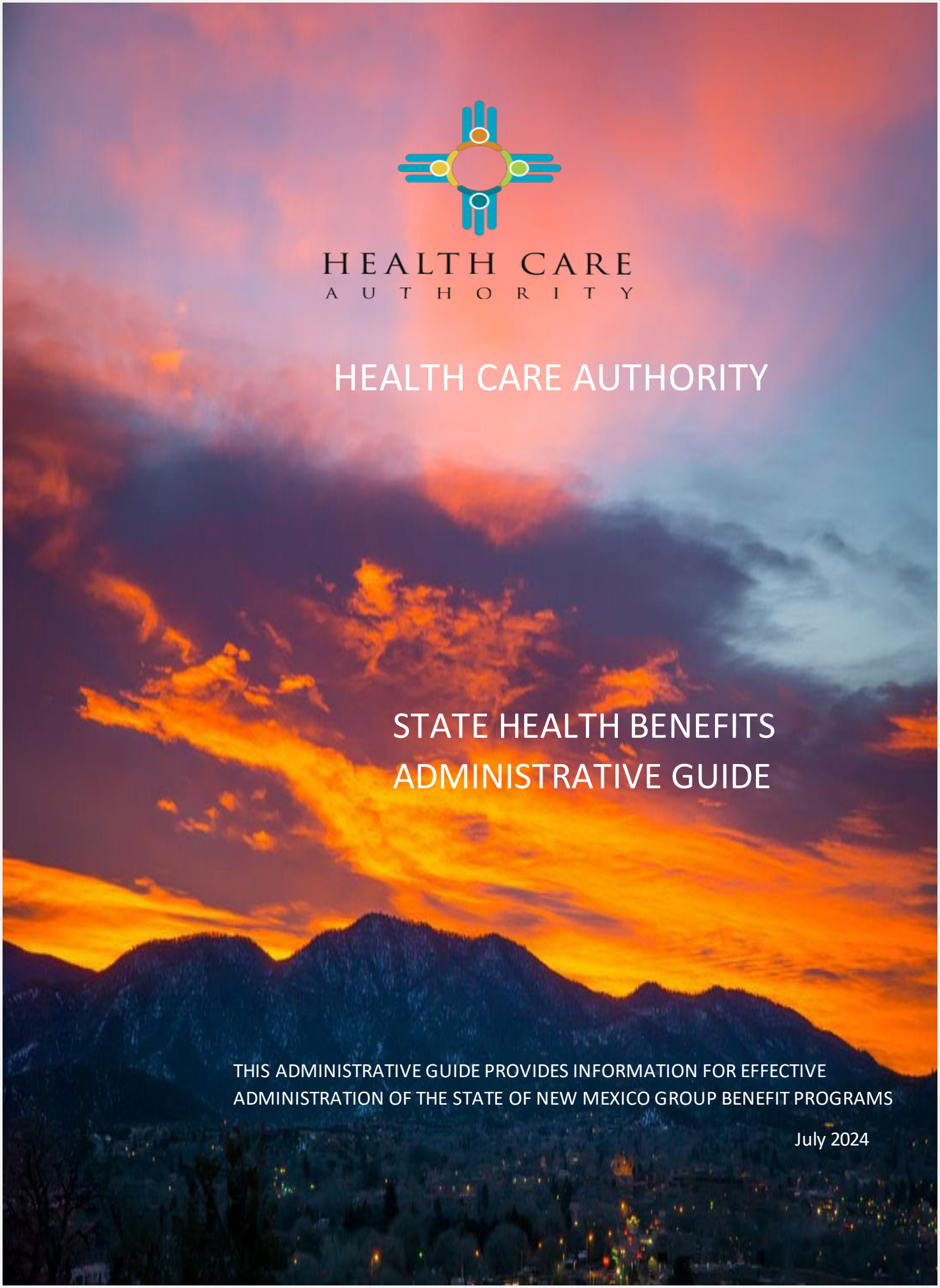

HEALTH CARE
AUTHORITY
HEALTH CARE AUTHORITY
STATE HEALTH BENEFITS
ADMINISTRATIVE GUIDE
THIS ADMINISTRATIVE GUIDE PROVIDES INFORMATION FOR EFFECTIVE ADMINISTRATION OF THE STATE OF NEW MEXICO GROUP BENEFIT PROGRAMS
July 2024

Table of Contents

INTRODUCTION

The success of the State of New Mexico (SoNM) Group Benefits Plan depends on employees and 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 SoNM Group Benefits Plan Package. This guide will be used by Plan participants, Erisa, the State's Benefits Third Party Administrator, all Group Human Resources (HR) Representatives, and/or Payroll Clerks in the various SoNM 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 guide and use it as a reference.

Within each entity, consistent and effective procedures must be established for enrolling employees and their dependents in the employee benefits plans during employment/eligibility processing, which occurs upon new hire, a qualifying event (see Qualifying Event in the "Eligibility and Effective Date" section of this guide), or during Open/Switch Enrollment. All newly eligible employee will be given theBenefits Eligibility Acknowledgement 2025 V1.pdf(Benefits Eligibility Acknowledgement 2025 V1.pdfi n English and Benefits Eligibility Acknowledgement 2025 Spanish V1.pdf in Spanish)which includes access to the benefit website and the all state group benefit plan information. Employees shall read and sign the Benefits Eligibility Acknowledgement form. Agency and LPB HR Representatives should make three (3) copies and provide employee(s) with two (2) copies - one for the employees' records and the other for employee to send to EASI GOV along with their enrollment packet. The third copy of the Benefits Eligibility Acknowledgement form shall be kept in the respective employee file.

STATE EMPLOYEES:

> The SoNM Third-Party Administrator, EASI GOV, 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 (EASI GOV) proprietary database for accurate Billing and Eligibility Tracking.

The rules for the SoNM Group Benefits Plan are based on requirements established by the Health Care Authority (HCA), State Health Benefits (SHB). This guide, as well as the benefits website, https://www.mybenefitsnm.com/, are primary references for all rules and administrative procedures for the SoNM Group Benefits Plan.

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, which can be found in each insurance plan's Summary Plan Descriptions (SPD) or in separate administrative guides provided by each individual carrier. Individual carrier summary plan descriptions can be found in the "Resource" section of this guide.

We hope that this guide will be helpful and frequently used. Feel free to contact EASI GOV with any questions at:

EASI Gov, 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

STATE HEALTH BENEFITS FUNCTION

The State of New Mexico State Health Benefits (SHB) of the Health Care Authority (HCA), is solely responsible for the procurement, implementation, and management of all benefits of those programs available through participating in the SoNM Group Benefits Plan. SHB oversees the State Benefits Fund, budget projections, and benefit plan design responsibilities.

Procurement

The Healthcare Purchasing Act, NMSA § 13-7-2, was enacted to ensure public employees', public school employees', and public employment schools retirees' 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, New Mexico Retiree Health Insurance Association, New Mexico Public Schools Insurance Authority, and Albuquerque Public Schools, participate collectively in the procurement of health plans, pharmacy benefit managers, benefit plan consultants, and any other benefit plans that will contribute to the Healthcare Purchasing Act's cost containment strategy.
- The IBAC works together when posting Request for Proposals.
- The IBAC analyzes the proposals, and the responses received from interested parties looking for the 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 SHB to include their employees under the SoNM Group Benefits Plan. Due to the specific eligibility requirements for LPBs, SHB routinely handles these requests, and the Health Care Authority Director approves admissions into the Plan.

Implementation

After benefit plan contracts are awarded and signed, SHB works with the vendors to establish communication materials, file exchanges, and any information system updates necessary to accommodate new vendors. Billing and payment requirements are also part of the implementation.

Administration

- Once the new carrier/vendor begins, SHB monitors the carrier's/vendor's performance by evaluating specific measurements and performance guarantees (PGs) to ensure all contractual goals are met.
- HCA and EASI GOV will communicate with participants about the various plans through written materials and details on the www.mybenefitsnm.com. EASI GOV performs benefits' administration for State employees, LPBs, Legislators, Consolidated Omnibus Budget Reconciliation Act (COBRA) participants (COBRA is for employees who have separated employment and any dependents ceasing eligibility), Short & Long-Term Disability, and Flexible Spending Accounts.

Other responsibilities of SHB include:

- Coordinating with the state's benefits' carriers on communication materials, creating training classes for administrators, and preparing news articles for the 'Round the Roundhouse newspaper, State Health Benefits Newsletter, Open/Switch Enrollment activities, and other special events and newsletters for employees.
- EASI GOV is the first level of appeal for eligibility concerns and SHB is the final level of appeal.
- Serving as the main contact for benefit premium refund requests that are more than four payroll periods (see Refunds section of this guide).
- Serving as the contact for third level appeals relating to services received and charges (fees) (see "Appeals/Grievance Carrier Information" section of this guide).

STATE AND LPB HUMAN RESOURCE REPRESENTATIVE RESPONSIBILITIES

State HR Representatives have view-only access to SHARE benefit modules. However, the Human Resources responsibilities (related to benefits) are:

- Managing and performing the administration for employees' PERA forms, Retirement, and Deferred Compensation enrollments.
    - **Maintaining accuracy of employee address and demographic information in SHARE is imperative. The carriers, SHB, and EASI GOV use the address for all mailed correspondence. Employees' addresses should be kept up to date.**
    - **Employee Name entered in SHARE should match the Driver's License or Real ID**
    - **Special characters (-, #, ~, etc.) should not be used when entering the name or address as it corrupts carrier eligibility files**
        - **Address should not exceed 30 characters.**
    - **Zip Codes should not contain space between the zip code and extension.**
        - **YES = 87532-1804 (NO = 87532 10804)**
- Managing employees' leave such as Family Medical Leave (FMLA)/Leave without Pay (LWOP), including determining and obtaining premium payments from employees if leave hours are not sufficient to cover premium costs and maintaining accurate tracking and copies of payments in employees' personnel files. Notify EASI GOV at 505-244-6000 or 1-855-618-1800 so they can stop benefits if an employee fails to fulfill their self-pay premiums (please see Self-Pay Premiums section).
- Entering employees' job termination dates into SHARE job data (see Deduction Not Taken section). Fax EASI GOV at 505-244-6009 all 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 EASI GOV if a job status changes that reduces work hours below 20 hours per week resulting in loss of benefit eligibility.
- Ask employees to read and sign the Benefits Eligibility Acknowledgement Form. Agency and LPB HR Representatives should make three (3) copies and provide employee(s) with two (2) copies - one for the employees' records and the other for employee to send to EASI GOV along with their enrollment packet. The original signed Benefits Eligibility Acknowledgement form should be filed in respective employee personnel files (required at time of hire and/or any Qualifying Event). If the employee has

further benefit questions, please refer them to the benefits website at **https://www.mybenefitsnm.com/ or Erisa at 855-618-1800 or Email at sonm@easitpa.com.**

- Informing employees of their obligations to fax proof of dependency or qualifying event proof paperwork such as marriage/divorce certificates, domestic partner affidavits/termination forms, and/or birth certificates, or proof of loss of coverage paperwork directly to EASI GOV at 505-244-6009 after submitting the on-line enrollment/change form when requesting benefit changes.

  NOTE: It is important to inform the employee that failure to submit all required documentation at the time of the enrollment/change form submission will result in an incomplete benefit enrollment and employees' dependents will not receive benefits. (see Enrollment Documentation Requirements).

- Providing employees with COBRA rights information (see "COBRA" section of this guide) and HIPAA Privacy notices (See "Forms" section of this guide). Ask employees to read HIPAA notice (HIPAA Policies and Procedures 2024.PDF).
- Preparing refund and payroll deduction requests, including all required documentation (see "Refund" and "Forms" sections of this guide).
- Keeping on file the original signed life insurance beneficiary designation form(s). Provide the employee a copy for their records and fax a copy to EASI GOV at 505-244-6009.
- Assisting employees or beneficiaries with submitting initial life insurance claims to EASI GOV. Agency and LPB HR Representatives should complete the Group Life and Accidental Death Claim Form found at https://www.mybenefitsnm.com/TermLife.html. The completed form should be faxed to EASI GOV at 505-244-6009. The life insurance carrier will then work directly with the beneficiary.
- Upon an employee's termination or retirement, HR should direct the employee to the Term Life website to access the Note of Conversion and Portability Rights Form: https://www.mybenefitsnm.com/portabilityandconversion.html the employee will use this form to apply to convert his/her life insurance to an individual policy.
- Referring employees to the Employee Certificate of Insurance for eligibility requirements for Conversion or Portability posted at https://www.mybenefitsnm.com/TermLife.html.
- Directing employees to EASI GOV and the https:// www.mybenefitsnm.com/ website for benefit-related questions.

HIPAA

The Health Insurance Portability and Accountability Act of 1996 is a federal law that requires the creation of national standards to protect sensitive patient health information from being disclosed without the patient's consent or knowledge.

