely return from military duty per the rules set forth in Uniformed Services Employment and Reemployment Rights Act (USERRA), benefits for the employees and eligible dependents must be re-activated with the same coverages (unless Qualifying Event occurs in the interim), with no waiting period.

XIII. SELF-PAY PREMIUM SITUATIONS

STATE EMPLOYEES:
There are three sets of circumstances in which an employee, who would otherwise lose eligibility for coverage under the plan, may continue coverage by paying the full premium. The Anti-Donations Act precludes the State from making a contribution toward these employees with the exception of FMLA.

An employee is responsible to pay 100% of benefit premiums (both the State and employee portions) when:

- An employee is on LWOP, without FMLA coverage, and has no leave time to cover premiums
- An employee exhausts all FMLA total hours and has no leave time to cover premiums, or
- An employee is on Workers Compensation coverage and has no leave time to cover premiums

1. **LEAVE WITHOUT PAY (LWOP):**

State employees on Leave Without Pay have the option to:

1. Change their benefits since LWOP is considered a Qualifying Event due to job status change (must be within 31 days of starting LWOP), or
2. Continue all coverage but are *required to pay premiums by the end of each pay period to keep benefits in effect*. Employees on LWOP are required to pay *both* the employee's and the State's premium amounts. Employees will receive invoices from their HR Rep and it is their responsibility to pay by the due date and follow the established billing process. While on LWOP, failure to pay premiums **by the end of each pay period** will result in cancellation of coverage.

In any instance of an employee going on LWOP, the State HR Rep must *immediately* issue required letters and documents found in the Forms section of this document. The State HR Rep is responsible for preparing invoices, collecting payments due, and **submitting payments to Risk Management Division Finance Bureau within five days of the end of each pay period**. The State HR Rep is responsible for maintaining accurate tracking of payments in the employee's personnel file, including copies of payments. If payment is not received three days before the end of the pay period, the HR Rep shall notify the employee that failure to pay will result in benefit termination. In the event an employee fails to make the required payment by the end of the pay period, the HR Rep shall immediately notify Erisa and the appropriate coding in job data will be completed to terminate benefits. HR Reps must also immediately send Erisa a COBRA Notification Form so that Erisa can send the employee the required COBRA information packet. If a participant on LWOP has their benefits cancelled due to lack of premium payment and they return to work, they will have to wait until the next open/switch enrollment, or a valid Qualifying Event, to enroll and start their benefits again.

Upon an employee's return to work, the HR Rep is responsible for changing the appropriate coding in job data to reflect "return from leave."

2. **Flexible Spending Account (FSA):** If an employee is enrolled in a Flexible Spending Account, the employee has three options:
    a) Continue pledged payment amounts through HR Reps (**HR Rep must add this to premium invoices**),
    b) Stop pledged payment amounts while on LWOP and re-establish payments upon return to work (**NOTE**: an employee will not have access/use of their funds during the period of non-payment), or
    c) Drop the program and reimbursement of expenses cease at the end of the month in which last payment is made.

The employee must notify the FSA carrier and Erisa of the LWOP status. Call the FSA Program Administrator for more details (Phone: (800) 933-7472 – CompuSys/Erisa).

3. **Unpaid leave under the FAMILY MEDICAL LEAVE ACT (FMLA):** Under the provisions of FMLA, an employee must be allowed up to 480 hours of leave per year for the employee's or close family member's serious illness or for the birth or adoption of a child provided they have a sufficient number of hours worked. While on leave under FMLA, the employer will continue its normal contribution toward coverage and the employee must pay the normal employee contribution.

    a. Eligible employees must have been employed for at least 1250 hours of service during the 12-month period immediately preceding the commencement of the leave.
    b. FMLA allows a 30 day grace period to submit premiums. It is the responsibility of the HR Rep to track and ensure premiums are being paid, keeping copies of payments. A 15 day Notice of Cancellation of coverage must be sent by the HR Rep to the employee prior to terminating coverage – and Erisa must be immediately notified if coverage is terminated.
    c. When an employee is on FMLA, payroll is active. If the employee has sufficient money in their paycheck, then the deductions occur as normal. If the employee does not have enough money in the paycheck to cover deductions, the employee must pay the monies owed or coverage will be terminated. State HR Reps must *immediately* issue required letters and documents found in the Forms section of this document if an FMLA employee begins paying their own premiums.
    d. In the event an employee fails to make the required payment by due date, the HR Rep shall immediately enter the appropriate coding in job data to terminate benefits. HR Reps must also immediately notify Erisa, who shall send the employee the required COBRA information packet.
    e. Upon return to work, coverage will be reinstated with no new waiting period. The HR Rep is responsible for changing the appropriate coding in job data. For spouse/Domestic Partner dependents' life coverage, satisfactory evidence of insurability will be required.

LPB EMPLOYEES:

LPB employees who do <u>not</u> have sufficient leave time to cover benefit premiums must self-pay their own premiums. These self-pay premiums must be given directly to their LPBs. The LPBs pay monthly invoices that include **<u>all</u>** LPB employees (i.e. active, FMLA, LWOP, Disability) which is why LPB self-pay employees give their premiums directly to their employer. Please work with your HR Reps for handling self-pay situations.

LEGISLATORS:

Legislators enrolled in the State's Group Benefits Plan will receive monthly invoices from the Administrative Services Division of the NM State General Services Department. It is each Legislator's responsibility to pay by the due date each month and follow the established billing process or risk losing benefits.

XIV. RETIREMENT

LPB EMPLOYEES:
Please contact your HR Representative if you are retiring. LPB HR Representatives must *immediately* notify Erisa of all employee retirements to ensure accurate billing.

STATE EMPLOYEES:

1. A retiring State employee who will receive retirement benefits from either PERA or ERB can continue health coverage through the Retiree Health Care Authority (RHCA) or through COBRA (short-term up to 18 months). They should arrange for coverage through RHCA 3 months prior to retirement. **Even if it is known that employees will pick up coverage through Retiree Health Care Authority, Erisa's COBRA Unit must still be notified that the employee no longer has medical, dental, vision coverage as a State employee.**

   RETIREE HEALTH CARE AUTHORITY
   Toll-free: **1-800-233-2576**

2. Medical coverage under RHCA will always be effective on the 1st of the month. Employees have the option to elect COBRA to prevent any lapse of coverage until RHCA becomes effective. COBRA coverage would be pro-rated on a daily rate for eligible members. (See COBRA section for more details).

3. Retirees do not meet eligibility requirements to continue the same life insurance coverage they had as active employees under the RHCA plan. Under certain circumstances, retirees can convert to an individual policy.
   a. HR Reps should provide retirees with the Notice of Conversion Privilege form immediately; employees only have 30 days to convert their life insurance.

NOTE: To participate in RHCA coverage, an employee must have participated in PERA.
The contact for the Public Employees Retirement Association is:

PUBLIC EMPLOYEES RETIREMENT ASSOCIATION (PERA)
P.O. Box 2123
33 Plaza La Prensa
Santa Fe, NM 87507
(505) 476-9300
Toll free: **1-800-342-3422**

XV. REFUNDS

LPB EMPLOYEES:
The State does not directly refund premiums to LPB employees. Adjustments are made on the monthly LPB billing from Erisa/State. See your HR Representatives for refund processes. LPB HR Reps must communicate closely with Erisa re: refunds and adjustments to monthly premium invoices.

LEGISLATORS & COBRA PARTICIPANTS:
Call Erisa at 505-244-6000 or 1-855-618-1800 to discuss any refund issues/questions.

