2024-2025
BENEFITS GUIDEBOOK
BENEFITS AND YOU!

PMS
PRESBYTERIAN MEDICAL SERVICES

Our purpose is you.

HUMAN RESOURCES BENEFITS ADMINISTRATION
1422 Paseo de Peralta
Santa Fe, NM 87501
505-443-1125
benefits@pmsnm.org

PMS
PRESBYTERIAN MEDICAL SERVICES

Our purpose is you.

Dear PMS employees,

Welcome to the Presbyterian Medical Services employee benefits program. It is our pleasure to provide you with a copy of the 2024-2025 Plan Year Employee Benefits Guidebook. Its purpose is to acquaint you with the benefits and health care plans offered by Presbyterian Medical Services.

Presbyterian Medical Services offers a competitive and comprehensive benefits package to its eligible employees. You have an extensive array of benefits from which to choose, and we encourage you to study this book thoroughly. The benefits package provided to you is an important part of the total compensation you receive as an employee, providing valuable protection for you and your family. Thoughtful consideration should be given to your choices to achieve the greatest return from this opportunity.

Sincerely,

Your Human Resources Department

PMS Mission Statement

Presbyterian Medical Services designs and delivers quality, accessible, integrated health, education, and human services in response to identified community needs of the multicultural people of the Southwest.

BENEFITS OPEN ENROLLMENT GUIDE

Open Enrollment: Monday, February 12th through Friday, February 23rd
Coverage effective: April 1, 2024 – March 31, 2025

WHAT'S INSIDE

The employee benefit programs described in this guide are effective in 2024-2025. The information in this guide is a summary of Presbyterian Medical Services' benefits, and every attempt has been made to ensure its accuracy.

The actual provisions of each benefit program will govern if there is any inconsistency between the information in this guide and PMS' formal plans, programs, policies, or contracts or any subsequent change in such plans, programs, policies, or contracts.

Benefits call center

888-868-5530
Monday–Friday, 6:00am–7:00pm

Benefits websit

HUMAN RESOURCES BENEFITS ADMINISTRATION
1422 Paseo de Peralta · Santa Fe, NM · 87501 · 505-443-1125 · benefits@pmsnm.org

BENEFIT CARRIER DIRECTORY

Benefit Questions		
PMS Benefits Call Center	mybensite.com/pmsnm Login 24/7	888-868-5530 Mon–Fri, 6:00 am- 7:00 pm Se habla Español
Medical Plans		
Blue Cross Blue Shield of New Mexico (BCBSNM) Group numbers: PPO: N42507 EPO: N42510 CDHP: N11609	bcbsnm.com MDLIVE.com/BCBSNM	Member Services 800-432-0750 MDLIVE Virtual Visits 888-858-5074
Dental Plan		
Delta Dental of NM Group number: 9766	deltadentalnm.com	877- 395-9420
Vision Plan		
VSP Group number: 12306197	vsp.com	800-877-7195
PMS Paid Employee Assistance Program (EAP)		
Mutual of Omaha	mutualofomaha.com/eap	800-316-2796
Voluntary Supplemental Benefits		
Mutual of Omaha Group number: G000BBNQ	Access to claim forms: mutualofomaha.com/support/forms Contact the Senior Benefits Administrator for Mutual of Omaha's claim submission email addresses	Life/ADD, Accident, Critical Illness 800-775-8805 Fax: 402-997-1835 Long/Short-Term Disability 800-877-5176
Norton LifeLock Identity Theft Protection Group Number: E0015156	lifelock.norton.com	800-607-9174
PMS Paid Life/Accidental Death & Dismemberment/Long Term Disability		
Mutual of Omaha	mutualofomaha.com/pmsnm	888-868-5530
PMS 403(b) Retirement Plans		
American Century Plan number: 056669001 800-345-3533 americancentury.com	**Mutual of America** Employer number: 006646 800-468-3785 mutualofamerica.com	**Vanguard** Plan number: 434089 800-569-4903 option 5 vanguard.com
PMS Discretionary Contribution Retirement Plan		
The Newport Group	newportgroup.com	844-749-9981 Check balances or update beneficiaries