Privacy

HCA has been careful to engineer agreements with vendors to minimize exposure regarding the HIPAA requirements. HCA consciously limits access to protected health information (PHI) and does not distribute PHI outside of HIPAA guidelines. HIPAA guidelines state that the PHI may be distributed to the Health Plan to facilitate the payment of a claim.

Standardized Data Code Sets

The United States Department of Health and Human Services has established standardized ways for all information related to health plan administration to be sent and received electronically. All entities, providers,

health plans, or employers who send information electronically were required to begin using these standardized code sets by October 16, 2003. HCA established a contingency plan to be effective April 2004 and is currently compliant with electronic eligibility transfers to all vendors.

Security

HCA continues to work in accordance with the SoNM's coordinated efforts for security requirements, along with other New Mexico state agencies (DOH-Department of Health, CYFD-Children, Youth, and Families, etc.).

COVERAGE OPTIONS

State of New Mexico eligible employees and those employed by Local Public Bodies (LPBs) covered by the SoNM Group Benefits Plan, have a range of coverage options from which to choose. The available benefits are: Medical, Prescription/Pharmacy, Dental, Vision, Employee Basic Term Life/Accidental Death & Dismemberment (AD&D), additional (Supplemental) Life/AD&D and Dependent Life Coverage. Other Benefits include, Short/Long Term Disability, and Flexible Spending Accounts (FSAs), which offer pre-tax savings for eligible medical expenses, dependent care expenses, and transit and parking.

Other voluntary benefits offered to employees include Accident, Critical Illness, Cancer, and Whole Life Insurance. Employees should contact the respective carriers for information and enrollment into these benefits. Information can be found at State Health Benefits. http://www.mybenefitsnm.com/volben.html

Employees also have access to an Employee Assistance Program (EAP), which offers confidential consultation on personal issues, legal information and resources, financial information, and referrals and resources for work-life needs. EAP is a free benefit offered to employees, their dependents, and all members of their household.

Legislators are eligible to participate in the SoNM Group Benefits Plan **except** for Disability, and FSA. Legislators are responsible to pay 100% of all premiums of these benefits with a 2% Administrative Fee.

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 including Administration Fee or otherwise follow statutes pertaining to the specific LPB.

All State Benefit options are available to benefit eligible employees, regardless of where they live; however, if both an employee and their spouse/domestic partner work for the State or participating LPB, they cannot enroll each other as a spouse/domestic partner in medical, dental, or vision, nor can they both cover their children. Employees can individually elect Additional (Supplemental) Life and can elect to cover the spouse/Domestic Partner under Dependent Life. Only one parent can cover their child(ren) under Dependent Life, both parents cannot both cover child(ren) and both employees cannot each obtain coverage for their spouse at the same time.

All newly hired State employees and most LPB employees who meet the eligibility requirements (see Eligibility and Effective date section of this guide) will be automatically insured for $50,000 Term Basic Life and AD&D as well as Basic Life for Line-Of-Duty employees (e.g., Law Enforcement Officers/Undercover Agents). The premium for Term Life employee coverage is paid 100% by the employer for both State and LPB employees. The premium for Basic Life for Line-Of-Duty employees is paid 100% by the line-of-duty employee's Agency.

The Disability program is a voluntary benefit and available only to SoNM and LPB employees; dependents and/or domestic partners are not eligible. The Disability premium is paid 100% by the employee, post-tax.

Covered employees who are terminated may be eligible for continued coverage under COBRA. See Administrative Guide section titled "COBRA" 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 the Term Life website: https://www.mybenefitsnm.com/TermLife.html.

All COBRA participants should check with EASI GOV for available coverage options.

ELIGIBILITY AND EFFECTIVE DATES

Eligibility:

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, 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) for (Medical, Dependent Care, and Transit and Parking).

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 "Annual Open/Switch Enrollment and Qualifying Event Enrollment" section of this guide for a list of qualifying events). POP participants cannot drop pre-tax status until the next annual POP enrollment or a Qualifying Event.

Premium Only Plan (POP)

The SoNM Premium Only Plan (POP) allows an employee to have their share of the contribution on the cost of medical, dental and/or vision coverage(s) deducted from their gross pay before taxes are calculated, which increases the employees' net pay.

POP PROCEDURE

All State employees are automatically enrolled in (POP). If an employee requests not to have the medical, dental and vision premiums taken post-tax, a POP Waiver Form must be completed and faxed to EASI GOV within 31 days of hire and **annually thereafter** during Open/Switch Enrollment.

- EASI GOV fax: **505-244-6009**, or
- Scanned and emailed to EASI GOV at **sonm@easitpa.com,** and to
- State Health Benefits at **hcashb@hca.nm.gov**

The form must be filled out at time of online enrollment. Employees can also change their POP option within 31 days of an eligible Qualifying Event (see Qualifying Event in the "Eligibility and Effective Date" section of this guide).

An employee **cannot** pick and choose specific coverages to be pre- or post-tax, either all benefits will be pre-taxed or none.

POP Waiver Form can be found at Employer Resources | Group Benefits Plan or POP-SoNM-NOTICE-OF-WAIVER-2024.pdf (SoNM); POP-LPB-NOTICE-OF-WAIVER-2024.pdf (LPB).

STATE EMPLOYEES

EASI GOV will provide SHB with a copy of this form to ensure deductions are changed from pre-tax to post-tax.

LPB EMPLOYEES

EASI GOV will provide LPB agency with a copy of the form or click here: Employer Resources | Group Benefits Plan to access the form (click on the POP Waiver Form tile).

Note: Non-POP participants can drop the benefit coverage at any time. Remember, POP is regulated by the Internal Revenue Service (IRS) and not by the State of New Mexico. Participants can find additional POP information at the end of this guide.

EMPLOYEE ELIGIBILITY

Employees who are hired as Classified, Governor-Exempt, Probationary, Temporary, Term, or Hourly, are eligible to elect coverage (Hourly employees must be scheduled to work a minimum of 20 hours/week and meet the prospective employers' waiting period). Elected Officials of the SoNM or Local Public Bodies (LPB) are considered eligible and not required to meet the 20 hours/week work schedule. Temporary employees whose original term of employment was to be less than six months, but whose employment has transitioned to be longer than 6 months, may be eligible for coverage if they are scheduled to work at least 20 hours per week in their extended employment. Employees will be eligible for benefits as long as the employee has met the required *eligibility-waiting period* (the eligibility waiting period is not required for State employees). Temporary employees who have benefit coverage through the SoNM and then transition to full-time employees are allowed to keep their current benefits without a lapse in coverage.

Dual coverage is not 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. 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.

Independent contractors for the state and LPBs are not eligible under the State benefit plan.

Note: Annualized salary is based upon a 40-hour workweek 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.

DEPENDENT ELIGIBILITY

Family members eligible for benefit coverage are:

- Spouse. Same-sex marriages are treated as married for all federal tax purposes, with the option of pre-tax premiums.
- Common-law marriages are not recognized under New Mexico statute; however, common-law marriages from states that 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 (Affidavit form).
  Note: according to Federal IRS Guidelines, premiums for Domestic Partners cannot be taken on a pre-tax basis.

- 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 employees in a regular parent-child relationship. Coverage terminates at the end of the last day of the month in which the dependent turns 26.

  NOTE: If an employee's spouse has stepchildren from a previous marriage and neither the employee nor spouse has adopted them or obtained legal guardianship, the stepchildren are not eligible for coverage.

- A newborn can be added to the employee's benefits with hospital proof of birth. However, if the employee does not submit an **official birth certificate within 90 days of the date of birth**, the infant will be retro-termed, and the employee will be responsible to pay all incurred birth/infant-related expenses and claims. As the infant was never covered (due to the retro-term), the infant would NOT be eligible for COBRA. In such a case, the infant may be added during a future Open/Switch Enrollment, if an official birth certificate is provided.
- A child aged 26 or over who is incapable of self-support because of a mental or physical disability is eligible for enrollment in medical, dental, and/or vision.

  Note: disabled dependent Life coverage is only available to those dependents who were disabled prior to age 26.
- Current Employees: To apply for continued medical and/or life coverage for a disabled dependent that is turning 26 years of age, complete and submit all required forms directly to the medical/life carriers (see https://www.mybenefitsnm.com/BenefitsInformation.html for **Adult Disabled Dependent Care Form** forms under each carrier listing). Approval/denial notification will be sent to the employee directly from the carrier. You must submit the approval to EASI GOV in a timely manner for processing.

  Note: requested forms must be submitted and approved by carrier prior to dependent turning 26.
- New employees seeking coverage for disabled dependents 26 years or older must complete and submit all required forms and proceed as specified above.
- A court order directing that an employee and/or employee's dependent provide insurance for an eligible dependent 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 SoNM Plan eligibility or otherwise extend coverage under the SoNM Plan.
- **Dual coverage is not allowed**. More than one employee participating in the Plan cannot cover an eligible dependent. If a dependent is also an employee of the State, the dependent cannot be covered under his or her own coverage and as a dependent under another state employee.

Dependents' benefits coverage cannot begin until the required Proof of Dependency/ Supporting Documentation (see "Enrollment Documentation Requirements" section of this guide) is faxed to EASI GOV at 505-244-6009 or scanned and emailed to **sonm@easitpa.com**. The employee must fax or email documents at the same time the enrollment/change form is submitted to EASI GOV. If an employee can 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.

If the required documents are not received within the 31 days, the dependent(s) will not be enrolled.

Effective Dates:

STATE EMPLOYEES

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

Agency paid basic life coverage is effective from the date of hire. Supplemental life elected under the guarantied issue will go into effect at the beginning of the third pay period. Coverage elected over the guarantied issue is subject to evidence of insurability (EOI) before approval by the carrier.

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

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 at: Enrollment Information | Group Benefits Plan

LPB EMPLOYEES

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 coverage is the first day of the month following date of enrollment. Timeline for LPB employees to submit their benefit enrollment forms and proof of dependency/supporting documentation to LPB HR Representative:

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 EASI GOV at time of enrollment. EASI GOV fax number is 505-244-6009. **Note:** Some LPBs do not allow exceptions. LPB employees must check with their HR Representative for effective date timelines.

LEGISLATORS

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

New Legislators: within 31 days of being sworn into office
Qualifying events: within 31 days of the date of the qualifying event

OPEN ENROLLMENT AND QUALIFYING EVENT ENROLLMENT

Open/Switch Enrollment is offered on an annual basis and held during the fall season. The effective date of changing made to coverage is the first day of the following year.

The table below shows the **EFFECTIVE DATES USED FOR** Enrollment and Qualifying Events:

Enrollment and Qualifying Event	Effective Date
Birth, adoption, legal guardianship, marriage.	Date is the day the event occurs
Domestic Partnership Affidavits	Date it is notarized
Divorce, Termination of domestic partnership	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 another 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
For eligible dependents enrolled at the same time as the employee, coverage becomes.	Date the employee's coverage becomes effective.
Temporary to Permanent	Benefits will remain continuous, with no interruption.

The requested election change must be consistent with the change-in-status event. For example, if an employee gets divorced, the employee's election under the cafeteria plan to cancel health coverage for any individual other than his or her spouse involved in the divorce would fail to correspond with that change-in-status event.

For benefit-eligible employees transitioning from a Temporary to Permanent position, benefits will remain continuous, with no interruption.

Court Orders, Mandates, and all other unforeseen events will be reviewed by HCA on a case-by-case basis, with an effective date determined upon review.

Loss of a provider or provider group is not considered a Qualifying Event to change carriers. Any other circumstance where the individual had other coverage and loses it due to circumstances beyond their control must be evaluated by HCA for eligibility.

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 EASI GOV 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.

ENROLLMENT

STATE EMPLOYEES

To enroll in benefits, State employees must go to:

Employee Resources | Group Benefits Plan Choose "State Employee," pick from your desired enrollment option (New Hire, Qualifying Event, Active Enrollment), and complete online enrollment form. (Click here to go directly to enrollment form). Once enrollment form is complete, click "Submit". EASI GOV will

record enrollment and enter into SHARE, this will begin employee's premium payroll deductions. Employees who wish to enroll dependents must submit Proof of Dependency, as well as all required supporting documentation. All required documents must be faxed to EASI GOV at **505-244-6009** or scanned and emailed to **sonm@easitpa.com** at time of enrollment. Failure to do so will result in no coverage for dependents. (Please see Enrollment Documentation Requirements section)

LPB EMPLOYEES

To enroll in benefits, LPB employees must go to:

Employee Resources | Group Benefits Plan Choose "LPB Employee," pick from your desired enrollment option (New Hire, Qualifying Event, Active Enrollment). Online Enrollment/Change Form must be completed for enrollment (exception: NMSU employees who must complete form specific to NMSU). Complete online form(s), print (form cannot be saved), sign and submit to HR Representative, along with all required documentation (marriage certificate/domestic partner affidavit, birth certificates and/or legal adoption/guardianship/Foster placement papers, etc.). HR Representative from participating Local Public Bodies should keep originals and either fax or mail these enrollment forms to EASI GOV. New hires' enrollment/change forms and supporting documentation must be submitted to EASI GOV at: 505-244-6009 or scanned and emailed to: sonm@easitpa.com 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 EASI GOV PRIOR to the Open/Switch Enrollment Period.