STATE EMPLOYEES:
Please follow these steps when submitting Refund Requests:

For current calendar year requests, please use the DFA refund request form, found under "Forms" at the bottom of page: http://www.nmdfa.state.nm.us/Central_Payroll_Bureau.aspx

- For requests of 4 pay periods or less: submit the forms directly to Central Payroll
- For requests of 5 pay periods or more: submit to RMD for review and approval. RMD will forward the request to DFA.

For past calendar year requests, please use the refund request forms found in the "Forms" section of this Benefits Administration Guide starting on page 58. There is a Memo for Agency Refund as well as a Memo for Employee Refund. One packet per Calendar Year is required.

1. **Copies of payroll deduction screens for the pay periods in question must be attached to each packet (employee refund and agency refund). Include the Contribution Schedule(s) for the specific Calendar Year the refund pertains to. If the refund pertains to more than one pay period please include an excel spreadsheet detailing each pay period, the premium that was withheld, and the amount that should have been withheld. Example:**

	Pd	S/H Pd	Difference	Pd	S/H Pd	Difference
PPE	Family Vision	Employee Vision	Employee Refnd	State Share Family Vision	State Share Employee Vision	State Refund

2. If an employee has moved to a different salary range during a calendar year and an adjustment was not made at that time, a separate refund request memo for each salary range must be prepared. If the employee worked for a different agency within the window of a refund request, a separate employer form must be prepared for that agency to be credited.

3. HR Reps: in order to avoid delays, please make certain that forms are complete, all pertinent information is attached and verification of eligibility for a refund has been done. No white out is acceptable. Please do not send EBB incomplete refund request forms; they will be returned.

For questions regarding State employee refunds, contact Risk Management at 505-827-0450.

XVI. DISABILITY

The State of New Mexico Disability Policy is a self-insured plan which was created to provide financial assistance to those that are unable to work for a period of time and lose income due to a sickness or injury (if not receiving Workers Compensation). This Disability Plan is not available to dependents. Participation in this Plan is voluntary. The premium is 100% paid by the *employee* after-tax. For claim forms and more details about the plan, please see the separate Disability Policy found on www.mybenefitsnm.com.

The State's Third Party Disability Administrator, CompuSys/Erisa, manages the Disability program. All applications, forms, medical updates, inquiries, etc. should be sent *directly* to CompuSys/Erisa at:

CompuSys/Erisa Group, Inc.
13706 Research Blvd. Suite 308
Austin, TX 78750
Fax: (512) 597- 4692
Ph. 1-800-933-7472

- An eligible employee must be employed and working with his/her State Agency or LPB for at least a year and have paid Disability premiums for at least 12 *consecutive* months prior to claiming disability.

- The Disability policy is comprised of two benefits: Short Term Disability **(60% of weekly wages up to $500/week, for a maximum of 24 weeks, *after* a 28 day waiting/elimination period. Once waiting/elimination period is completed, Short Term Disability benefits are paid weekly)** and Long Term Disability (**2 years maximum or until approved for social security or retirement, 40% of wages up to $2,000/month paid monthly via direct deposit, one month in arrears**.)

- Employees must continue to make required premium contributions while on Short Term Disability to continue eligibility. HR Reps must remain in close contact with CompuSys/Erisa to notify them that premiums are being paid if on a self-pay situation. If premiums are not being paid, the claim will be closed due to non-premium payment.

- A claim for Disability can be filed even if the employee has not exhausted all of their annual, sick or donated leave time. The purpose of a Disability claim is to help prevent the employee from exhausting all of their leave balances so that when they return to work they may still have leave in their balances.

- A claim for Disability is initiated by the employee submitting completed claim forms to CompuSys/Erisa – see the Disability Policy on www.mybenefitsnm.com for access to the forms. **It is the employee's responsibility to ensure all required forms and documentation are faxed directly to CompuSys/Erisa**. CompuSys/Erisa will send an email/letter to the individual who signed the Employer form notifying the HR Rep and employee that the claim has been accepted, denied or pending for additional information.

- The HR Representative must remain in close contact with CompuSys/Erisa to ensure the claims are not overpaid due to a claimant returning to work, terminating employment, or being approved for social security or retirement. **It is the claimant's responsibility to pay back to the State any over-payments received.**

Coordination of Short Term Disability Benefits and Other Paid Leave Formula if employee makes $20.83 hourly or less:

Hourly Wage X 40 = Weekly Wage
Ex. 15.00 hr X 40= $600
Weekly Wage X 60% = Disability Benefit Amount (maximum $500)
Ex. $600 X 60%= $360
Weekly Wage – Benefit Amount = Amount that can be paid by other sources (annual, donated, sick, etc….)
Ex: $600-$360= $240
Amount that can be paid / hourly wage = **number of hours that can be paid from other sources of payment**
Ex: $240/ $15 hr = **16 hours**

Coordination of Short Term Disability Benefits and Other Paid Leave Formula if employee makes $20.84 hourly or more:

Hourly Wage X 40= Weekly Wage
Ex: $22 hr X 40 = $880
Weekly Wage X 60% = Disability Benefit Amount (maximum $500)
Ex: $880 X 60% = **$528 so we will pay to the maximum of $500**
Weekly Wage – Benefit Amount = Amount that can be paid by other sources (annual, donated, sick, etc…)
Ex: $880 - **$500** = $380
Amount that can be paid / hourly wage = **number of hours that can be paid from other sources of payment**
Ex: $380 / $22 hr = **17.27 hours**

For more information please see the Disability Policy on www.mybenefitsnm.com

XVII. Premium Statements for Local Public Bodies (LPBs)

Monthly premium statements for all LPBs will be prepared by Erisa and sent electronically by the Administrative Services Division (ASD) of the NM State General Services Department.

When submitting monthly premium payments, based on SunSystems-generated invoices, each LPB must submit only **two (2)** payment checks: one check is for the combined total of all Life coverage premiums, and the second check is for the combined total of all other benefits premiums (medical, dental, vision, disability). **All established billing processes must be followed and payment received as instructed on the electronic invoices. The invoice received from ASD must accompany the remittance check(s).**

PLEASE NOTE: **Late payments will be assessed a late penalty fee.**

Erisa, the State's Group Benefits Plan administrator, periodically conducts audits to ensure accurate data on LPB participants, including exact benefit coverages. Due to the importance of maintaining current benefit details, LPBs must return to Erisa the requested audit information within two (2) weeks of receipt.

XVIII. COBRA ADMINISTRATION

Employers who have 20 or more employees, and offer health coverage to those employees, are required to offer a continuation of coverage to those employees and their dependents under the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) based on Qualifying Events. Please refer to the COBRA Administration section of this guide for the qualifying events, forms and additional requirements.

Erisa's COBRA Unit provides the following services to assist the State's Group Benefits Plan in its compliance with COBRA:

- Notify qualified beneficiaries about their right to continue coverage.
- Calculate premium billings and notify the Administrative Services Division of the NM State General Services Department, who will send out monthly invoices to COBRA participants (former employees, spouses/domestic partners, divorced spouses/ex-domestic partners, and children).
- Follow up on individuals who are late with premium payments and terminate individuals as appropriate.
- Monitor the expiration date of coverage and terminate individuals at the end of their continuation period (maximum of 18 months).
- Notify participants turning 65 that COBRA coverage will cease the first of the month upon attaining age 65. At this time, all eligible dependents will be informed that they may continue up to a 36-month maximum.
- Respond to questions from participating employees or dependents about the status of their coverage.

COBRA OVERVIEW

1. Once Erisa receives the COBRA transmittal from the HR Representative, a qualifying event letter is sent to the eligible participant and/or dependents. This letter gives payment timeframes, important addresses and telephone numbers.

2. Once the participant decides to enroll in COBRA, the application is sent directly to Erisa. The application is reviewed for completeness and then enrolled into the billing system (24-48 hour turnaround).