For detailed information about the Discretionary Contribution plan or to sign up for the 403(b) plan, go to the *Additional Benefits* section of the benefits website mybensite.com/pmsnm

ENROLLMENT OPPORTUNITIES

There are three opportunities to make benefit enrollment elections:

- **Option 1 – when you are hired as a new employee**
- **Option 2 – when you have a qualifying life event (QLE)**
- **Option 3 – during Open Enrollment**

Option 1 Hired as a New Employee

Newly hired benefits-eligible employees have 31 days from the first day of employment to enroll in benefits plans. You have two enrollment options – the **benefits website** or the **benefits call center**. If you do not enroll within 31 days from the date your employment begins, you cannot enroll until the next Open Enrollment period. Choose your options carefully. Once enrolled, you cannot make changes until the next Open Enrollment unless you have a QLE event. **Even if declining medical, dental, vision and/or supplemental plans, you will be automatically enrolled in the company-paid benefits**. For more information, please refer to the enrollment instructions provided to you by the Benefits Administrator during New Employee Orientation or go to the **benefits website**.

Option 2 Qualifying Life Event (QLE)

If you have a QLE, you normally have **31 days from the QLE** to make any changes to your benefits. Examples of QLE's include marriage, legal separation or divorce, death of a spouse or family member, birth or adoption of a child, loss of other healthcare coverage, loss of dependent eligibility, a dependent changes student status and becomes eligible for coverage under a student health plan, or your spouse has elected to cover you under your spouse's group health plan.

PMS also considers a change in benefits-status from full-time (0.75 FTE – 1.0 FTE) to part-time (0.5 FTE – 0.75 FTE), or vice-versa, as a QLE. If you experience a gain or loss of eligibility for premium assistance under Medicaid or State Children's Health Insurance Program (SCHIP) coverage, you have 60 days to make any changes. For instructions on how to make these changes, go to the **benefits website** or call the **benefits call center**.

Option 3 Open Enrollment

Open Enrollment takes place each year in February for an April 1st effective date. This gives you the opportunity to review benefit plan options and make changes for the following plan year. The benefit plan year is April 1st through March 31st. During Open Enrollment you must either utilize the **benefits website** or the **benefits call center** to make your selections. Before Open Enrollment begins, the Human Resources Department mails and emails notices announcing Open Enrollment dates and instructions.

Benefits call center **888-868-5530** **Monday-Friday, 6:00am – 7:00pm** **Se habla Español**
Benefits website **mybensite.com/pmsnm**

PMS BENEFIT PLANS

PMS offers two employee benefits programs based on full-time/part-time status. Full-time employees and part-time employees are eligible to enroll in the benefits described in this guide. For purposes of benefits, **full-time employees** are defined as those who work .75 to 1.0 FTE (30 to 40 hours per week). **Part-time employees** are defined as those who work .5 to .74 FTE (20 to 29.6 hours per week). **FTE decrease**: Employees with a .75 FTE or above who decrease their FTE status to between .5 and .74 FTE (inclusive), will be eligible for the part-time benefits program and premiums.