LEGISLATORS

To enroll in benefits, Legislators must go to: https://www.mybenefitsnm.com/employee-new-hire-lpb.html New Hire LPB | SoNM Group Benefits Plan. Click on "Getting Started as a Legislator." In left margin click on Legislators, Local public Bodies.

Enrollment/Change Form must be completed for enrollment. Complete and print form (will not be saved), sign, and then fax to EASI GOV at: **505-244-6009**, or scan and email to: **sonm@easitpa.com**, along with all required documentation (marriage certificate/domestic partner affidavit, birth certificates and/or legal adoption/guardianship/Foster placement papers, etc.). Legislators are eligible to participate in the SoNM Group Benefits Plan and Employee Assistance Program (EAP), but not eligible for the Disability and FSA including Transit and Parking. Legislators are responsible for paying 100% of all benefit premiums.

ELECTED OFFICIALS:

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.

Employee Assistance Program (EAP):

STATE EMPLOYEES:

All eligible State employees, their dependents, and household members are eligible to participate in the Employee Assistance Program (EAP). No enrollment is necessary, and employees do not pay a premium for the EAP benefit.

LPB EMPLOYEES:

LPB employees must contact their HR Representative to see if their employer participates in the EAP benefit.

Basic Life Insurance

STATE EMPLOYEES:

All State employees who are eligible for benefits are automatically enrolled in basic life coverage. The SoNM pays 100% of the basic life premium.

LPB EMPLOYEES:

LPBs that offer life coverage through the State's Plan will pay 100% of Basic Life premiums for their benefit-eligible employees. Employees must contact their HR Representative to see if their employer participates in Life coverage under the SoNM.

(**LPB employees 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). 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.

Supplemental Life

PROCEDURE FOR OBTAINING ADDITIONAL (SUPPLEMENTAL) LIFE COVERAGE FOR BOTH STATE & PARTICIPATING LPB EMPLOYEE

Click here for Supplemental Life Insurance Plan

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. Employees are responsible for 100% of the premiums for Additional (Supplemental) Life and Dependent Life coverage through payroll deduction.

To elect coverage/additional supplemental coverage, go to https://www.mybenefitsnm.com/enrollmentInformation.html. Once submitted, EASI GOV will notify the carrier of the employee's request. The carrier will then contact the employee via the email address provided to request any additional information/documentation (coverage above the Guaranteed Issue (GI) will require an EOI (Evidence of Insurability)). After evaluation, the carrier will notify the employee of approval or denial. If you have not been contacted by the carrier within two weeks of your submission, please contact EASI GOV.

Supplemental Amount of Life Insurance

Class 1 (Active Legislators):

Guaranteed Issue (GI) Amount	Maximum Amount (any elected amount above the GI)

The amount elected in increments of $10,000, subject to a maximum of $150,000 and minimum of $10,000.	The amount elected in increments of $10,000, subject to a maximum of $400,000 and a minimum of $10,000.

Class 2 – 5 (Benefit-eligible SoNM and LPB Employees):

Guaranteed Issue Amount	**Maximum Amount (any elected amount above the GI)**
The amount elected in increments of $10,000, subject to a maximum of $150,000 and minimum of $10,000.	The amount elected in increments of $10,000, subject to a maximum of $500,000 and a minimum of $10,000.

Dependent Life Insurance Benefit

Amount of Dependent Life Insurance

Spouse/Domestic Partner:

Guaranteed Issue Amount	**Maximum Amount (any elected amount above the GI)**
The amount elected in increments of $10,000, subject to a maximum of $30,000 and minimum of $10,000.	The amount elected in increments of $10,000, subject to a maximum of $250,000 and a minimum of $10,000.

Evidence of Insurability (EOI) requirement

A Medical History Statement is required for: A spouse/domestic partner enrolling outside of a new hire/new marriage/new Affidavit of Domestic Partnership.

Maximum Amount: The amount elected in increments of $5,000, subject to a maximum of $15,000 and a minimum of $5,000.

Dependent Life coverage for child(ren) will become effective on the first day of the pay period following date of submission. Coverage for dependent children does not require Evidence of Insurability (EOI).

Note: employees must be active/at work (not on leave of any kind) in order to be eligible to elect Additional Employee Life or Spouse/Domestic Partner Life coverage, with the exception of Family Medical Leave (FML). Dependent (spouse/child(ren)/domestic partner) coverage may be elected if dependent is ill (confined at home or in a hospital/care facility); however, benefits will have a deferred effective date and will not take effect until dependent is well and performing normal daily activities.

For any questions or guidance needed, please contact the plan administrator:

EASI Gov, Inc.
1200 San Pedro Dr. NE Albuquerque, NM 87110
Customer Service Center 855-618-1800

Options for enrollment and other documents may be found at the Term Life website:
https://www.mybenefitsnm.com/TermLife.html

Contact EASI GOV at 505.244.6000 for any assistance needed in completing Evidence of Insurability, Insurability, or managing beneficiary designations. For assistance with Portability and Conversion, contact The Hartford at 877-320-0484.

PROCEDURE FOR OBTAINING ADDITIONAL (SUPPLEMENTAL) LIFE COVERAGE FOR BOTH STATE & PARTICIPATING LPB EMPLOYEE

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. Employees are responsible for 100% of the premiums for Additional (Supplemental) Life and Dependent Life coverage through payroll deduction.

To elect coverage/additional supplemental coverage, go to Enrollment Information | Group Benefits Plan. Once submitted, EASI GOV will notify the carrier of the employee's request. The carrier will then contact the employee via the email address provided to request any additional information/documentation (coverage above the Guaranteed Issue (GI) will require EOI (Evidence of Insurability)). After evaluation, the carrier will notify the employee of approval.

The Hartford will generate an email notification if an email address is available. The email will come from medical.uw@thehartford.com

Please check your Junk Email folder if you do not see anything in your In Email folder within five (5) to ten (10) business days.

If an email address is not provided, a paper notification will be mailed to a member via USPS with instructions for the URL to submit EOI.

Employees will have 60 days to submit EOI.

Within the 60 days employees will receive 2 reminders:

1st at 21 days, and

2nd at 45 days.

Reminders will only be generated when employees do not submit EOI within 60 days or start and do not complete the process.

Once EOI is submitted, if a decision can be rendered, a letter is automatically generated to be mailed to the employee.

If additional information is required by medical underwriting before a final decision can be reached:

An initial request is mailed to the employee.

A follow-up letter is mailed to the employee at 21 days.

If the requested information is not received within 60 days, the file is closed at The Hartford.

Please note, the enrollee can re-open the Incomplete file within 60 days after they received the "Closed-Incomplete" letter.

The standard turnaround time for processing mail received is five business days.

***Please note this may be extended by up to 10 business days during our Peak business season (November through April).**

STARTING PAYROLL DEDUCTIONS

As soon as an employee has enrolled and the effective date of coverage has been determined, EASI GOV will process the enrollment to begin appropriate payroll deductions for the correct pay period. LPB employees must refer to their specific Employee Pay Period Calendar for appropriate pay period deduction dates as procedures may vary with LPB's.

Each year, HCA 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, every pay period, to ensure that all benefit deductions are being taken correctly.

State employees:

EASI GOV ensures accurate entry of employee elections into PeopleSoft SHARE to initiate correct payroll deductions.

LPB employees:

LPB HR Representative should follow their own guidelines to initiate payroll deductions.

The Flexible Spending Account (FSA)

STATE EMPLOYEES

FSA is offered annually. Pledge deductions begin with the first pay period in January. Employees pay 100% of the pledged amount for this option.

LPB EMPLOYEES:

LPB employees should check with their respective HR Representative to determine if their own LPB offers FSA.

NOTE:

State Employees

For any enrollment/changes to Medical, Dental, Vision, and Disability coverage due to a Qualifying Event (which must be within 31 days of the QE date), payroll deductions must begin at the start of the pay cycle in which the Qualifying Event occurred. The effective date of the change is the actual date of the qualifying event; however, the premiums will be 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: Employees who drop disability and then start coverage again later, in order 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 EASI GOV to obtain participants premium payment start dates.

DROPPING BENEFIT COVERAGES

When an employee cancels medical/dental/vision coverage, re-enrollment cannot occur until the next open/switch enrollment event, or a Qualifying Event occurs. Since Disability and Supplemental/Dependent Life premiums are post-tax, employees can change these coverages at any time.

IMPORTANT: An employee is required to pay premiums for 12 consecutive months before they become eligible for Disability benefits. If an employee enrolls in Dependent (Spouse/Domestic Partner) and/or Supplemental Life later, it will require completing the Evidence of Insurability process.

REMOVING DEPENDENTS

Employees must notify EASI GOV when dependents' eligibility ends due to one of the following circumstances:

- Spouse and employee divorce.
- Dependent marries.
- Dependent is under age 26 and chooses to elect coverage elsewhere.
- Dependent fails to meet eligibility guidelines.

The dependent must be waived from benefits.

NOTE: Spouse/domestic partner/child(ren) MUST NEVER BE DELETED from the system.

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

Coverage for a spouse becoming non-eligible due to divorce; coverage must be terminated on the same date as the Divorce Decree.

Domestic Partners will be terminated from coverage on the date of termination of domestic partnership.

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.

If the ineligible dependent is the employee's last or only dependent, EASI GOV 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.

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.

TRANSFERS

State Employees: State employees who transfer from one State agency to another, or to a covered LPB, with no break from employment, may transfer their employee benefits coverage without the waiting period required of new employees. Benefits will remain unchanged, be effective the first day of employment at the new agency and have no break in coverage. Temporary employees who have benefit coverage through SoNM, who then transition to full-time employees are allowed to keep their current benefits without a lapse in coverage.

Local Public Bodies (LPB): LPB employees must check with their agency and HR Representative to clarify hiring requirements and their specified mandatory waiting period. Coverage for transferring employees will remain unchanged as employees cannot add or delete coverage(s) at the time of transfer. If the employee chooses to add a benefit, he or she will then be treated as a New Hire and must adhere to the appropriate eligibility waiting periods. It is recommended that employees transfer only at the beginning of a pay period as premiums cannot be prorated.

NOTE: If an employee experiences a break in service (as little as one day), and is then rehired, then the employee is considered a New Hire. Reinstatements are only considered with a court order and must be reviewed for approval. Temporary employees who have benefit coverage through the SoNM and then transition to full-time employees are allowed to keep their current benefits without a lapse in coverage.

TERMINATION OF EMPLOYMENT

Following are the steps to follow when a STATE employees terminate employment:

1. Terminated employee's HR Representative updates the terminated employees' personnel files and enters the date of termination in the SHARE job data module.
2. HR Representative immediately notify EASI GOV of the termination by faxing a COBRA Notice of Termination form to EASI GOV at 505-244-6009. EASI GOV will then mail a COBRA information packet to the employee or dependent(s). Federal Law requires that the COBRA information packet be sent by EASI GOV within 14 days of receipt of notice of the qualifying event, so it is imperative that the HR Representative notify EASI GOV immediately with any termination/retirement notices.
3. Benefit coverage and premium deductions are automatically stopped in SHARE upon entering the termination in job data module of SHARE. 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.**
4. Agency HR Representatives must submit the Notification to Terminate Benefits Due to Non-Payment to EASI GOV for the following reasons of terminations:
    a. Benefits termination due to non-payment of premiums
    b. The premiums were not paid via self-pay or payroll deduction on time
    c. Benefit termination date is earlier than job termination date
    d. Employees were terminated after the start of a new payroll period and the termination of benefit is earlier than the termination date in Job Data (SHARE)

Life Coverage After Termination of Employment

Employee Life coverage ends on the earliest of the following:

- the last day of the month following the date The Policy Terminates; the last day of the month following the date employee is no longer in a class eligible for coverage, or the Policy no longer insures employees' class.
- the last day of the month following the date the premium payment is due but not paid.
- the last day of the month following the date Employer terminates employment; or
- the last day of the month following the date employee is no longer Actively at Work, unless continued in accordance with any one of the Continuation Provisions.

Coverage for employee dependents will end on the earliest of the following:

- the last day of the month following the date Employee coverage ends.
- the last day of the month following the date the required premium is due but not paid.
- the last day of the month following the date Employee is no longer eligible for dependent coverage.
- the last day of the month following the date Carrier or employer terminate Dependent coverage; or
- the last day of the month following the date Dependent no longer meets the definition of Dependent, unless continued in accordance with the Continuation Provisions.

5. Life Insurance carrier(s) are notified of the employee's termination and/or dependents' loss of coverage via the weekly eligibility file.