3. A billing statement is produced once the enrollment form is received and once a month thereafter. Bills will be prorated for a partial month payment for the first and last month if COBRA was started/ended in the middle of a month.

4. Participants will receive monthly invoices from the Administrative Services Division of the NM State General Services Department. It is the participants' responsibility to pay by the due date each month and follow the established billing process. Failure to pay premiums will result in cancellation of coverage.

5. Any changes (eg.: request to end COBRA, address or coverage changes) are sent in writing or by way of fax to Erisa and processed by the COBRA Unit.

6. If the employee had continued coverage under COBRA during the period between termination and

rehire, notify Erisa's COBRA unit of your COBRA termination date.

BASICS OF COBRA COMPLIANCE

1. The HR Representative must notify every employee and every covered dependent of all their rights under COBRA when they first become covered under the group plan. Separate notices must be sent if separate residences are maintained. This applies to all current and future employees and covered dependents.

2. Each time a qualifying event occurs, Erisa must notify, within 14 days of receipt of notice of the qualifying event, each qualified beneficiary of his or her continuation rights, benefits and premium rates applicable to the plan (s) for which they are eligible.

3. For each kind of notification, good faith compliance has been defined as first class mail, addressed to the employee and covered dependents, sent to the last known home address. If the dependent lives at a separate address, separate notifications must be sent.

WHAT IS A COBRA QUALIFYING EVENT?

A qualifying event is any of the following events which would cause a loss of coverage by a qualifying beneficiary under the plan:

1. Termination (other than for gross misconduct) of the employee's employment, for any reason (layoff, resignation, retirement, etc.)

2. Reduction of hours worked by an employee

3. Survivors upon death of the employee

4. Divorce or legal separation

5. Dependent child ceasing to meet eligibility requirements

6. Coverage lost because the active employee elects to make an alternate primary coverage, thus becoming ineligible under the State plan

WHO IS A PRE - QUALIFIED BENEFICIARY?

A pre-qualified COBRA beneficiary is any employee, or covered dependent, who was covered on the date before the qualifying event and would lose coverage under the plan, at any time, because of the qualifying event.

RISK MANAGEMENT DIVISION'S POLICY:

Domestic Partners and the dependent children of Domestic Partners will be eligible for COBRA if they incur a qualifying event the same as an employee.

Length of COBRA Continuation Coverage

The chart below summarizes the length of continuation coverage to which an employee or dependent is entitled as a qualified beneficiary.

Qualified Beneficiary	Length of Coverage	Initial Qualifying Event
The employee and their dependents including newborns and adopted children	• 18 months from the date of the qualifying event • an additional 11 months if you become disabled within the first 60 days of the qualifying event	• reduction in work hours • termination of employment
Dependents including newborns and adopted children.	• 36 months from the date of the qualifying event	• divorce or legal separation • child's loss of dependent status • entitlement to Medicare • death
The employee and their dependents	• an additional 11 months, or a total of 29 months from the date of the qualifying event which started the COBRA continuation coverage	• if before or within 60 days of the initial COBRA continuation coverage, the employee (or their dependent) become disabled, coverage may be extended for 11 months
Dependents	• an additional 18 months or a total of as many as 36 months from the date of the first qualifying event	• if the dependent has already elected 18 months of COBRA coverage and experiences a second qualifying event, coverage may be extended to 36 months from the first qualifying event

HOW TO COMPLETE THE COBRA NOTIFICATION FORM

Used for State, LPB's and Domestic Partner set-up

NOTE: The COBRA notification form **must be submitted by HR Reps to Erisa** when loss of any benefit coverage occurs. This includes life and disability. The purpose of this form is to remove the employee/dependent from active benefits AND to alert Erisa's COBRA Unit to issue the initial COBRA enrollment packet. If the information is not complete, Erisa will return the form to the HR Representative who sent the COBRA initiation notification.

1. Please fill out form COMPLETELY, making sure to indicate Social Security Number, Name and Date of Birth for **each** individual. Make sure a complete address is provided.
2. Indicate *COBRA Effective Date* (month, date, year) that COBRA coverage will begin. The effective date is the day after the person is terminated from the State's plan.
3. Indicate *level of coverage* (E= Employee Only, S = Employee plus Spouse, C = Employee + Child/ Children, F = Family Coverage).
4. Indicate *Event Code* using the following list:

   1) Reduction in Work Hours 2) Termination of Employment
   3) Death of Employee 4) Dependent Ceasing to be Eligible
   5) Legal Separation or Divorce 6) Social Security Disability
   7) Voluntary Termination 8) Retirement
5. Indicate the *Plan Number* as it appears on the current COBRA notification form.
6. Indicate *Original Hire Date* (month, date, year).
7. Indicate *Original Effective Date* (month, date, year) of coverage that the employee or dependent became covered under any State sponsored plan. (Dependent effective dates may vary from the employee's date of coverage if the employee has added dependents.)
8. Indicate *Termination Date of Coverage* on the Active Plan (date of benefit plan termination not employment). Remember this date should be on a pay period ending date if coverage is for employee or employee and family. Dependents may have a termination date in the middle of a pay period (dependent reaches age 26 or divorce is finalized on a specific day).
9. Notification forms for dependents must have employees' information on top line, followed by dependents information.

Note: Dependents information should include date of birth, social security number, address, event, original effective date and termination date. Do not complete the "Hire Date" for dependents.

STATE OF NEW MEXICO
COBRA Notification Form

Client Name: State of New Mexico
State Agency/LPB Code: _____
Group Rep Name: _____
Group Rep Telephone #: _____
Date Submitted: _____

Email To: SONM@easitpa.com

please complete one form per employee

SS #	Name	Complete Address City, State & Zip Code	Date of Birth

Cobra Eff. Date	*Level	**Qualifying Event Code	Plan #	Date of Hire	Orig Eff. Date of Coverage	Term Date of Coverage

***Level:** E=Employee, S=Employee plus spouse, F=Family C=Employee plus child/children

Plan Number: #1=BCBS PPO, #2=PRES HMO, #3=BCBS HMO, #4=Delta Dental, #5=Vision Service Plan

****Event Code:** 1=Reduction in Work Hours 2=Termination of Employment
3=Death of Employee 4=Voluntary Termination
5=Legal Separation or Divorce 6=Social Security Disability
7=Voluntary Termination 8=Retirement

Reason For Termination:

XIX. FORMS

Following are samples of some of the materials you will use in administering the State's Group Benefits Plan:

1. **INSTRUCTIONS FOR NEW HIRE WELCOME MEMO**
2. **NEW HIRE ORIENTATION ACKNOWLEDGEMENT FORM**
3. **NEW HIRE ORIENTATION PACKET CHECKLIST**
4. **COBRA FORM–NOTICE OF RIGHTS TO CONTINUE COVERAGE**
5. **STATE EMPLOYEE FMLA/LWOP PREMIUM TRANSMITTAL FORM**
6. **LWOP MEMO: FIRST NOTICE TO EMPLOYEE**
7. **LWOP SAMPLE LETTER FOR CANCELATION OF COVERAGE**
8. **NOTICE- GROUP INSURANCE COVERAGE DURING LEAVE PER FMLA**
9. **AFFIDAVIT OF DOMESTIC PARTNERSHIP**
10. **DOMESTIC PARTNERSHIP: NOTICE OF TERMINATION**
11. **HIPAA PRIVACY POLICIES AND PROCEDURES**
12. **EMPLOYEE NOTICE OF PRIVACY PRACTICES** ***(MUST BE READ & SIGNED BY EMPLOYEE UPON HIRE)***
13. **PREMIUM ONLY PLAN (POP) SUMMARY**
14. **EMPLOYEE REFUND: PAST CALENDAR YEAR REQUEST FOR REFUND FORM**
15. **AGENCY REFUND: PAST CALENDAR YEAR REQUEST FOR REFUND FORM**