Benefit	Full-Time Program .75 FTE to 1.0 FTE Employees (Grandfathered employees*)	Part-Time Program .5 FTE < .75 FTE Employees
Medical	Administered by BlueCross BlueShield of NM. Three plans to choose from: • CDHP + HRA • EPO • PPO	Administered by BlueCross BlueShield of NM. Three plans to choose from: • CDHP + HRA • EPO • PPO Part-time employee pays a higher percentage of the premium.
Dental	Administered by Delta Dental of NM. Delta Dental Premier, coupled with Delta Dental PPO.	Administered by Delta Dental of NM. Delta Dental Premier, coupled with Delta Dental PPO. Part- time employee pays a higher percentage of the premium.
Vision	Administered by VSP.	Administered by VSP.
Basic Life Insurance	Administered by Mutual of Omaha. 2 times annual salary, max $200,000. Designated Provider max is $400,000. Premiums are paid 100% by PMS.	Administered by Mutual of Omaha. 1 times annual salary, max $100,000. Designated Provider max is $200,000. Premiums are paid 100% by PMS.
Accidental Death & Dismemberment Insurance (AD&D)	Administered by Mutual of Omaha. Up to 2 times annual salary, max $200,000. Designated Provider max is $400,000. Premiums are paid 100% by PMS.	Administered by Mutual of Omaha. Up to 1 times annual salary, max $100,000. Designated Provider max is $200,000. Premiums are paid 100% by PMS.
Long-Term Disability Insurance (LTD)	Administered by Mutual of Omaha. After elimination period, 60% of basic monthly earnings, max $13,500. Premiums are paid 100% by PMS.	Administered by Mutual of Omaha. After elimination period, 60% of basic monthly earnings, max $13,500. Premiums are paid 100% by PMS.
Employee Assistance Program (EAP)	Administered by Mutual of Omaha. Premiums are paid 100% by PMS.	Administered by Mutual of Omaha. Premiums are paid 100% by PMS.

Benefit	Full-Time Program .75 FTE to 1.0 FTE Employees (Grandfathered employees*)	Part-Time Program .5 FTE < .75 FTE Employees
Supplemental Benefits (Accident, Critical Illness Short-Term Disability and Term Life Insurance)	Administered by Mutual of Omaha. Premiums are paid 100% by the employee.	Administered by Mutual of Omaha. Premiums are paid 100% by the employee.
Supplemental Identity Theft Protection	Administered by Norton LifeLock. Premiums are paid 100% by the employee.	Administered by Norton LifeLock. Premiums are paid 100% by the employee.
Discretionary Contribution Plan	Administered by The Newport Group. Contributions are paid 100% by PMS.	Administered by The Newport Group. Contributions are paid 100% by PMS.
403(b) Retirement Savings Plan	Administered by your choice of vendors: • American Century • Mutual of America • Vanguard	Administered by your choice of vendors: • American Century • Mutual of America • Vanguard
Paid Time Off (PTO)	See Paid Time Off policy for details.	See Paid Time Off policy for details.
Holidays	7 paid holidays per calendar year, pro-rated to FTE level.	7 paid holidays per calendar year pro-rated to FTE level.
Floating Holiday	1 day pro-rated to FTE level	1 day pro-rated to FTE level.
Birthday Holiday	1 day pro-rated to FTE level	1 day pro-rated to FTE level.
Bereavement	Up to 3 days pro-rated to FTE level	Benefit not available.
Educational Assistance	75% to $1,500 max	Benefit not available.
Professional Continuing Education	Up to 40 or 20 hours per calendar year, prorated to FTE and based upon licensure.	Up to 29 or 14.5 hours per calendar year, prorated to FTE and based upon licensure.
Professional Stipend	See Payment of Licensure and Other Fees policy for details.	See Payment of Licensure and Other Fees policy for details.
Jury Duty	Paid jury duty leave. See Leave for Civic Responsibilities policy for details.	Paid jury duty leave. See Leave for Civic Responsibilities policy for details.
Leave of Absence	Contact HR Administrator for various leave policies.	Contact HR Administrator for various leave policies.

Refer to each policy for detailed information on the benefits listed above.

**Grandfathered Status:* Employees in the part time category on March 31, 2014 were Grandfathered and will continue to be eligible to participate in the benefits program offered to full-time employees. Please refer to Benefits Summary Plan Descriptions and PMS HR policies for more detailed information pertaining to part-time benefits.

PMS BENEFITS WEBSITE

While the information in this booklet will help familiarize you with benefits coverage options that are currently available, you can obtain more information regarding our benefits plans, including benefit summaries, from Staurolite 2.0 and the benefits website.