6. Insurance: Employee's HR Representative should direct the employee to the Life Insurance 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, if they desire. Portability of Insurance is also an option under the plan. For more information click here. Please refer to the Certificate of Insurance for eligibility requirements for Conversion or Portability. For Portability and Conversion form, please contact EASI GOV at 505.244.6000.

7. Any termination with a retroactive date must be coordinated through the State Health Benefits to ensure data accuracy and compliance with COBRA and the Patient Protection and Affordable Care Act (PPACA) requirements. (See Deductions Not Taken section of this guide)

MILITARY LEAVE

Upon submission of Military Activation Orders to Human Resources, the employee's Agency HR Representative must immediately notify **EASI GOV by Fax at 505-244-6009 or Email: sonm@easitpa.com.**

When an employee enters full-time active military service, the federal government provides all benefits (medical, dental, vision) for the employee and their dependents. Employees have the right to elect to continue their existing employer-based health plan coverage for the employee and their dependents for up to 24 months while in the military.

If the employee does not wish to continue coverage while on active duty, the employee must fill out an enrollment form under the Employee Benefits Website: https://www.mybenefitsnm.com and waive coverage. The employee's HR Representative must enter a job status change of Leave of Absence/Military Leave (LOA/MIL) in order to stop all benefit coverage and premiums from being required.

NOTE: Do not use this code for National Guard 2- week summer training.

Should employees wish to keep their current coverage for themselves and covered dependents while on leave, then employees will continue paying the benefit premiums, both the state portion of the premium as well as their own portions of the premiums, throughout the duration of leave up to 24 months. Employees must plan and arrange with their Agency HR Representative to continue Self-payment of full premiums (both state and employee portions of the premiums).

NOTE: Employee premiums must remain current, if not coverage will terminate.

If the military service is for 30 or fewer days, the employee is not required to pay more than the normal employee share of any premium.

See the "Resource" section of this guide for more information.

LPB EMPLOYEES

LPB HR Representative must fax copies of Military Activation Orders **to EASI GOV at 505-244-6009** to deactivate employees' and their dependents' benefits. An enrollment/change form must accompany the active order when faxed to EASI GOV.

STATE and LPB EMPLOYEES

Upon timely return from military duty per the rules set forth in the 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.

SELF-PAY PREMIUM

STATE EMPLOYEES:

Active employees who would otherwise lose eligibility for coverage under the SoNM Group Benefits plan, may continue coverage by paying the full premium in three circumstances. The Anti-Donations Act precludes the SoNM from contributing toward these employees' premiums, except in instances of FMLA.

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

1. **An employee is on LWOP, without FMLA coverage, and has no leave time to cover premiums,**
2. **An employee exhausts all FMLA total hours and has no leave time to cover premiums, or**
3. **An employee is under Workers' Compensation coverage and has no leave time to cover premiums.**

NOTE: Payments must remain current, or coverage can be terminated. ***Employee's Agency or LPB HR Representative will send at least three (3) notification letters to an employee at his or her address on file for non-payment of benefit premiums before coverage is terminated.***

LEAVE WITHOUT PAY (LWOP):

STATE EMPLOYEES on Leave without Pay have the option to:

- Change their benefits since LWOP is considered a Qualifying Event due to job status change (must be within 31 days of starting LWOP), or

- Continuing all coverage with the knowledge they will be required to pay their portion, as well as the State's premium amounts, by the end of each pay period to keep benefits in effect.

NOTE: Employees on LWOP are required to pay both their own and the State's premium amounts.

Employees will receive notification from their Agency HR Representative, 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 and LPB HR Representative must immediately issue required letters and documents found in the Forms section of this document. The State and LPB HR Representative is responsible for preparing invoices, collecting payments due, and submitting such payments to the Health Care Authority's Finance Bureau within five (5) days of the end of each pay period. The State and LPB HR Representative is responsible for maintaining accurate tracking of payments in the employee's personnel file, including copies of employee's payments. If payment is not received three (3) days before the end of the pay period, the State and LPB HR Representative shall notify the employee that failure to pay will result in termination of benefits. In the event an employee fails to make the required payment by the end of the pay period, the State and LPB HR Representative shall immediately notify EASI GOV and the appropriate coding in job data will be completed to terminate benefits. State and LPB HR Representative must also immediately send EASI GOV a **COBRA Notification Form** so that EASI GOV can send the employee the required COBRA information packet.

If state employees on LWOP have 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 undergo a valid Qualifying Event to enroll and start their benefits again.

Upon an employee's return to work, the State and LPB HR Representative is responsible for changing the appropriate coding in the SHARE job data module to reflect, "Return from leave."

Flexible Spending Account (FSA): If an employee is enrolled in a Flexible Spending Account, the employee has three options:

1. Continue pledged payment amounts to his or her FSA through employee's State or LPB HR Representative (HR Representative must add this to premium invoices).
2. 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).
3. 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 EASI GOV of the LWOP status. Call the FSA Program Administrator for more details at (855) 618-1800 (EASI Gov, Inc.).

FAMILY MEDICAL LEAVE ACT (FMLA) (UNPAID):

STATE EMPLOYEES:

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 employees, 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.

Eligible employees must have worked for at least 1,250 hours of service during the 12-month period immediately preceding the commencement of the leave.

FMLA allows a 30-day grace period to submit premiums. It is the responsibility of the employee's Agency or LPB HR Representative to track and ensure premiums are being paid, keeping copies of employees' payments. If the employees' payments are not received timely, the employee's Agency or LPB HR Representative must send a 15-day Notice of Cancellation of coverage to the employee prior to terminating coverage. If payment has not been received after 7 days of sending the Notice of Cancellation, the employee's Agency or LPB HR Representative must immediately notify EASI GOV by way of the Notification to Terminate Benefits Due to Non-Payment Form in order to cancel coverage and be effective on the last date premiums were paid in full. The employee's Agency or LPB HR Representative must include the Notice of Cancellation and all other supporting documentation with the Notification to Terminate Benefits Due to Non-Payment Form.

When an employee is on FMLA, payroll is active, and employee's unused leave balances will be used to generate a paycheck. If the employee has enough leave in their balances to generate a paycheck, employee's deductions will occur as normal. If the employee does not have enough money in their bi-weekly pay to cover the benefit deductions for that pay period, then the employee must pay the premiums owed. If the employee fails to pay these premiums, then his or her coverage will be terminated. The employee's agency HR Representative must immediately issue required letters and documents found in the "Forms" section of this guide if an employee on FMLA begins paying their own premiums.

In the event an employee fails to make the required payment by the due date, the state agency HR Representative shall immediately enter the appropriate coding in the SHARE job data module to terminate benefits. HR Representative must also immediately notify EASI GOV, who will send the employee the required COBRA information packet.

Upon an employee's request, health coverage will be reinstated with no new waiting period once an employee returns to work. The agency HR Representative is responsible for changing the appropriate coding in the SHARE job data module. For Life coverage(s), as long as if the employee returns to work within a 12-month period, all coverages may be reinstated without an EOI for employee or Spouse/Domestic Partner.

LPB EMPLOYEES

LPB employees who don't have enough leave time to cover benefit premiums must self-pay their own premiums. These self-pay premiums must be given directly to their LPB HR/Payroll Dept. The LPBs pay monthly invoices that include all LPB employees (i.e., active, FMLA, LWOP, Disability), which is why LPB self-pay employees give their premiums directly to their employer. LPB employees should work with their LPB HR Representatives to handle self-pay situations.

LEGISLATORS:

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

DEDUCTIONS NOT TAKEN PROCESS

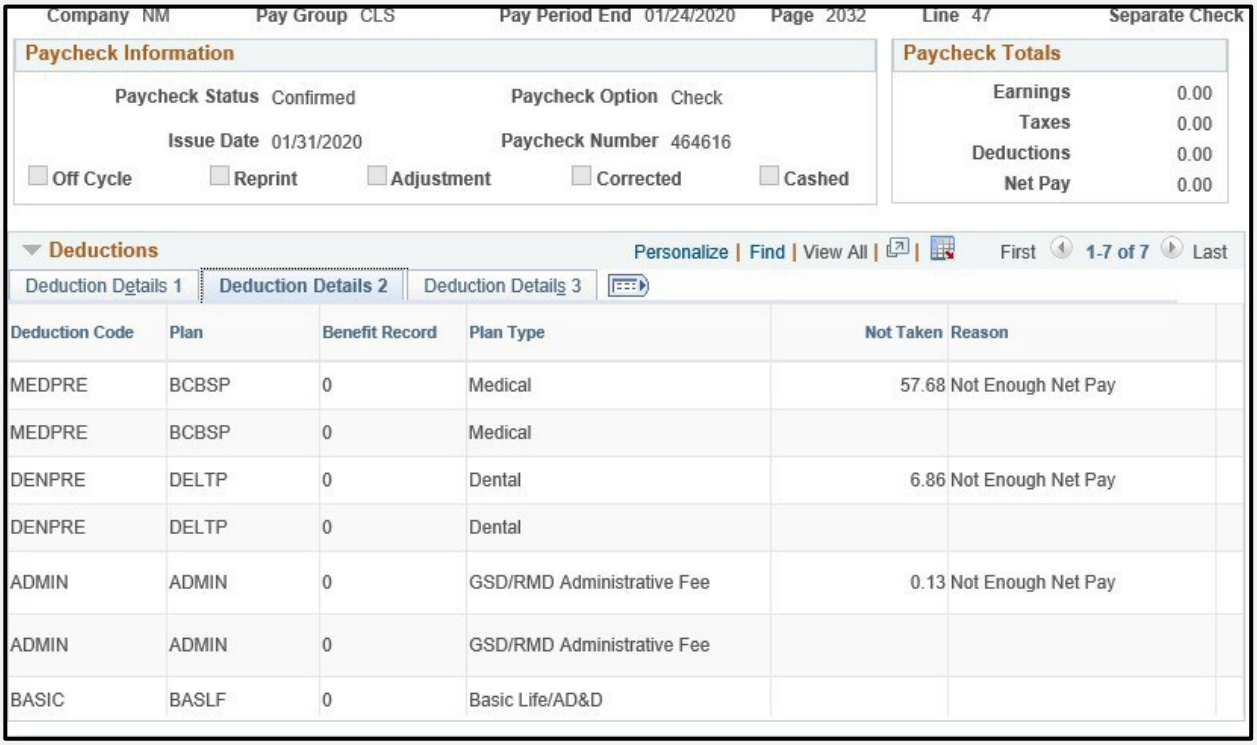
Payroll deduction: If premiums were not deducted from a state employee's payroll, the Agency HR Representative shall follow these steps:

The example below shows where you can find the deductions that were not taken:

a. Agency HR Representatives should review paychecks to determine the correct benefit termination date. The termination date is based on the last pay period ending of which the premiums were collected from employee via payroll deduction. The example below shows on pay period ending (PPE) 01/10/2020, all premiums were taken. This date will be used to determine the benefit termination date.

Agency HR Representatives should use the day after the PPE, which in this example would be 01/11/2021, when completing the Notification to Term Benefits form.

b. Submit a one-time deduction request for the amounts not taken.



Company NM Pay Group CLS Pay Period End 01/24/2020 Page 2032 Line 47 Separate Check

Paycheck Information

Paycheck Status Confirmed Paycheck Option Check

Issue Date 01/31/2020 Paycheck Number 464616

☐ Off Cycle ☐ Reprint ☐ Adjustment ☐ Corrected ☐ Cashed

Paycheck Totals

Earnings	0.00
Taxes	0.00
Deductions	0.00
Net Pay	0.00

Deductions Personalize | Find | View All | First 1-7 of 7 Last

Deduction Details 1 | Deduction Details 2 | Deduction Details 3

Deduction Code	Plan	Benefit Record	Plan Type	Not Taken	Reason
MEDPRE	BCBSP	0	Medical	57.68	Not Enough Net Pay
MEDPRE	BCBSP	0	Medical		
DENPRE	DELTP	0	Dental	6.86	Not Enough Net Pay
DENPRE	DELTP	0	Dental		
ADMIN	ADMIN	0	GSD/RMD Administrative Fee	0.13	Not Enough Net Pay
ADMIN	ADMIN	0	GSD/RMD Administrative Fee		
BASIC	BASLF	0	Basic Life/AD&D		

HR Representative can also run the following query in SHARE: NMS_BN_DEDUCTIONS_NOT_TAKEN, which will show all deductions that have not been taken for employee(s) for a specific agency and pay period. HR departments should run the query on Monday after payroll week.

Reasons for Terminations

1. Benefits termination due to non-payment of premiums
2. The premiums were not paid via self-pay or payroll deduction on time
3. Benefit termination date is earlier than job termination date
4. Employees were terminated after the start of a new payroll period and the termination of benefit is earlier then the termination date in the SHARE Job Data.