Form #1: Instructions for New Hire Welcome Memorandum

It is the HR Representative's responsibility to:

1. **Upon hire, <u>if</u> employees are eligible for benefits, please give them a copy of the most recent Employee Benefits Instruction Sheet found on the State's benefits website at the below link.**

2. **Ensure that employees:**

    a. **Read the instructions,**
    b. **Understand their required actions and due dates,**
    c. **Sign the sheet (both employee and HR Rep),**
    d. **Receive a signed copy for themselves, and**
    e. **You (HR) keep the original signed sheet in their personnel files.**

3. **In addition, give new eligible employees the Form #2 "New hire Orientation Acknowledgement Form" provided in this Admin Guide (both employees & HR Reps sign Form #2. Employees receive a copy and HR Rep keeps signed original in personnel files)**

Link to the most recent Employee Benefits Instruction Sheet:

https://www.mybenefitsnm.com/documents/Employee%20Benefits%20Instructions_hand-out_Dec2014.PDF

Form #2: New Hire Orientation Acknowledgement Form

NEW HIRE ORIENTATION ACKNOWLEDGEMENT FORM

This memo is to advise you of certain benefits and rights that you are entitled to under the State of New Mexico Group Benefits Plan. You should read this notice carefully and, if you have any questions, please talk with:

- State Employees: talk with the Third Party Administrator, Erisa, at 1-855-618-1800
- Local Public Body (LPB) Employees: talk with your HR Representative

STATE OF NEW MEXICO EMPLOYEES:

I acknowledge receipt of the Employee Benefits Instruction Sheet. This instruction sheet is also available at: https://www.mybenefitsnm.com/documents/Employee%20Benefit%20Instructions%20Hand-Out%20(revised).PDF .

Contact Erisa at 1-855-618-1800 for questions related to:

- Medical, Pharmacy, Dental, Vision
- Domestic Partnership Coverage for Medical/Pharmacy/Dental/Vision
- Basic/Additional (Supplemental)/Dependent Life
- Disability
- Flexible Spending Account

Contact your HR Representative for questions related to:

- Retirement (PERA/ERA)
- Retiree Health Care (RHC)
- Leave Plans (vacation, sick, donated vacation)
- Employee Assistance Plan (EAP)

LOCAL PUBLIC BODY (LPB) EMPLOYEES:

I acknowledge that I am to receive all benefits information from my HR Representative.

I understand I have up to 31 days from the date of my hire to enroll myself and any dependents in the Benefit Plans offered to me as a participant in the State's Group Benefits Plan. Apart from life insurance, I understand that if I do not submit the enrollment form timely, I will be required to wait for the next open enrollment period or a qualifying event. I understand that I may later submit an application for life insurance but it may subject to Evidence of Insurability (EOI).

I understand the premiums payable for the Plan's benefits are based upon a full 40-hour workweek annualized salary even though I may or may not work a full 40-hour workweek.

Please note:

1. Eligible State & LPB employees are automatically covered under the State's "Basic Life Package" and the State or LPB pays 100% of the premium (this

includes Basic Life and Accidental Death & Dismemberment). Employees may also choose to enroll in the Additional (Supplemental) Life and Dependent Life. This optional coverage is paid 100% by the employee.

2. You may choose the medical/dental/vision plan for single, employee + spouse/domestic partner, employee + child/children, or family coverage.

My signature constitutes my acknowledgement that I have been informed of the enrollment and eligibility requirements of the State of New Mexico's Group Benefits Plan.

Employee Name (Printed): _____

Employee Signature: _____ Date: _____

Agency: _____

HR Representative Signature: _____ Date: _____

Form #3: New Hire Orientation Packet Checklist

NEW HIRE ORIENTATION PACKET CHECKLIST

___ Provide new hire the Welcome Letter to New Employees
___ New hire has read & signed the New Hire Acknowledgement Form – HR Representative keeps original in personnel file and provides a copy to employee
___ STATE employees: New hire has read & signed the Employee Benefits Instruction Sheet (found on benefits website at: https://www.mybenefitsnm.com/documents/Employee%20Benefit%20Instructions%20Hand-Out%20(revised).PDF HR Representative keeps original in personnel file and provides a copy to employee
___ Directions have been provided to the State benefits website (www.mybenefitsnm.com)
___ Provide new hire the POP Summary sheet and POP Waiver form; if applicable
___ Provide new hire a copy of RMD's Privacy Policies & Procedures (HIPAA)
___ New hire has read & signed the Notice of Privacy Practices (HIPAA) – HR Representative keeps original in personnel file and provides a copy to employee
___ Schedule the employee to attend an Orientation meeting; OR if not possible due to an employee's location, explain benefits by telephone (State employees will receive health/life benefit information from www.mybenefitsnm.com and Erisa at 1-855-618-1800).
___ Instruct **State** employees to enroll in benefits online at the Enrollment section at the following website: www.mybenefitsnm.com . They must click on "submit" at the end of the online enrollment to send enrollment directly to Erisa for processing. Proof of Dependency documentation must be faxed to Erisa *on the same day* as enrollment (fax: 505-244-6009)
___ Instruct **LPB** employees to enroll in benefits through their HR Representatives. Completed & signed enrollment forms, as well as Proof of Dependency documentation, must be sent to Erisa immediately for processing
___ If employees enroll in life coverage, they must complete & sign a beneficiary form which must be kept by their HR Representatives in their personnel files
___ **State** employees: payroll deductions will begin automatically once Erisa enters enrollment information into SHARE
___ **LPB** employees: HR Representatives must set up proper payroll deductions for all coverage
___ Instruct employees that it is their responsibility to regularly review their pay advices to ensure correct benefit premiums are being deducted

PRINT employee's name _____

_____ _____ _____ _____
Employee's Signature Date HR Representative's signature Date

Form #4: COBRA Form: Notice of Rights to Continue Coverage

To: **The Family of _____**
EMPLOYEE'S NAME

NOTICE OF RIGHTS TO CONTINUE COVERAGE

On April 7, 1986, a federal law was enacted [Public Law 99-272, Title X] requiring that most employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end. This notice is intended to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provisions of the law. [***BOTH YOU AND YOUR SPOUSE SHOULD TAKE THE TIME TO READ THIS NOTICE CAREFULLY.***]

If you are a participant in the State's Group Benefits Plan and are covered by a Blue Cross & Blue Shield or Presbyterian Health Plan, Delta Dental, or Vision Service Plan (VSP) you have the right to choose this continuation coverage if:

1) Reduction in Work Hours	2) Termination of Employment, except for gross misconduct
3) Death of Employee	4) Dependent Ceasing to be Eligible
5) Legal Separation or Divorce	6) Social Security Disability
7) Voluntary Termination	8) Retirement

Under the law, **the employee or a family member** has the responsibility to inform the Human Resources Office, who will inform the Third Party Administrator, Erisa, if there is a divorce, legal separation, or a child losing dependent status under the laws of the State of New Mexico, within 31 days of the date of the event or the date in which coverage would end under the plan because of the event, whichever is later. The HR Representative has the responsibility to notify the Erisa of any of the COBRA qualifying events.

Erisa will send you a COBRA enrollment packet, including notification of your right to choose continuation of coverage. Under the law, you have 60 days from the date you lose coverage to elect COBRA.

If you choose continuation of coverage, it must be identical to the coverage you had as of the qualifying event. Please call Erisa's COBRA Unit for details on length of coverage.