HR Representative should submit by email the completed Notification to Terminate Benefits Due to Non-Payment Form and all supporting documentation (emails exchanges between HR office and employee attempting to collect the premiums), to EASI GOV; with a copy to SHB (contact information shown below). Once received, EASI GOV will terminate benefits in SHARE and notify carriers of termination date. The Notification to Terminate Benefits due to Non-Payment: https://www.mybenefitsnm.com//Documents/Notification-to-Term-Benefits.pdf

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

State Health Benefits
cc: hcashb@hca.nm.gov

RETIREMENT

LPB EMPLOYEES:

LPB employees should contact their HR Representative when they are retiring. LPB HR Representative must immediately notify EASI GOV of all employee retirements to ensure accurate billing.

STATE EMPLOYEES:

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). Employees should arrange for coverage through RHCA three (3) months prior to retirement. Even if it is known that employees will pick up coverage through Retiree Health Care Authority, Agency HR Representative's must still notify EASI GOV COBRA Unit that the employee no longer has medical, dental, and vision coverage as a state employee.

Retiree Health Care Authority (RHCA)

Medical coverage under RHCA will always be effective on the first 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 of this guide for more details).

Upon retirement, employees are eligible for life coverage under RHCA. Retirees may be eligible to convert to an individual policy of comparable coverage. (For further information, please see RHCA's Summary of Benefits at: RHCA Retiree Summary of Benefits (www.nmrhca.org).

HR Representative should provide retiring employees 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

REFUNDS

Refunds may be issued to state employees or LPBs when it has been found that overpayments of premiums have occurred.

STATE EMPLOYEES:

Agency HR Representatives should follow the steps below when submitting Refund Requests:

For current calendar year requests, please use the DFA (Department of Finance and Administration) refund request form, found under "Forms" at the bottom of the DFA webpage: http://www.nmdfa.state.nm.us/Central_Payroll_Bureau.aspx

- For refund requests of four (4) pay periods or less: submit the forms directly to Central Payroll
- For requests of five (5) pay periods or more: submit to HCA for review and approval. HCA will forward the request to DFA.
- For prior calendar year requests, please use the refund request forms found in the "Forms" section in this guide. There is a Memo for Agency Refund as well as a Memo for Employee Refund. One packet per Calendar Year is required.

LPB EMPLOYEES:

The State does not directly refund premiums to LPB employees. Adjustments are made on the monthly LPB billing from EASI GOV. Each LPB employee should consult his or her HR Representative for refund processes. LPB HR Representative must communicate closely with EASI GOV regarding refunds and adjustments to monthly premium invoices.

LEGISLATORS & COBRA PARTICIPANTS:

Call EASI GOV at 505-244-6000 or 1-855-618-1800 to discuss any refund issues/questions.

FORMS:

EMPLOYEE REFUND: PRIOR CALENDAR YEAR REQUEST FOR REFUND FORM

AGENCY REFUND: PRIOR CALENDAR YEAR REQUEST FOR REFUND FORM

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 for which the refund pertains. If the refund pertains to more than one pay period, agency HR Representatives should include an excel spreadsheet detailing each pay period, the premium that was withheld, and the amount that should have been withheld.

An example of the spreadsheet detailing the information that the agency HR Representative should submit to SHB is below:

Spreadsheet Example:

	Employee				Agency		
PPE Date	Premium Paid	Premium Should Have Paid	Difference		Premium Paid	Premium Should Have Paid	Difference

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 by the agency HR Representative. 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.

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

DISABILITY

The State of New Mexico Disability Policy is a self-insured plan, which was created to provide financial assistance to employees that are unable to work for a period of time and lose income due to a sickness or injury (if not receiving Workers' Compensation). Disability benefits are provided in accordance with the provisions of the State of New Mexico Self-Insured Program. Eligible employees must have paid disability premiums for at least 12 consecutive months prior to claiming disability. Disability premiums are paid 100% by employees after-tax.

This Disability Plan is not available to dependents and participation in this Plan is voluntary.

For claim forms and more details about the plan, please see the separate Disability Policy found on https://www.mybenefitsnm.com/Disability.html.

The State's Third Third-Party Disability Administrator, EASI GOV, manages the Disability program. All applications, forms, medical updates, inquiries, etc. should be sent directly to EASI GOV at:

EASI Gov, Inc.
1200 San Pedro DR NE Albuquerque, NM 87110
Fax: (505) 705 – 3311
Ph. 1-855-618-1800 (press 1)

An eligible employee must be employed and work with his or 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 is 60% of weekly wages up to $500 per week, for a maximum of 24 weeks after a 28-day waiting/elimination period. Once the waiting/elimination period is completed, Short Term Disability benefits are paid weekly.

Long Term Disability is 18 months maximum or until approved for social security or retirement and is 40% of wages up to $2,000/month paid monthly via direct deposit. It is one month in arrears (i.e., June's payment is for the month of May).

Employees must continue to make the required premium contributions while on Short Term Disability to continue eligibility. HR Representative must remain in close contact with EASI GOV 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 remaining.

It is the employee's responsibility to ensure all required forms and documentation are faxed directly to EASI GOV. EASI GOV will send an email or letter to the individual who signed the Employer form notifying the employee and HR Representative that the claim has been accepted, denied or is pending for additional information.

The HR Representative must remain in close contact with EASI GOV 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 for any overpayment received.

Benefit Payments

Example 1:

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

Example 2:

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

Premium Statements for Local Public Bodies (LPBs)

Monthly premium statements, also known as invoices, for all LPBs will be prepared by EASI GOV and sent electronically by the Administrative Services Division (ASD) of the New Mexico State Health Care Authority. These invoices are generated through Sun Systems.

When submitting monthly premium payments, based on the Sun Systems-generated invoices, each LPB must submit two 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. LPBs must submit the invoice it received from ASD along with the remittance check(s).

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

EASI GOV, 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 EASI GOV, the requested audit information within fourteen days of the date LPBs received EASI GOV requests.

APPEALS/GRIEVANCE CARRIER INFORMATION

In the event an employee grievance regarding a decision made by one of the SoNM medical, dental, and vision carriers for which employee has been paying premiums (for example: if carrier denied, reduced, or terminated a requested healthcare service on the grounds it was either not a covered benefit or it was not medically necessary), the grievance will be subject to the Utilization Management Review procedure. Employees may submit grievances to the specific carrier in writing. In the event an employee wishes to speak to the insurance carrier directly, each carrier has a Customer Service Center that will assist in completing the required forms. Please be advised that carriers shall not take any retaliatory action against an employee or any employee's dependent for filing a complaint.

Employee or covered dependents may request a copy and detailed written explanation of the grievance procedures by calling the particular medical, dental, or vision carrier. Members have 180 days from the date of the initial denial to file an appeal with the carrier.

Adverse Determination Appeal Review Procedures

Employees should refer to the respective medical/health carriers' Summary Plan Description book under Member's Rights, Appeals, and Grievances for carrier contact information. Each medical/ health carriers SPDs can be found in the "Resource" section of this guide.

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 SoNM, Health Care Authority. Upon receipt of the formal complaint, the Health Care Authority will review the case and respond to the parties involved within 30 days. If the formal complaint is due to an emergency, a response will be given within 48 hours of receipt of such a formal complaint.

Contact Health Care Authority at:

Health Care Authority
State Health Benefits
1474 Rodeo Rd.
Santa Fe, NM 87505

First appeal: Call the carrier directly.

Second appeal: Carrier medical panel.

Third appeal: Contact HCA/SHB director at JoLou.Trujillo-Ottino@hca.nm.gov

COBRA

Employers that have 20 or more employees and offer health coverage to those employees must 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.

Basics of Cobra Compliance

Agency HR Representatives 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.

Each time a qualifying event occurs, ESI GOV 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.

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

Human resources

> Provide employees with COBRA rights information, as well as HIPAA Privacy notices (found at the end of the Forms section in this Administrative Guide). Ask employees to read/sign HIPAA notice and keep the signed original in respective employee's personnel file (only required at time of hire).

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

- Notifies qualified beneficiaries about their rights to continue coverage.
- Calculates premium billings and notifies the Administrative Services Division of the New Mexico State Health Care Authority. ASD sends 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.
- Monitors the expiration date of coverage and terminates 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.
- Responds to questions from participating employees or dependents about the status of their coverage.

Overview of COBRA Election Procedures

Once EASI GOV 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.

Once the participant decides to enroll in COBRA, employees should send their completed application directly to EASI GOV. The application is reviewed for completeness and then enrolled into the billing system (24-48-hour turnaround).

EASI GOV will produce an invoice 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.

Participants will receive COBRA monthly invoices from the Administrative Services Division of the New Mexico State Health Care Authority. It is the participant's responsibility to pay by the due date each month and follow the established billing process. Failure to pay premiums will result in cancellation of COBRA coverage.

COBRA participants should send any changes, such as request to end COBRA, address or coverage changes, in writing, or by way of fax to EASI GOV; these change requests are processed by EASI GOV COBRA Unit.

If an employee had continued coverage under COBRA during the period between the time, he or she terminated employment and the time he or she is subsequently rehired, employee must immediately notify EASI GOV COBRA unit of employee's COBRA termination date.

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:

- **Termination** (other than for gross misconduct) of the employee's employment for any reason such as layoff, resignation, retirement, etc.
- **Reduction of hours worked by an employee**
- **Survivors upon death of the employee**
- **Divorce or legal separation**
- **Dependent child ceasing to meet eligibility requirements**
- **COBRA participant obtains other health care 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.

Health Care Authority'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 COBRA continuation coverage for which an employee or dependent is entitled as a qualified beneficiary.

QUALIFIED EVENT	QUALIFIED BENEFICIARIES	MAXIMUM PERIOD OF CONTINUATION COVEAGE
Termination (for reasons other than gross misconduct) or reduction in hours of employment	Employee Spouse Dependent Child	18 consecutive months
Employee enrollment in Medicare	Spouse Dependent Child	36 consecutive months
Divorce or legal separation	Spouse Dependent Child	36 consecutive months
Death of employee	Spouse Dependent Child	36 consecutive months
Loss of "dependent child" status under the plan	Dependent Child	36 consecutive months

HOW TO COMPLETE THE COBRA NOTIFICATION FORM

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

HR Representatives must submit the COBRA notification form to EASI GOV when one of their employees loses any benefit coverage due to a qualifying event. This includes life and disability benefits. The purpose of this form is to remove the employee/dependent from active benefits AND to alert EASI GOV COBRA Unit to issue the initial COBRA enrollment packet. If the information is not complete, EASI GOV will return the form to the HR Representative who sent the COBRA initiation notification.

HR Representatives must:

1. 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, and 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, and 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 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.

FORM LINKS:

1. Benefits Eligibility Acknowledgement 2025 V1.pdf **English (*MUST BE READ & SIGNED BY EMPLOYEE UPON HIRE)***
2. *Benefits Eligibility Acknowledgement 2025 Spanish V1.pdf* ***Spanish (MUST BE READ & SIGNED BY EMPLOYEE UPON HIRE)***
3. HIPAA Policies and Procedures 2024.PDF
4. COBRA FORM–NOTICE OF RIGHTS TO CONTINUE COVERAGE **(MUST BE READ & SIGNED BY EMPLOYEE UPON HIRE)**
5. AFFIDAVIT OF DOMESTIC PARTNERSHIP
6. DOMESTIC PARTNERSHIP: NOTICE OF TERMINATION
7. **PREMIUM ONLY PLAN (POP) WAIVER FORM (POP-SoNM-NOTICE-OF-WAIVER-2024.pdf) (POP-LPB-NOTICE-OF-WAIVER-2024.pdf)**
8. **FMLA & LWOP PREMIUM TRANSMITTAL FORM (FMLA and LWOP Premiums Dues | Group Benefits)(LPB)**
9. **MEMO: FIRST NOTICE TO EMPLOYEE (FMLA) (LWOP)**
10. **MEMO: SECOND NOTICE TO EMPLOYEE (FMLA) (LWOP)**
11. **MEMO: FINAL NOTICE TO EMPLOYEE (FMLA) (LWOP)**
12. **EMPLOYEE REFUND: PRIOR CALENDAR YEAR REQUEST FOR REFUND FORM**
13. **AGENCY REFUND: PRIOR CALENDAR YEAR REQUEST FOR REFUND FORM**
14. **Disabled Dependent Certification Forms: (Blue Cross Blue Shield) (Presbyterian) Delta Dental (Frm45)**

ENROLLMENT DOCUMENTATION REQUIREMENTS

All documentation must be submitted during New Hire Enrollment, Open/Switch Enrollment, or Qualifying Event within 31 days.

NOTE: if employees have previously provided documentation for dependents, then they do not need to submit documentation a second time. If employees are unsure if they have submitted the paperwork before, they may resubmit or contact EASI GOV at 1-855-618-1800 to confirm.

Adding a Domestic Partner:

Signed and notarized Domestic Partnership form (**Note:** must be 12 or more months since any prior identified domestic partnership or marriage).

Adding a Dependent Child:

- Birth Certificate
- Court Issued Guardianship/Kinship Papers
- Court Issued Custodial Papers (must not have expired)
- Adoption Papers

Adding a Domestic Partner's Children:

Birth Certificate or similar court-issued paperwork as described above identifying the domestic partner as the parent or legal guardian.

Adding a Newborn:

A newborn may be added within 31 days of the date of birth; proof of birth from the hospital may be submitted in place of a birth certificate, but the birth certificate must be submitted within 90 days of the date of birth.

Adding or Dropping Coverage Due to a Change in Other Coverage:

- Documentation from the other provider clearly showing the employee and/or the dependent(s) who is/are affected and who will be added or dropped as the covered participant; must include the effective date in which the other coverage started or ended.
- If the change is related to Medicaid, employee must submit the full letter of notice from Medicaid provider to EASI GOV.

Divorce or Separation:

A copy of the relevant pages showing the date of separation or divorce and the name of the ex-spouse. By Department of Labor rules, the notice of separation or divorce must be submitted within 30 days to EASI GOV as the ex-spouse is eligible for COBRA.

Dependent Turning 26:

Dependents turning 26 automatically drop at the end of their birthday month, no documentation is required.

Adult Disabled Dependents:

To receive plan coverage, an adult disabled dependent must have been on employee's coverage prior to turning 26; employee must complete a disabled dependent certification form and submit to his or her medical carrier for approval. Once the form has been approved by the employee's medical or life carrier, the

approval should be submitted to EASI GOV for processing. Forms may be found under the respective carrier listings at: https://www.mybenefitsnm.com/BenefitsInformation.html

GLOSSARY

Accidental Injury—A bodily injury caused solely by external, traumatic, and unforeseen means. Accidental Injury does not include disease or infection, hernia or cerebral vascular accident. Dental injury caused by chewing, biting, or malocclusion is not considered an Accidental Injury.

Acupuncture—The use of needles inserted into the human body for the prevention, cure, or correction of any disease, illness, injury, pain, or other condition.

Adjustment Factor—The percentage by which the Medicare allowable amount is multiplied in order to arrive at the "Non-Contracting Allowable Amount."

Administrative Services Agreement—A contract for Health Care Services which by its terms limits eligibility to members of a specified group.

Admission—The period of time between the dates when a patient enters a facility as an inpatient and is discharged as an inpatient.

Affidavit—a legal document that provides a written statement or declaration of facts.

Alcohol Abuse Treatment Facility, Alcohol Abuse Treatment Program—An appropriately licensed provider of medical detoxification and rehabilitation treatment for alcohol abuse.

Ambulance—A specially designed and equipped vehicle used only for transporting the sick and injured. It must have customary safety and lifesaving equipment such as first-aid supplies and oxygen equipment.

Appliance—A device used to provide a functional or therapeutic effect.

Benefit Booklet — This document or evidence of coverage issued to you along with your separately issued

Summary of Benefits explains the benefits, limitations, exclusions, terms, and conditions of your health coverage.

Blue Access for Members (BAM)—On-line programs and tools that BCBSNM offers its members to help track claims payments, make health care choices, and reduce health care costs.

Calendar Year—A Calendar Year (also known as a benefit period) is a period of one year that begins on January 1 and ends on December 31 of the same year (also referred to as Calendar Year).

Certified Nurse Practitioner—A Registered Nurse whose qualifications are endorsed by the Board of Nursing for expanded practice as a Certified Nurse Practitioner and whose name and pertinent information is entered on the list of Certified Nurse Practitioners maintained by the Board of Nursing.

Chemical Dependency—Conditions defined by patterns of usage that continue despite occupational, marital, or physical problems that are related to compulsive use of alcohol, drugs or other substance.

Chemotherapy—Drug therapy administered as treatment for malignant conditions and diseases of certain body systems.

Chiropractic Services—Any service or supply administered by a chiropractor acting within the scope of his/her licensure and according to the standards of chiropractic medicine in New Mexico or the state in which services are rendered.

Chiropractor—A person who is a Doctor of Chiropractic (D.C.) licensed by the appropriate governmental agency to practice Chiropractic medicine.

Claim—refers only to post-service bills for services already received and sent to carrier (or its designee) for benefit determination.

Claims Administrator—entity providing consulting services in connection with the operation of the benefit plan(s), including the processing and payment of claims and other such functions.

Classified service—means all positions in the executive branch of state government which are not exempt by law.

Clinical Psychologist—A person with a doctoral degree in clinical psychology licensed or certified in accordance with the New Mexico Professional Psychologist Act or similar statute in another state.

COBRA—generally requires that group health plans sponsored by employers with 20 or more employees in the prior year offer employees and their families the opportunity for a temporary extension of health coverage (called continuation coverage) in certain instances where coverage under the plan would otherwise end.

Coinsurance—A percentage of covered charges that members are required to pay for a covered service after the deductible has been met.

Contracted Provider — A Provider that has a contract the carrier(s).

Copayment—The fixed-dollar amount that a member must pay to a health care provider upfront in order to receive a specific service or benefit covered under the plan. Copays do not count toward deductible.

Cosmetic Surgery Services—Cosmetic Surgery Services are a beautification or aesthetic surgery to improve an individual's appearance by surgical alteration of physical characteristics.

Cost Effective—A procedure, service, or supply that is an economically efficient use of resources with respect to cost, relative to the benefits and harms associated with the procedure, service, or supply.

Covered Charge—The amount that carrier allows for covered services using a variety of pricing methods and based on generally accepted claim coding rules.

Non-Contracting Allowable Amount—The maximum amount, not to exceed billed charges, that will be allowed for a covered service received from a non-contracted provider in most cases.

Medicare Allowable—The amount allowed by CMS for Medicare-participating provider services.

Covered Services—Those services and other items for which benefits are available under the terms of the benefit plan of an eligible plan member.

Days—calendar days unless otherwise specified.

Deductible—The amount of covered charges that member must pay in a calendar year before plan begins to pay its share of covered charges incurred during the same benefit period.

Dental-Related Services—Services performed for treatment or conditions related to the teeth or structures supporting the teeth.

Dentist, Oral Surgeon—A Doctor of Dental Surgery (D.D.S.) or Doctor of Medical Dentistry (D.M.D.) who is licensed to practice prevention, diagnosis, and treatment of diseases, Accidental Injuries and malformation of the teeth, jaws, and mouth.

Diagnostic Services—Procedures such as laboratory and pathology tests, x-ray services, EKGs and EEGs that do not require the use of an operating or recovery room and that are ordered by a provider to determine a condition or disease.

Dialysis—The treatment of a kidney ailment during which impurities are mechanically removed from the body with Dialysis equipment.

Disability insurance—provides financial assistance to those who are not able to work for a period of time due to a non-work-related illness or injury. The premium is one hundred percent (100%) paid by the employee after-tax.

Doctor of Oriental Medicine—A person who is a Doctor of Oriental Medicine (D.O.M.) licensed by the appropriate governmental agency to practice Acupuncture and oriental medicine.

Domestic Partner—means two individual who share a common, primary residence for at least 12 consecutive months, sign an affidavit of domestic partnership, and meet all of the following criteria:

1.Both domestic partners must be unmarried.

2.Domestic partners must have been in a mutually exclusive relationship, intending to do so indefinitely, and the relationship is similar to a marriage relationship in the State of New Mexico.

3. Domestic partners must meet the age requirements for marriage in New Mexico (18 years of age) and be mentally competent to consent to contract.

4.Domestic partners must not be related by blood to the degree prohibited in a legal marriage in the State of New Mexico.

5.Domestic partners must be jointly responsible for the common welfare of each other and share financial obligations.

6.Domestic partner must not be married or a member of another domestic partnership; nor have been so during the past 12 months. If domestic partnership dissolves and the same two people want to become partners again, they must once again meet the 12-month requirements.

7.Domestic partners must provide proof of one of the following: joint mortgage or lease; joint ownership of a motor vehicle; joint bank account; joint credit account; domestic partner named as beneficiary of life insurance; domestic partner named as beneficiary of retirement benefits; domestic partner named as primary beneficiary in the employee's will; domestic partner assigned durable property or health care power of attorney; or documentation of sharing of household expenses by both partners.

Drug Formulary—is a list of generic and brand-name prescription medications covered by health insurance plan.

Drug Plan Rider—The document that explains the coverage available to members for prescription drugs, insulin, diabetic supplies, and certain nutritional products.

Durable Medical Equipment— Any equipment that can withstand repeated use, is made to serve a medical purpose, and is generally considered useless to a person who is not ill or injured.

EASI GOV—state of New Mexico third-party administrator for the state Group Benefits Plan.

Effective Date of Coverage—date on which a member's coverage under this plan begins. See HR for more information.

Eligible Child—The following family members of the Subscriber through the end of the month during which the child turns age 26:

- natural or legally adopted child of the Subscriber, Subscriber's spouse, or the Subscriber's Domestic Partner

- child placed in the Subscriber's home for purposes of adoption (including a child for whom the Subscriber, Subscriber's spouse, or the Subscriber's Domestic Partner is a party in a suit in which the adoption of the child by the Subscriber, Subscriber's spouse, or the Subscriber's Domestic Partner is being sought)
- stepchild of the Subscriber, Subscriber's spouse, or the Subscriber's Domestic Partner
- child for whom the Subscriber, Subscriber's spouse, or the Subscriber's Domestic Partner must provide coverage because of a court order or administrative order pursuant to state law

Eligible Family Members—Family members of the Subscriber, limited to the following:

- the Subscriber's legal spouse
- the Subscriber's Domestic Partner
- the Subscriber's Eligible Child or the Eligible Child of the Subscriber's Spouse or Subscriber's Domestic Partner through the end of the month in which the child reaches age 26 (Once a covered child reaches age 26, the child is automatically removed from coverage and rates adjusted accordingly - unless the child is an Eligible Family Member under this Plan due to a disability.)
- the Subscriber's unmarried child or the unmarried child of the Subscriber's Spouse or Subscriber's Domestic Partner age 26 or older who was enrolled as the Subscriber's covered child in this Plan at the time of reaching the age limit, and who is medically certified as disabled, chiefly dependent upon the Subscriber for support and maintenance, and incapable of self-sustaining employment by reason of his/her disability.

Emergency, Emergency Care—Medical or surgical procedures, treatments, or services delivered after the sudden onset of an injury or illness.

EOI—Evidence of Insurability; it is a part of the application process for life or health insurance policy during which an applicant provides health information to a respective insurer.

EPO—Exclusive Provider Organization; a health plan that uses the same network as the PPO plan, however there are no out-of-network benefits available. All services are covered with a co-payment or percentage coinsurance.

ERB—New Mexico Educational Retirement Board. Provides retirement benefits to active and retired employees of New Mexico public schools, institutions of higher learning, and certain employees at state agencies who work in educational programs.

FDA—The United States Food and Drug Administration.

FMLA (Family Medical Leave Act)—FMLA entitles eligible employees of covered employers to take unpaid, job-protected leave for specified family and medical reasons with continuation of group health insurance coverage under the same terms and conditions as if the employee had not taken leave.

FSA (Flexible Spending Account)—this account allows participants to use pre-tax dollars to pay for eligible expenses.

Generic drug—prescription medications that are produced by multiple manufacturers and not identified by a brand name.

Genetic Inborn Error of Metabolism—A rare, inherited disorder that is present at birth; if untreated, results in mental retardation or death, and requires that the affected person consume Special Medical Foods.

GI—Guaranteed Issue. Refers to life insurance coverage that is guaranteed to be issued to applicants regardless of their health status, age, or income – and guarantees that the policy will be renewed as long as the policy holder continues to pay the policy premium.

Governor Exempt Employees—are political appointees who serve at the pleasure of the governor.

HIPAA—The Health Insurance Portability and Accountability Act (HIPAA) was passed by Congress in 1996. Its original version mandated enhanced portability of employer-based health insurance for individuals changing jobs and made reference referred to future requirements regarding administrative simplification (common data code sets), privacy, and security. The federal Department of Health and Human Services, Office of Civil Rights is the governing entity with regard to HIPAA regulations while penalty enforcement is conducted through the federal Department of Justice.

HIPAA Privacy Rule—establishes national standards to protect individuals' medical records and other personal health information and applies to health plans, health care clearinghouses, and those health care providers that conduct certain health care transactions electronically.

HMO (Health Maintenance Organization)—a health plan that uses a network of participating providers. Participants must use these providers for all medical care in order for the services to be covered.

IBAC—Interagency Benefit Advisory Committee

Identification Card (ID Card)—The ID Card carrier issues to the subscriber that identifies the cardholder as a plan member.

Indemnity Plan—a health plan that is not tied to any particular network. Participants may use any provider; however, a deductible must be met before any services are covered, participants must file their own claims and may be responsible for paying the difference between the Usual, Customary and Reasonable charge and what the provider charges.