The law provides that your continuation coverage may be terminated for any of the following reasons:

1. The State of New Mexico no longer provides group health coverage to any of its employees;
2. Employer group is no longer a participant in the State's Group Benefits Plan;
3. The premium for your contribution coverage is not paid on time;

4. You become covered by another group plan, unless the plan contains any exclusions or limitations;
5. You become entitled to Medicare;
6. Your classification of disability ends.

Premium payments are due upon receipt of the monthly invoice. There is a grace period of 45 days for payment of the monthly premium. **Any attempt to make payment after the expiration of the 45-day grace period will not be accepted. Failure to make premium payment will result in termination of coverage.**

This law applies to medical, dental and vision coverage beginning on July 1, 2000 under Section 10002(d) of COBRA.

If you have any questions about the law please contact Erisa COBRA Unit at 1-855-618-1800.

Form #5: State Employee FMLA/LWOP/Disability Premium Transmittal Form

FMLA/LWOP/DISABILITY BENEFIT PREMIUM FORM

PLEASE SUBMIT FORM TO THE EMPLOYEE BENEFITS BUREAU: BENEFIT PREMIUM INVOICE FOR EMPLOYEES ON LWOP, FMLA and/or DISABILITY CONTINUANCE.

State Agency Name _____

HR Rep _____ Phone # _____

Employee Name _____

LWOP ☐ Disability ☐ FMLA ☐ Other: ☐

Coverage Type: Single ☐ Emp+Spouse ☐ Emp+Child(ren) ☐ Family ☐

Pay Period Ending: _____

Carrier	Employee Portion Due LWOP, Disability, FMLA	State Portion Due LWOP
Blue Cross Blue Shield	$	$
Presbyterian	$	$
Delta Dental	$	$
Vision Service Plan	$	$
Disability	$	$
Flexible Spending Account (FSA)	$	$
Dependent Life	$	$
Supplemental Life	$	$
RMD Admin Fee	$	$
Total:	$	$

NO PERSONAL CHECKS: THE TOTAL MAY BE ON ONE MONEY ORDER/CASHIERS CHECK AND MADE PAYABLE TO RISK MANAGEMENT DIVISION

LEAVE WITHOUT PAY (LWOP): Employees on LWOP are responsible for 100% of the gross premium for all coverage benefits in force. Failure to do so will result in a loss of coverage, which cannot be automatically reinstated when they return to active work. This includes employees receiving Disability benefits.

FAMILY MEDICAL LEAVE ACT (FMLA): Employees on FMLA must pay the employee share of the gross premium for all benefits in force, if there is not enough leave to cover payroll deduction. Failure to do so will result in a loss of coverage, which may be reinstated when they return to active work. This includes employees receiving Disability benefits.

DISABILITY: Employees on Short-Term Disability must continue to pay their disability premium to be eligible for disability benefits. If they are keeping other benefits, they are also required to pay whatever portion they are responsible for. Employees terminated while on STD are no longer eligible for benefits. Once an employee has been approved and is receiving a Long-Term benefit, disability premiums are waived.

Form #6: LWOP MEMO First NOTICE TO EMPLOYEE

FOR USE WITH STATE EMPLOYEES

MEMORANDUM

DATE:

TO:

FROM:

SUBJECT: GROUP INSURANCE COVERAGE DURING LEAVE WITHOUT PAY (LWOP)

Date Leave Without Pay began _____
Group Benefits Plan coverage(s) _____

State employees on Leave Without Pay are required to pay premiums **by the end of the pay period in which they are due**, in order to keep their benefits in effect. If you are on LWOP you are required to pay *both* the employee's and the State's premium amounts. Premiums must be received by your HR Rep prior to pay period end date and the HR Rep must submit payment to RMD within 5 days from pay period end date.

It is extremely important to pay close attention to the payment requirements outlined below so that coverage is not lost.

CARRIER PAYPERIOD AMOUNT DUE DATE (S) PREMIUMS DUE

The insurance premiums are due on the dates shown and are payable by cashier's check or by money order. Remember medical, dental, vision, life, Disability, Flex NM (FSA), and Administrative Fees can be made on one Money Order or Cashier's Check and must be made out payable to Risk Management Division.

Non-payment of the premium amount(s) by the due dates specified above will result in cancellation of your coverage, which may not be reinstated when you return to work. To get coverage again, you may have to wait for the next open enrollment, or a valid Qualifying Event.

If you have any questions, please contact me at _____. Thank you for giving this matter your prompt attention.

Form #7: LWOP Sample Letter for Cancelation of Coverage

SEND CERTIFIED MAIL

(DATE)

(INSIDE ADDRESS)

Dear:

Upon receiving a personnel action form placing you on Leave Without Pay (LWOP)/ Unpaid Family Medical Leave(FMLA) status beginning _____ (Date), this office sent you a memorandum providing you with the dates and amount of premiums due in order to keep your benefits coverage in effect. FMLA guidelines allow a 30 day grace period for submitting premiums.

To date, we have not had a response from you. Therefore, this letter is to advise you that your benefits coverage(s) will be canceled if payment is not received in this office by _____ (Date).

We regret that this action has become necessary. However, premiums need to be submitted by the due date. Due to lack of response, we can only assume that you have no need to continue your benefits. Upon return to work, benefits can be reinstated if you have been on FMLA. If you have been on LWOP and not unpaid FMLA, you will have to wait until the next open/switch enrollment period, or a valid Qualifying Event, to start your benefit coverage again.

Sincerely,

Name
Title

Form #8: Notice- Group Insurance Coverage During Leave per FMLA

FOR USE WITH STATE EMPLOYEES
NOTICE TO EMPLOYEE

MEMORANDUM

DATE:

TO:

FROM:

SUBJECT: GROUP INSURANCE COVERAGE DURING FAMILY MEDICAL LEAVE (FMLA)

Date Family Medical Leave began _____
Group Benefits Plan coverage(s) _____

State employees on Family Medical Leave are required to pay premiums by the end of the pay period in which they are due, in order to keep benefits in effect. If you are on FMLA you are required to pay only the employee's share of the premium. FMLA allows a 30 day grace period for submitting premiums.

It is extremely important to pay close attention to the payment requirements outlined below so that coverage is not lost.

CARRIER PAYPERIOD AMOUNT DUE DATE (S) PREMIUMS DUE

The insurance premiums are due on the dates shown and are payable by cashier's check or by money order. Remember medical, dental, vision, life, disability, Flex NM (FSA), and Administrative Fees can be made on one Money Order or Cashier's Check and must be made out payable to Risk Management Division.

Non-payment of the premium amount(s) by the due dates specified above will result in cancellation of your coverage. Failure to pay premiums while on FMLA will result in the termination of group insurance. Upon return to active work, coverage will be reinstated.

If you have any questions, please contact me at _____. Thank you for giving this matter your prompt attention.

Form #9

Affidavit of Domestic Partnership

SUSANA MARTÍNEZ
GOVERNOR
ED BURCKLE
CABINET SECRETARY
GENERAL SERVICES
DEPARTMENT
A.J. FORTE
DIRECTOR
RISK MANAGEMENT DIVISION

State of New Mexico
General Services Department

ADMINISTRATIVE SERVICES DIVISION
(505) 827-0620
BUILDING SERVICES DIVISION
(505) 827-2349
PROPERTY CONTROL DIVISION
(505)827-2141
PURCHASING DIVISION
(505) 827-0742
RISK MANAGEMENT DIVISION
(505) 827-0442
STATE PRINTING & GRAPHIC SERVICES BUREAU
(505) 476-1950

TRANSPORTATION SERVICES DIVISION
(505) 476-1902

AFFIDAVIT OF DOMESTIC PARTNERSHIP

As required by Executive Order 2003-010, this affidavit must be used to apply for domestic partner benefits and must be filed with the state employee's human resources office.