In-Network Providers—providers who have agreed to accept a negotiated rate from the health plan as payment in full for covered services.

Inpatient Services—Care provided while member is confined as an inpatient in a hospital or treatment center for at least 24 hours.

Involuntary Loss of Coverage—loss of other coverage due to legal separation, divorce, death, moving out of a service area, termination of employment, reduction in hours or termination of employer contributions (even if the affected Member continues such coverage by paying the amount previously paid by the employer).

IRS Section 125 (Cafeteria) Plan—is a benefit provided by employer which allows a contribution of certain amount of gross income to a designated account before taxes are calculated

Late Applicant—Unless eligible for a Special Enrollment, applications from the following enrollees will be considered late:

- anyone not enrolled within 31 days of becoming eligible for coverage under this health care plan (e.g., a child added more than 31 days after legal adoption, a new spouse or stepchild added more than 31 days after marriage)
- anyone enrolling on the Group's initial enrollment date who was not covered under the Group's prior plan (but who was eligible for such coverage)
- anyone eligible but not enrolled during the Group's initial enrollment
- anyone who voluntarily terminates his/her coverage and applies for reinstatement of such coverage at a later date (except as provided under the USERRA of 1994)

Legislative employee—is any person other than a state legislator who draws a salary or compensation from the budget of the legislature.

Local Public Body (LPB)—refers to an officer, employee, or servant of a governmental entity.

LWOP—leave without pay.

Major Restorative—dental repair or replacement of teeth. Examples include root canals, bridges, crowns and dentures.

Managed Health Care Plans—A "Managed Health Care Plan" is a health plan that requires a member to use, or encourages a member to use, a "Network" Provider (your Provider network is determined by the type of health plan you have).

Medicaid—A state-funded program that provides medical care.

Medically Necessary, Medical Necessity—Health Care Services determined by a provider, in consultation with carriers, to be appropriate or necessary, according to any applicable generally accepted principles and practices of good medical care or practice guidelines developed by the federal government, national or professional medical societies, boards and associations, or any applicable clinical protocols or practice guidelines developed by carriers consistent with such federal, national, and professional practice guidelines, for the diagnosis or direct care and treatment of a physical, Mental Disorder or Chemical Dependency condition, illness, or disease.

Member—An enrollee (the Subscriber or any Eligible Family Member) who is enrolled for coverage and entitled to receive benefits under the plan in accordance with the terms of the Administrative Service Agreement.

Military leave—is an approved, with pay, absence from work for an employee who is a member of the National Guard or Armed Forces.

Minor restorative—common dental repairs including simple extractions, one to four surface fillings, periodontics such as root planning, and one scaling.

Network Provider (In-Network Provider)—A contracted provider that has agreed to provide services to members in specific type of health plan (e.g., PPO, etc.).

NM Retiree Health Care Authority (NM RHCA)—New Mexico Retiree Health Care Authority | provides health coverage to retirees of state agencies, and their families, and eligible participating public entities.

Non-preferred brand drug (also known as a non-formulary brand drug)—prescription medication that may be produced by multiple manufacturers. Usually, one or more medications within a therapeutic class are considered preferred, and the remaining medications within that class are considered non-preferred.

Occupational Therapist—A person registered to practice occupational therapy.

Occupational Therapy—The use of rehabilitative techniques to improve a patient's functional ability to perform activities of daily living.

Optometrist—A Doctor of Optometry (O.D.) licensed to examine and test eyes and treat visual defects by prescribing and adapting corrective lenses and other optical aids.

Orthopedic Appliance—An individualized rigid or semirigid support that eliminates, restricts, or supports motion of a weak, injured, deformed, or diseased body part, for example, functional hand or leg brace, Milwaukee brace, or fracture brace.

OSI—The Office of Superintendent of Insurance.

Out-of-Network Providers—providers who have not entered into an agreement with the health plan.

Out of Pocket Maximum—a cap, or limit, on the amount of money you have to pay for covered health care services in a plan year. Once met your health plan will pay 100% of all covered health care cost for the rest of the plan year.

Outpatient Services—Medical/Surgical Services received in the outpatient department of a hospital, observation room, Emergency room, Ambulatory Surgical Facility, freestanding Dialysis Facility, or other covered outpatient treatment Facility.

Participating pharmacy—a pharmacy that has entered into an agreement with CVS Caremark to provide prescription medications to you and your covered dependents and accept the coinsurance and copayments for those medications.

Physical Therapist— A licensed Physical Therapist. A Physical Therapist treats disease or accidental injury by physical and mechanical means (regulated exercise, water, light, or heat).

Physical Therapy—The use of physical agents to treat disability resulting from disease or injury.

Physician—A Doctor of Medicine (M.D.) or Osteopathy (D.O.) and who is licensed to practice medicine under the laws of the state or jurisdiction where the services are provided.

Physician Assistant—A graduate of a Physician Assistant or Surgeon Assistant program approved by a nationally recognized accreditation body or a skilled person who is currently certified by the National Commission on Certification of Physician Assistants, who is licensed in the state of New Mexico (or by the appropriate state regulatory body) to practice medicine under the supervision of a licensed Physician.

Podiatrist—A licensed Doctor of Podiatric Medicine (D.P.M.). A Podiatrist treats the conditions of the feet.

PERA—Public Employees Retirement Association of New Mexico. Provides retirement benefits to retired state, municipal, and county employees of the state of New Mexico.

Portability—refers to an employee's option to retain certain benefits when switching employers.

PPE—means pay period ending.

PPO (Preferred Provider Organization)—a health plan that uses a broader network than an HMO. Services obtained from participating providers are covered at a higher rate than services obtained from non-participating providers. A deductible applies to certain services.

Preferred brand drug (also known as a formulary brand drug)—brand name prescription medication that has been selected to be on the preferred list either because it is only produced by one manufacturer, or because it is preferred over other available medications within the same therapeutic class.

Premium only plan (**POP**)**—**is the most basic – and most popular – type of Section 125 **Cafeteria Plan** that allows employer-sponsored premium payments to be paid by the employee on a pre-tax basis instead of after-tax.

Preventive Care—services such as annual physical exams, mammograms, Pap smears and prostate antigen testing.

Prior Authorization—An advance confirmation to determine medical necessity, as may be required where permitted by law, for certain services to be eligible for benefits.

Probationer—means an employee in the classified service who has not completed the one-year probationary period.

Prosthetics or Prosthetic Device—An externally attached or surgically implanted artificial substitute for an absent body part, for example, an artificial eye or limb.

Provider—A duly licensed hospital or other licensed facility, physician, or other health care professional authorized to furnish health care services within the scope of their license.

Respiratory Therapist—A person qualified for employment in the field of respiratory therapy

Retiree Health Care Authority (RHCA)—see NM Retiree Health Care Authority (NM RHCA)

Routine Newborn Care—Care of a child immediately following birth that includes:

- routine Hospital nursery services, including alpha-fetoprotein IV screening
- routine medical care in the Hospital after delivery
- pediatrician
- services related to circumcision of a male newborn
- standby care at a C-section procedure

Routine Screening Colonoscopy/Mammogram — Tests to screen for occult colorectal and/or breast cancer in persons who, at the time of testing, are not known to have active cancer of the colon or breast, respectively.

Service Area—The geographic area where carriers are licensed to conduct business in New Mexico.

Short-Term Rehabilitation—Inpatient, outpatient, office- and home-based occupational, physical, and speech therapy techniques that are medically necessary to restore and improve lost bodily functions following illness or accidental Injury.

Skilled Nursing Care—Care that can be provided only by someone with at least the qualifications of a Licensed Practical Nurse (L.P.N.) or Registered Nurse (R.N.).

Special Enrollment—When an otherwise eligible employee or eligible family member did not enroll in the plan when initially eligible, there are certain instances (or "qualifying events") during which the employee and his/her eligible family members, if any, may enroll in the plan at a later date - or more than 31 days after becoming eligible-and not considered late applicants.

Special Medical Foods— Nutritional substances in any form that are consumed or administered internally under the supervision of a physician, specifically processed or formulated to be distinct in one or more nutrients present in natural food; intended for the medical and nutritional management of patients with limited capacity to metabolize ordinary foodstuffs, or certain nutrients contained in ordinary foodstuffs, or who have other specific nutrient requirements as established by medical evaluation; and essential to optimize growth, health, and metabolic homeostasis. Special Medical Foods are covered only when prescribed by a Physician for treatment of genetic orders of metabolism, and the member is under the physician's ongoing care. Special Medical Foods are not for use by the general public and may not be available in stores or supermarkets. Special Medical Foods are not those foods included in a healthy diet intended to decrease the risk of disease, such as reduced-fat foods, low sodium foods, or weight loss products.

Summary of Benefits and Coverage (SBC)—provides an overview of covered services.

Supplemental Coverage—is optional, employee-paid life insurance that is generally offered by an employer.

Telemedicine—The use by a licensed health care professional, acting within the scope of their license, of interactive, simultaneous audio and video or store-and-forward technology using information and telecommunications technologies to deliver health care services at a site other than the site where the patient

is located, including the use of electronic media for consultation relating to the diagnosis or treatment of the patient in real time or through the use of store-and-forward technology.

Temporary—is the employment of a candidate in a position created for a duration of less than one year.

Urgent Care—Medically necessary health care services received for an unforeseen condition that is not life-threatening. This condition does, however, require prompt medical attention to prevent a serious deterioration of health (e.g., high fever, cuts requiring stitches).

Voluntary benefits—are perks provided by an employer and employees may choose to voluntarily participate.

RESOURCES

Home | SoNM Group Benefits Plan

Benefits Information | Group Benefits Plan

Trifold_Benefits_Plan_Brochure_091824_MASTER.pdf

Employee Resources | Group Benefits Plan

State_of_New_Mexico_premium_rates_July1_24_June3025.pdf

Insurance_Carriers_Summary Plan Descriptions

State of NM Group Benefits Plan: Forms, Guidelines, and Policies

The Uniformed Service Employment and Re-employment Rights Act

US Department of Labor USERRA

Frequently Asked Group Insurance Questions (FAQ)

1. **Is insurance enrollment automatic?**

No, enrollment forms must be completed online **within 31 days from the date of employment** if you wish to enroll or waive the medical dental and vision benefits.

2. **What is the difference between Acknowledgement Form and Enrollment Form?**

Acknowledgment Form and Enrollment Form are two different forms.

Reading and signing Acknowledgment form you are acknowledging that you received, read, and understood information on benefits.

When you sign up for your benefits on www.mybenefitsnm.com it is done via Enrollment Form. When you are done with your enrollment, please print a copy of this form for your files and a copy for HR Medical files.

3. **Where do I enroll?**

Website for online enrollment: Home | SoNM Group Benefits Plan

4. **When does my insurance go into effect?**

The effective date of coverage is the first day of the 3rd full pay period following completion and submission of enrollment forms to EASI GOV.

5. **Who is EASI GOV?**

EASI GOV (formerly ERISA) is the Third-Party Administrator for the SoNM. Any questions regarding Health Benefits, Flexible Spending Accounts (FSA), COBRA, and Disability should be directed to EASI GOV.

6. **How do I contact EASI GOV?**

Contact information for EASI GOV is:

Location:

EASI GOV, Inc. Office

1200 San Pedro Drive NE

Albuquerque, NM 87110

Website:

Home | SoNM Group Benefits Plan

Phone:

Albuquerque: 505.244.6000

Toll Free: 855.618.1800

Fax: 505.244.6009

Email:

SONM@easitpa.com

FSA@easitpa.com

Business hours are:

M—F 8AM-5PM

Saturday and Sunday: Closed

EASI GOV IS CLOSED for:

- New Year
- Martin Luther King Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day (2 days), and
- Christmas (2 days)

7. What is the timeframe for enrollment?

You have 31 days to enroll from the date of hire.

If an eligible employee misses the 31 days, they will have to wait until open enrollment or qualifying event.

8. When is the premium deducted?

Premiums are deducted in the arrears after the effective date of coverage from the employee's 3rd payroll check after commencing employment.

9. How long can I keep my children as dependents on my insurance?

Children may remain on the insurance plan until age 26 regardless of their marital status, residence student status or tax filing status.

10.My spouse and I are having a baby soon. When should I add my child to coverage?

You have 31 days from the date of birth to add your newborn to your insurance. You will do it online and since the system does not recognize ADD only, you will have to re-enroll yourself and all your dependents who were enrolled at the time of your original enrollment. The effective date of the coverage for your newborn will be retroactive to the date of birth and premiums will be deducted accordingly. Please refer to the Bi-Weekly contribution schedule for the rates. Employees must submit an official birth certificate within 90 days of the date of birth. Failure to do so will result in cancellation of coverage retroactively to the date of birth.

11.What is OPEN Enrollment?

OPEN enrollment is one time event which is conducted to allow eligible employees to enroll in one or several of the group insurance plans offered to employees in NM State government.