A. DECLARATION OF DOMESTIC PARTNERSHIP

I, _____, declare that I am in a domestic partnership with
(Print State Employee's Name)

_____. Further, we declare that:
(Print Domestic Partner's Name)

1. We are in an exclusive and committed relationship for the benefit of each other, and our relationship is the same as, or similar to, a marriage relationship in the State of New Mexico.
2. We share and have shared together for 12 or more consecutive months a common, primary residence.
3. We are jointly responsible for each other's common welfare and we share financial obligations.
4. Neither of us is married or a member of another domestic partnership; nor have either of us been so during the past 12 months.
5. We are both at least 18 years of age.
6. We are both legally competent to sign this Affidavit of Domestic Partnership.
7. We are not related by blood to a degree of closeness that would prevent us from being married to each other in the State of New Mexico.

B. BENEFITS FOR THE ELIGIBLE DEPENDENTS CHILDREN OF THE DOMESTIC PARTNER

Domestic partner benefits are also available to the domestic partner's children, provided, however, that the child is primarily dependent upon the employee or domestic partner for support and is an eligible dependent child because:

1. Either of the domestic partners is the biological parent of the child;
2. Either or both partners are legally adoptive parents of the child; or
3. The child has been placed in the Domestic Partners' household as part of an adoptive placement, legal guardianship, or by court order (excludes foster children).

We declare that the following named individual(s) is/are eligible dependent child(ren):

_____
(For each Eligible Dependent Child, list the child's name and describe the relationship to the Domestic Partner)
_____

_____

C. EXCLUSIONS

Except for the eligible individuals named in Section B above, the following persons are not covered by Domestic Partner benefits and are not considered eligible dependents: parents, foster children, mere roommates, and other relatives who are related to the state employee to such a degree of closeness that marriage would be prohibited in the State of New Mexico.

D. ACKNOWLEDGMENTS

1. By signing this Affidavit of Domestic Partnership, we agree to notify the human resources office at the state employee's job in writing within 31 days (a) of any change in our status as domestic partners when any of the items in the Declaration of Domestic Partnership (paragraph, A above) no longer apply, (b) because we wish to terminate our domestic partnership (termination notice must be done using the Risk Management Division form "Affidavit of Termination of Domestic Partnership"), or (c) in the event a dependent ceases to meet the eligibility requirements for benefit coverage.

2. We understand that the value of insurance benefits provided to the domestic partner is considered by the federal Internal Revenue Service as taxable income to the employee, that the value thereof is subject to social security and federal income tax withholding, and that current state tax laws require state income tax withholding as well.

3. We understand that the State of New Mexico will pay its portion of the premium on the domestic partner's and dependent benefits, if any, in the same proportion as is paid for similar benefit premium portions paid for spouses and dependents of married persons covered by the state employee's benefits program, and that the state employee is required to pay their portion of the premium on the domestic partner's and dependent benefits, if any, in the same proportion as is required for similar benefit premium portions that married state employees pay for spouses and dependents.

4. We acknowledge that we are hereby advised to seek competent legal advice about present and future financial obligations we may be undertaking before we sign this Affidavit of Domestic Partnership.

5. We understand that at any time we may be requested in writing by the Risk Management Division Director to provide reasonable written proof that we are jointly responsible for the common welfare of each other, that we share financial obligations, and/or to show that the named dependents, if any, are eligible for benefits coverage, and that if we fail to provide such requested proof, then the domestic partner or dependent benefits can be denied or terminated.

6. WE UNDERSTAND THAT ANY MISREPRESENTATION OF FACT MADE IN THIS AFFIDAVIT OF DOMESTIC PARTNERSHIP MAY RESULT IN LOSS OF BENEFITS AND/OR DISCIPLINARY ACTION, AND THAT AS A RESULT OF SUCH MISREPRESENTATION THE STATE EMPLOYEE MAY BE REQUIRED TO REIMBURSE THE STATE OF NEW MEXICO FOR ANY COST FOR PROVIDING BENEFIT COVERAGE OR FOR PROVIDING THE ACTUAL BENEFITS, SUCH COSTS INCLUDING, AMONG OTHER THINGS, ATTORNEY'S FEES.

E. NOTARIZATION

We affirm, under penalty of perjury, that the assertions in this Affidavit of Domestic Partnership are true and correct. *(Both partners must sign this legal document in the presence of a Notary Public.)*

_____ _____
Signature of State Employee (Print State Employee's Name)

_____ _____
Signature of Domestic Partner (Print Domestic Partner's Name)

_____
Common Residence Address City State Zip Code

_____
Mailing Address City State Zip Code

STATE OF NEW MEXICO)
) ss.
COUNTY OF _____)
(County Name)

SUBSCRIBED AND SWORN to this _____ day of _____ 20____, by

_____, an employee of the State of New Mexico, and
(Print State Employee's Name)

_____, the State Employee's Domestic Partner.
(Print Domestic Partner's Name)

_____
Notary Public

My Commission Expires:

Form #10

Notice of Termination of Domestic Partnership

SUSANA MARTÍNEZ
GOVERNOR
ED BURCKLE
CABINET SECRETARY
GENERAL SERVICES
DEPARTMENT
A.J. FORTE
DIRECTOR
RISK MANAGEMENT DIVISION

State of New Mexico
General Services Department

ADMINISTRATIVE SERVICES DIVISION
(505) 827-0620
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(505) 827-2349
PROPERTY CONTROL DIVISION
(505)827-2141
PURCHASING DIVISION
(505) 827-0742
RISK MANAGEMENT DIVISION
(505) 827-0442
STATE PRINTING & GRAPHIC SERVICES
BUREAU
(505) 476-1950

TRANSPORTATION SERVICES DIVISION
(505) 476-1902

❖ NOTICE OF TERMINATIONOF DOMESTIC PARTNERSHIP

❖ *Executive Order 2003-010*

Return this form to the State Employee's Human Resources Office within 31 calendar days from the date the domestic partnership terminated.

1. I, the undersigned, do declare that my former partner, _____, and I are no longer in a Domestic Partner. *(Print Former Domestic Partner's Name)*

2. (*Fill out this part only if the termination is caused by death or marriage of the domestic partner; otherwise leave this blank and skip to the signature section below.)*

   If the termination is caused by the death or marriage of the domestic partner, please indicate the date of the death or the marriage: *(Month/Day/Year)*_____. This date is the actual termination date of the Domestic Partnership.

I declare, under penalty of perjury, that the above statements are true and correct. *(Sign this Notice in the presence of a Notary Public.)*

_____ _____
Signature (Print Name)

_____
Mailing Address City State Zip Code

STATE OF NEW MEXICO)
) ss.
COUNTY OF _____)
(County Name)

SUBSCRIBED AND SWORN to this _____ day of _____ 20___, by _____;
an employee of the State of New Mexico. *(Month/Year)* *(Print Employee's Name)*

_____
Notary Public

_____
My Commission Expires

Form #11: HIPAA Privacy Policies and Procedures

Privacy Policies and Procedures For
The Risk Management Division, General Services Department
State of New Mexico

Purpose
The purpose of these policies and procedures is to provide formal guidance to employees of the Risk Management Division (RMD) and Erisa Administrative Services, Inc. (Erisa) with regard to the receiving, handling, and disseminating of protected healthcare information (PHI) as it pertains to the administration of health plans.

The primary guiding factor behind these policies and procedures is to ensure that PHI is only used and disseminated appropriately. Specifically, that PHI be used only in the activities related to the administration of the health plans and NOT be disseminated such that the information may be used for other types of personnel decisions such as promotions, terminations, etc.

All policies and procedures of RMD and Erisa are public documents and are to be placed on permanent file with RMD and Erisa and made available upon request.