12.When does OPEN Enrollment occur?

This event occurs only when new insurance is introduced, re-enrollment is offered, or a new contractual period goes into effect.

13.When is Open/Switch Enrollment?

Open Enrollment is usually in October, presentations are conducted, and information disseminated. Coverage is effective on January 1 of the following year.

14.What happens if I miss my enrollment?

If you miss your benefit enrollment, you will have to wait until the next open enrollment or qualifying event.

15.How much does insurance cost?

Please refer to the premium rates as they are published in the State of New Mexico Bi-Weekly Contribution Schedule (https://www.mybenefitsnm.com/PremiumRatesSAE.html) State Employee Premiums | SoNM Group Benefits Plan. The premiums are based on the employee's annual earnings, full-time employment. Changes in an employee's annual earnings could result in either an increase or decrease in the premium amount.

16.Are any of the premium rates deducted on a pre-tax basis?

Yes. Pre-tax premium conversion allows employees to have their health, dental, and vision insurance premiums deducted from their pay before taxes are deducted. Pre-tax premiums deductions for the above-mentioned coverage are not allowed for Domestic Partners.

17.How can I enroll in additional life insurance coverage?

All eligible employees are automatically enrolled in basic life insurance as the state pays 100% of the premiums. As new hires, employees may elect additional life insurance that is equal to 3 times their annual salary without medical underwriting and prior approval. Please visit Voluntary Benefits State of New Mexico | Group Benefits (mybenefitsnm.com/volben.html) for benefit plan options and contact The Hartford for additional information.

EOI Form

If you are applying for the $500, 000 policy you will have to complete **the Evidence of Insurability (EOI)** form. It is the employee's responsibility to make sure this is completed in a timely manner. Please check your junk email folder if you do not see this email in your In box.

18. What is a Flexible Spending Account (FSA)?

A Flexible Spending Account allows employees to set aside money PRE-TAX for eligible expenses. There are three options:

Health Care Flexible Spending Account—covers eligible health care expenses

Dependent Care Flexible Spending Account—covers daycare expenses for eligible dependents

Transit and Parking Benefits—covers transit and parking expenses incurred traveling to/from work

19.How do I enroll in Flexible Spending Accounts?

You have the option to enroll in any or all three Flexible Spending Accounts during the initial enrollment in benefits. However, if at first you waive enrollment but change your mind before the 31 days has lapsed or if you have experienced a qualifying event, you have the option to submit an online enrollment form for each benefit at www.mybenefits.com

20.Can I cancel my insurance if I cannot afford it?

No. An employee must experience a qualifying status change (QSC) event in order to make a change during the plan year.

21.When can I cancel my insurance?

An employee may cancel insurance only during annual OPEN Enrollment.

22.Can I keep my insurance coverage if I decide to separate from employment?

Yes. COBRA allows you continuation of coverage, for yourself and/or qualified dependents, for up to 18 months following termination date.

23.What happens to my insurance coverage if I decide to take a leave of absence?

If you do not receive pay during the leave—to prevent lapse of coverage—the premiums for insurance coverage must be paid by cahiers check or money order. Please contact your Human Resources Department for more details regarding the continuation of insurance coverage while on any type of leave of absence.

24.How do I know I have my benefit coverage?

First, call EASI GOV at (505) 244-6000 to verify your enrollment.

Second, check your paycheck for accuracy and premium deductions.

25.How do I get my insurance card?

Insurance cards will be mailed to you.

26.I did not get my benefit cards. What do I do?

Contact carriers and request cards.

Benefit Carrier contacts link: Contact Us | Group Benefits Plan

OPEN ENROLLMENT FOR BENEFIT PLAN YEAR 2025

https://www.mybenefitsnm.com/OpenEnrollment.html

FREQUENTLY ASKED QUESTIONS

General Enrollment Questions

When is Open Enrollment?
Open Enrollment begins October 1 and ends on October 31 at 11:59 p.m. MT.

Where can I find information about Open Enrollment for Benefit Plan Year 2025?
Visit https://www.mybenefitsnm.com/OpenEnrollment.html for program information, virtual meeting dates, and more.

How do I find out what coverage(s) I currently have?
To see your current 2024 elections, go to https://www.mybenefitsnm.com/employeePortalSub3.html. You can also go to SHARE and utilize the Share Self-Service Manual. The manual contains instructions on how to view current elected benefits. You can also contact EASI GOV at (505) 244-6000.

If I am happy with my current coverage, do I need to submit elections during Open Enrollment?
No action is needed if you are happy with your current elections for medical with Presbyterian or Blue Cross and Blue Shield of New Mexico and for dental, vision, and life insurance coverage. However, there are two benefits that may require action:

1. **Cigna will no longer be available in 2025.** If you are currently enrolled in a Cigna plan, you are welcome to select a new medical plan during Open Enrollment. If you do not select a new medical plan during Open Enrollment, you will automatically be enrolled in another medical plan that most closely aligns with your Cigna plan.
2. **Some Flexible Spending Accounts (FSAs) require you to enroll or reenroll each year.** FSA Health and Dependent Care coverage does not roll over. You may choose to contribute to the FSA Health and/or Dependent Care programs in 2025. (If you are currently enrolled in either the FSA Parking or FSA Transportation, these plans roll over each year.)

Can I make changes to my FSA Transportation or FSA Parking accounts?
Yes. You can make a change to your contribution amount, or you can stop contributing to the accounts. If you stop contributing, you still have access to any funds that remain in the accounts. Your FSA Transportation and FSA Parking account balances roll over each year.

If I'm currently enrolled in the FSA Health or FSA Dependent Care program, do I still need to reenroll?
Yes. If you want to contribute to an FSA in 2025, you must reenroll during Open Enrollment. Your coverage does not roll over.

Links to the enrollment tool will post October 1. To enroll in an FSA, employees must submit an FSA Electronic Form, which can be found on the Open Enrollment page at https://www.mybenefitsnm.com/OpenEnrollment.html.

What if I'm deployed on military duty during Open Enrollment?
Once you've received your deployment orders, you must contact both your Human Resources Department and EASI Gov, Inc. (formerly ERISA) to be properly placed on military leave. This applies throughout the year.

What if I return from military leave during Open Enrollment?
Contact both your Human Resources Department and EASI Gov, Inc. (formerly ERISA) on your return from leave.

What documents do I need to submit when adding dependents to my plan?
You must submit a marriage certificate for your spouse, an affidavit for a domestic partner, and birth certificates, legal guardianship, or adoption forms for any children.

2025 Premiums

What is POP, and what is its purpose? Why would you waive POP?
POP stands for Premium Only Plan. POP allows your premiums for health care coverage to be deducted before taxes are taken out of your pay. Paying for coverage before taxes are taken out reduces your tax withholdings and puts a bit more money back into your paycheck.

If you wish to have your health benefit premiums taken out on an after-tax basis, you must submit a new POP waiver form during Open Enrollment, even if you do not wish to make any changes to your benefit elections.

Are there any premium changes to health care plans for 2025?
At this time, there are no premium changes for fiscal year 2025 (July 1, 2024 – June 30, 2025). Visit https://www.mybenefitsnm.com/documents/State_of_New_Mexico_premium_rates_July1_24_June3025.pdf to see the current health care plan premiums.

Premiums may be adjusted as of July 1, 2025. You will be notified in advance of any changes.

What are the premiums for the medical plan options?
Visit https://www.mybenefitsnm.com/PremiumRatesSAE.html. You can check the current rate sheet and cross reference by coverage level and income for biweekly deductions.

Medical Coverage

I'm enrolled in a Cigna medical plan. What do I need to do during Open Enrollment?
Cigna will no longer be an available option in 2025. If you are currently enrolled in a Cigna plan, you must select a new medical plan during Open Enrollment. Visit https://www.mybenefitsnm.com/OpenEnrollment.html to learn more about the other medical plan options.

Note: If you do not select a new medical plan during Open Enrollment, you will automatically be enrolled in another medical plan that most closely aligns with your current Cigna plan.

What happens if I don't select a new medical plan during Open Enrollment?
If you are currently enrolled in a medical plan other than Cigna, you will remain in that plan.

If you are currently enrolled in a Cigna medical plan and you do not select a new medical plan during Open Enrollment, you will automatically be enrolled in an alternative medical plan that most closely aligns with your current Cigna plan.

Is my provider in the Blue Cross and Blue Shield of New Mexico and/or Presbyterian networks?
Use the links below to find in-network providers:

- **Blue Cross and Blue Shield of New Mexico:** https://www.bcbsnm.com/sonm/doctors-and-hospitals
- **Presbyterian:** https://www.phs.org/health-plans/employer-plans/Pages/state-of-new-mexico.aspx

Note: Blue Cross and Blue Shield of New Mexico has PPO and HMO plans. The PPO plan has two in-network benefit levels, Tier I and Tier II.

If you need assistance with determining whether your providers are in the Blue Cross and Blue Shield of New Mexico and/or Presbyterian networks, compile the names and addresses of your providers and call the plans at:

- **Blue Cross and Blue Shield of New Mexico:** 877-994-2583
- **Presbyterian:** 888-ASK-PRES (888-275-7737)

My current Cigna provider isn't in the Blue Cross and Blue Shield of New Mexico or the Presbyterian network. What do I do?
If your doctor is not an in-network provider with Blue Cross and Blue Shield of New Mexico or Presbyterian, you can select a new in-network provider from the Blue Cross and Blue Shield of New Mexico or Presbyterian networks. Alternatively, you could enroll in the Blue Cross and Blue Shield of New Mexico PPO and use your current Cigna provider and receive out-of-network benefits.

If you are in the course of treatment for certain conditions, you may be eligible to continue seeing your current Cigna provider for a period of time. Continuity of care is available for qualifying medical conditions such as inpatient care and pregnancy care. To learn more, contact Blue Cross and Blue Shield of New Mexico or Presbyterian.

If I enroll in a new medical plan, will I get a new ID card?
Yes. You will receive new ID cards for you and your enrolled dependents. This includes if you choose a new medical plan during Open Enrollment or if you are automatically enrolled in a new medical plan because your Cigna plan will no longer be available.

For the Blue Cross and Blue Shield of New Mexico and Presbyterian plans, what is the difference between the Tier I, Tier II, and Tier III services?
If you are enrolled in a Blue Cross and Blue Shield of New Mexico or a Presbyterian plan, you have access to providers in all tiers:

- Tier I providers: You receive the highest level of benefits when you use a Tier I provider.
- Tier II providers: You receive a higher level of benefits when you use a Tier II provider.
- Tier III providers: You receive a lower level of benefits when you see a Tier III (or out-of-network) provider.

The benefit of choosing a Tier I provider is potential savings on out-of-pocket costs. If a service or provider is not available in Tier I, you still have the flexibility to receive care from providers in Tier II. You can also go to a Tier III (or out-of-network) provider if you are enrolled in the Blue Cross and Blue Shield of New Mexico plan.

Note: Blue Cross and Blue Shield of New Mexico is the only provider with three tiers of providers, including out-of-network coverage.

Use the links below to find providers:

- **Blue Cross and Blue Shield of New Mexico:** https://www.bcbsnm.com/sonm/doctors-and-hospitals
- **Presbyterian:** https://www.phs.org/health-plans/employer-plans/Pages/state-of-new-mexico.aspx

Will my prescription drugs change if I move to a new medical plan?
No. No matter which medical plan you are enrolled in, prescription drug coverage is provided by CVS Caremark.

Will my prescription drug prior authorizations transfer to my new medical plan?
Yes, your prescription drug prior authorizations will automatically transfer to your new medical plan.

Life Insurance Coverage

Can I increase my life insurance coverage during Open Enrollment?
Yes. If you or your spouse has existing supplemental life insurance, you may increase coverage by one increment of $10,000, up to the guaranteed amount, during Open Enrollment. You will not need to provide evidence of insurability (EOI) for this increase in coverage.

If you wish to elect more than $10,000 or an amount over the guaranteed amount, you will need to provide EOI. Coverage will be approved or denied by The Hartford.

Important! If you elect to increase life insurance coverage, be sure to include the total amount of life insurance you want, not just the amount of the increase.

You may also choose to enroll in life insurance for the first time during Open Enrollment. You will need to provide EOI and go through The Hartford's approval process for any coverage amount.

Disability Coverage

What is the Disability Plan? Should I enroll in it?
The Disability Plan provides financial protection. It pays a portion of your wages if you are unable to work due to illness or injury. This includes disability related to maternity. Disability benefits are provided in accordance with the provisions of the State of New Mexico Self-Insured Program.

You are eligible if you have paid disability premiums for at least 12 consecutive months prior to claiming disability. You pay the full cost of premiums for the Disability Plan on an after-tax basis if you choose to enroll. The Disability Plan is not available to dependents.

Questions

If you have additional questions, please contact EASI Gov, Inc. (formerly ERISA) at (505) 244-6000 or sonm@easitpa.com.