Scope
These guidelines apply to all RMD and Erisa Administrative Services, Inc. (Erisa) and/or employees engaged in health plan administration who, through the course of their normal duties, may come into contact with PHI.

PHI is defined by Federal Law to be individually identifiable health information transmitted or maintained by a covered entity, regardless of form. As this pertains to RMD and Erisa, PHI will be in the form of employee appeals regarding decisions made by our health plan vendors, or PHI from the vendors themselves. Not all appeals contained PHI, though.

These guidelines apply to benefit plan administrators but there are exceptions for worker's compensation or disability programs, are not subject to the same requirements.

Identification Of Affected Workforce Members

All employees, be they full or part-time, temporary or permanent, of the Employee Benefits Bureau (EBB) may come into contact with PHI and are, therefore, subject to these policies and procedures.

The Deputy Director of RMD, by means of his/her oversight of EBB, may come into contact with PHI and is, therefore, subject to these policies and procedures.

The Director of RMD, by means of his/her oversight of the Division, may come into contact with PHI related to health plan administration and is, therefore, subject to these policies and procedures.

The Cabinet Secretary of the General Services Department, by means of his/her oversight of the Department, may come into contact with PHI related to health plan administration and is, therefore, subject to these policies and procedures.

Any other employee of the State of New Mexico who comes into contact with PHI designated for the use of health plan administration is subject to these policies and procedures.

Acceptance of PHI

PHI, according to law, may be received in any form. This includes paper, emails, faxes, and conversationally (oral).

The source of PHI may only be (1) a plan member seeking assistance in obtaining payment from a health plan for a service or supply or (2) from a business associate assisting RMD in the guidelines. Any such business associates will have in place contractual requirements mandating compliance to the same HIPAA regulations.

Any actionable request must be received in a written format. In other words, if PHI is received orally, it must be followed up with written documentation for any action to be taken.

Upon acceptance, all material containing PHI will be documented in a central location and assigned to a specific individual for disposition.

Handling PHI

PHI, if provided by the member, may be used by the appropriate personnel to assist in making a payment determination.

PHI may not be used in any way to assist in making an eligibility determination. Eligibility requirements have been established without regard to an individual's health status.

Additional PHI may not be requested by RMD from any source other than the member.

Disseminating and/or Disclosure of PHI

PHI shall not be disseminated to other areas of State or Local Government except as provided in the following Exceptions paragraph.

PHI shall not be disseminated to entities outside of State or Local Government except as provided in the following Exceptions paragraph.

PHI shall only be disseminated beyond the assigned individual within RMD in order to facilitate health plan administration. Such dissemination shall only be with and limited to the minimum number of individuals necessary for plan administration.

No PHI shall be disseminated on a routine or recurring basis except as provided in the following Exceptions paragraph.

Members may request to view their own PHI. As outlined, PHI will only be on file at RMD if sent by the member. PHI will only be provided after due diligence is applied to determine requestor's

identity. All other requests for PHI will be denied except as provided in the following Exceptions paragraph.

Exceptions to PHI Dissemination and/or Disclosure

PHI may be disseminated without member consent in the following circumstances:

To facilitate payment with a health plan:. If an appeal is received and it is clear that information is received by RMD which was not available to the determining health plan, this information may be disseminated to the health plan for their review and possible payment of denied services. If, after review of an appeal, RMD determines that a service or product should be paid for by the plan, PHI should not be disseminated to the health plan. Once in health plan possession, PHI is subject to published health plan privacy guidelines.

During a health emergency or when you are incapacitated, we will use our professional judgment to decide if sharing your health information is in your best interest.

We will disseminate PHI when required by federal, state or local law.

If law enforcement officials ask, PHI may be disseminated under the following circumstances: to identify or locate a fugitive or missing person, to disclose information about a death RMD believes may be the result of a crime, to disclose information RMD believes may be related to a crime on State of New Mexico property, or as required by a court order, subpoena, warrant, summons or other legal request.

PHI may be disclosed if such disclosure would prevent or lessen a serious and immediate threat to the health or safety of any person or the general public.

PHI may be disclosed with federal officials for national security purposes as authorized by law.

PHI may be disclosed as required by worker's compensation laws.

PHI may be disclosed to the Secretary of the U.S. Department of Health and Human Services (HHS) when HHS requests the health information to determine if we are following privacy law.

Providing Notice of Privacy Practices

Notice of privacy practices shall be communicated to all State Employees upon implementation.

Notice of privacy practices shall include all employee rights afforded under these policies and procedures.

Notice of privacy practices shall be communicated no less than annually thereafter.

Form #12: Employee Notice of Privacy Practices (must be read & signed by employee upon hire)

Risk Management Division – Employee

Notice of Privacy Practices

Many people are worried today about how their personal health information is being used – and with very good reason. Information about your health is a very personal thing and its improper use can leave one feeling violated and victimized. The Risk Management Division (RMD) and Erisa Administrative Services, Inc. (Erisa), are equally concerned. This notice details how your medical information may be used and disclosed as well as how you can gain access to this information.

RMD and Erisa are required by federal law to maintain and protect the privacy of your health information and provide you with notice of its legal duties and privacy practices. If you have any questions regarding this notice or the privacy of your health information, please contact RMD/Erisa at PO Box 6850, Santa Fe, NM 87502-0110, or by telephone at 1-855-618-1800.

When Your Health Information Can Be Used or Disclosed by RMD and Erisa Administrative Services, Inc. (Erisa)

RMD and Erisa have always been aware of the sensitivity of protected (or personal) health information (PHI). As such, RMD/Erisa has limited the amount of PHI it receives in its facilities. In addition, RMD/Erisa has ensured that each of its business associates (i.e. health plans) has committed to the same stringent privacy guidelines in dealing with your PHI.

The following categories describe the ways that RMD and Erisa may use and disclose your PHI.

1. Payment Functions – RMD and Erisa may use or disclose your PHI to facilitate payment for the treatment and services you receive. For example, if you send PHI to RMD as part of an appeal of a health plan decision, RMD may share that PHI with the health plan in order to facilitate the payment of the charges should they be determined to be covered under your plan.

2. Health Care Operations – RMD and Erisa may use or disclose your PHI in order to conduct insurance-related activities. These activities include, but are not limited to, premium ratings, quality assurance processes (audits), fraud and abuse detection and investigation.

3. Legal Requirements / Law Enforcement – RMD and Erisa may use or disclose your PHI, as required by law, in compliance with a court order or subpoena.

4. Public Health / Public Safety – RMD and Erisa may use your PHI to prevent or lessen a serious and immediate threat to the health or safety of any person or the general public.

5. Health Oversight Activities – Your PHI may be disclosed to health oversight agencies, such as the New Mexico Department of Insurance (DOI), during the course of audits,

investigations, inspections or other proceedings related to the oversight of the health care system.

6. Coroners, Medical Examiners and Funeral Directors – RMD and Erisa may disclose your PHI to coroners, medical examiners and funeral directors.

7. Organ and Tissue Donation – RMD and Erisa may disclose your PHI to organizations involved in procuring, banking or transplanting organs and tissues, as necessary.

8. National Security – RMD and Erisa may disclose your PHI for military, national security, prisoner, and government benefits purposes.

9. Worker's Compensation – RMD and Erisa may disclose your PHI, as necessary, to comply with worker's compensation or similar laws.

10. Marketing – RMD and Erisa may use your PHI in order to contact you about health-related benefits and services that may be of interest to you.

When Your Health Information Cannot Be Used or Disclosed by RMD or Erisa

RMD and Erisa Administrative Services, Inc.(Erisa) may not use or disclose your health information without your written authorization, except as designated above in this notice. If you authorize the use PHI by RMD/Erisa for another purpose, you may revoke your authorization in writing at any time. This revocation, however, cannot undo any disclosures that were already made with your permission.

Your Rights Regarding Your Health Information

1. Right to Request Restrictions – You have the right to request restrictions on the way your PHI is used and disclosed in certain situations. RMD and Erisa are not required to agree to the restrictions but will apply them where prudent and reasonable. If you would like to make a request for restrictions, you must do so in writing to RMD at PO Box 6850, Santa Fe, NM 87502-0110.

2. Right to Request Confidential Communications – You have the right to receive your PHI through a reasonable alternative means or at an alternative location for confidentiality purposes. Be sure to include your "alternative location" request in writing to RMD at PO Box 6850, Santa Fe, NM 87502-0110. We are not required to agree to all such requests.

3. Right to Inspect and Copy – You have the right to inspect and copy your PHI 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 RMD at PO Box 6850, Santa Fe, NM 87502-0110. We may charge you a reasonable fee to cover expenses associated with your request.

4. Right to Request Amendment – You have the right to request that RMD and Erisa amend your PHI that you believe is incorrect or incomplete. Upon review, should RMD/Erisa deny your requested amendment, you will be provided with information about the denial and how

it may be appealed. To request an amendment, please do so in writing to RMD at PO Box 6850, Santa Fe, NM 87502-0110.

5. Right to Know to Whom Your PHI Has Been Disclosed – You have a right to receive a list or "accounting of disclosures" of your PHI, with the exception of disclosures made for payment functions or health care operations. To request this accounting, please submit your request in writing to RMD at PO Box 6850, Santa Fe, NM 87502-0110.

6. Right to Review This Notice – You have a right to receive a paper copy of this Privacy Notice at any time. To obtain a paper copy of this Notice, send your written request to RMD at PO Box 6850, Santa Fe, NM 87502-0110.

Should you wish to discuss these rights in more detail, or if you would like to exercise one or more of these rights, contact RMD/Erisa at PO Box 6850, Santa Fe, NM 87502-0110 or by telephone at 1-855-618-1800.

Changes to this Notice
RMD reserves the right to amend this Notice of Privacy Practices in the future and to make the new Notice effective for all health information that it maintains. RMD will promptly distribute the new Notice to you whenever a material change is made. Until such time, RMD is required by law to comply with the current version of this Notice.

Complaints
Please direct any complaints about this Notice or about how your PHI is handled, in writing, to RMD at PO Box 6850, Santa Fe, NM 87502-0110. RMD assures you that you will not be retaliated against in any way for filing a complaint. 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.

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I, the undersigned, have been provided with Risk Management Division's (RMD) Privacy Policies and Procedures as well as the Privacy Notice provided to our membership. Both documents have been explained to me and I am in full understanding of their spirit and intent.

Furthermore, I understand the importance of maintaining the privacy of our membership and will do so as provided by RMD's Policies and Procedures. I recognize that a failure to comply with the policies and procedures may result in disciplinary action as determined by RMD's Privacy Officer.

_____|_____|_____
Employee Signature Printed Name Date

Cc: Personnel File
Privacy Officer

Form #13: Premium Only Plan (POP) Summary

POP is the State's **PREMIUM ONLY PLAN**. This is a pre-tax premium conversion plan that allows employees to have their health, dental, and vision insurance premiums removed from their pay **BEFORE TAXES** are calculated and deducted. LPB EMPLOYEES: please check with your LPB agency to see if they participate in POP.

Reducing taxable income **INCREASES NET TAKE HOME PAY!** This is how POP saves you money; it's that simple.

To simplify the process you will be automatically enrolled unless you return a waiver form rejecting this benefit (LPB employees: please check with your HR Representatives).

For more information on how POP works, please review this pamphlet or contact your Agency HR Representative.

WHO IS ELIGIBLE TO PARTICIPATE?

All employees who are enrolled in any of the State's group health, dental, and/or vision plans will be enrolled in the Premium Only Plan (unless waived). New employees become eligible when their insurance becomes effective.

WHAT MUST I DO?

If you wish to participate or continue to participate, do nothing: you will be automatically enrolled. If you do not wish to participate in POP, complete a letter requesting the waiver of the POP plan.

HOW DOES THE PLAN WORK?

When insurance premiums are deducted from a paycheck, the deductions are normally made after FICA and federal income taxes are taken out. This means premiums are paid with "after tax dollars." With this plan, eligible premiums are deducted before any tax or Social Security (FICA) deductions are made. Health, dental, and vision coverage are then paid for with "pre-tax dollars." The income reported on your annual W-2 form is reduced by the amount of the insurance premiums and taxable income is therefore lower. This is permitted under special sections of the Internal Revenue Code.

IF I WAIVE COVERAGE CAN I ENROLL LATER?

Not until the next annual POP enrollment period. Late enrollments to the POP plan are not permitted under IRS regulations.

Form #14: Employee: ***Prior Calendar Year*** Request For Refund Form

Prior Calendar Year Request for Refund Form (Employee)

Date: _____

From: _____ Phone: _____
Human Resources Representative or Payroll Officer

_____
State Agency

_____
State Agency Address

_____ _____ _____
Employee ID/SSN Employee Name Agency Code

Please select the benefit option to be refunded:

	Administrative Fee		Disability
	Presbyterian		Delta Dental
	Blue Cross Blue Shield		Vision Service Plan
	Lovelace		Flexible Spending Plan (FSA)
	Dependent Life		Additional (Supplemental) Life

Period: _____ _____
First Pay Period End Date (mm/dd/yyyy) Last Pay Period End Date (mm/dd/yyyy)

Employee Portion:

SHARE HCM Code:		Amount:	
SHARE HCM Code:		Amount:	
SHARE HCM Code:		Amount:	
SHARE HCM Code:		Amount:	
SHARE HCM Code:		Amount:	
SHARE HCM Code:		Amount:	
SHARE HCM Code:		Amount:	
		Total Amount:	

In order for this request to be processed, a copy of the applicable payroll deduction screen and spreadsheet must be attached.

Brief Explanation of Refund Request:

_____
_____
_____

EBB Approval: _____ Date: _____

Make Warrants Payable To:_____
Employee Name

_____
Address

_____
City/State/Zip Code

FOR GSD/ASD USE ONLY: A copy should be sent to Erisa without attachments rev Jan. 2015

Form #15: Agency: *Prior Calendar Year* Request For Refund Form

Prior Calendar Year Request for Refund Form (Agency)

Date: _____

From: _____ Phone: _____
Human Resources Representative or Payroll Officer

_____
State Agency

_____
State Agency Address

_____ _____ _____
Employee ID/SSN Employee Name Agency Code

Please select the benefit option to be refunded:

	Administrative Fee		Disability
	Presbyterian		Delta Dental
	Blue Cross Blue Shield		Vision Service Plan
	Lovelace		Flexible Spending Plan (FSA)
	Dependent Life		Additional (Supplemental) Life

Period: _____ _____
First Pay Period End Date (mm/dd/yyyy) Last Pay Period End Date (mm/dd/yyyy)

Agency Portion:

SHARE HCM Code:		Amount:	
SHARE HCM Code:		Amount:	
SHARE HCM Code:		Amount:	
SHARE HCM Code:		Amount:	
SHARE HCM Code:		Amount:	
SHARE HCM Code:		Amount:	
SHARE HCM Code:		Amount:	
		Total Amount:	

In order for this request to be processed, a copy of the applicable payroll deduction screen and spreadsheet must be attached.

Brief Explanation of Refund Request:

_____
_____
_____

Make Warrant Payable To: _____
Agency Name

_____
Address

_____
City/State/Zip Code

FOR GSD/ASD USE ONLY: A copy should be sent to Erisa without attachments rev Jan. 2015