Staurolite 2.0: Click on "Benefits and you"

PMS benefits website: mybensite.com/pmsnm

The PMS employee benefits website will provide you with a comprehensive overview of your employee benefits including:

- Access to general plan information
- Links to provider directories
- Summary plan descriptions
- Open Enrollment information
- Comprehensive benefits booklets
- Valuable contact information
- Downloadable benefit forms and documents
- Online enrollment

FAMILY MEMBER ELIGIBILITY

Family Member Coverage

Employees who are .5 FTE or above and elect health insurance coverage can add eligible family members to their coverage.

Family Member Eligibility

Eligible family members include the following:

Legal spouse (recognized by state law)

Legal child, regardless of marital or student status up to age 26 defined as:

- Naturally born, legally adopted, stepchildren or child for whom the employee is the legal guardian

Examples of family members that do not meet our eligibility requirements and cannot be covered under our benefits plans:

- Common law spouse (New Mexico does not recognize common law marriage)
- Divorced spouse (even if you are required by a court order to provide benefits coverage for your ex-spouse, you are not allowed to cover them under the PMS benefits plans)
- Domestic partner, fiancé, boyfriend, or girlfriend
- Grandchildren (unless you have adopted or obtained legal guardianship)

If an enrolled family member loses eligibility during the year, you are required to remove that family member from the plan within 31 days of the change in eligibility. All children who reach the age limit of 26 will automatically be removed from the plan.

If you are not sure if your family member meets the eligibility definition, call the Benefits call center at 888-868-5530.

Note: You must provide family member eligibility documentation during your enrollment process. This includes a marriage certificate for your spouse and birth certificates for your children. Family members will not be enrolled in coverage without this documentation.

PMS MEDICAL PLANS

Eligibility Criteria

Employees at .50 FTE or above. Coverage is effective the first of the month after 60 days of continuous employment.

Presbyterian Medical Services offers eligible employees the choice between three self-insured medical plans: CDHP+HRA, EPO, and PPO. The administrator for these plans is Blue Cross and Blue Shield of New Mexico (BCBSNM). The BCBSNM network is one of the largest in the state and the US, and gives you access to providers both nationally and internationally. For a list of BCBSNM providers, go to www.bcbsnm.com.

All medical plans cover your preventive and certain behavioral health services at 100% with no out-of-pocket costs for in-network providers. In addition, all plans include a prescription drug benefit.

Below is a highlight of the medical plan options available. For a more detailed summary of the medical plan provisions, see the 2024 Benefit Plan Summaries booklet.

For more information on how these plans work go to the PMS employee benefits website.

Consumer Directed Health Plan + Health Reimbursement Arrangement (CDHP+HRA)

This consumer-directed health plan places greater control of healthcare expenditures in the hands of the plan participants. To help offset a portion of the deductible, PMS contributes $500 for individual coverage and $1,000 for family coverage into a Health Reimbursement Account (HRA) (prorated for the first calendar year of coverage). Until the HRA is exhausted, you pay nothing out of pocket for eligible PMS and/or BCBSNM PPO network and out-of-network services. Once the HRA is exhausted, you pay the remainder of the deductible. Once the deductible has been met, the coinsurance applies where the plan pays a percentage of the remaining claims (see side-by-side comparison in the Benefit Plan Summaries 2024 booklet). Any funds remaining in your HRA at the end of the calendar year will be rolled over into the next calendar year's HRA to a maximum of two times the annual HRA amount. Out-of-network services are covered at a reduced amount and subject to BCBSNM's allowable cost.

Exclusive Provider Option (EPO)

This plan keeps costs under control by restricting coverage to PMS and/or BCBSNM PPO Network providers and facilities (except in the case of emergency or prior medical approval). Office visits are subject to a co-payment. With exception of lab and x-ray services, all other services received during the office visit are subject to the deductible and coinsurance (see Side-By-Side comparison in the Benefit Plan Summaries 2024 booklet).

Preferred Provider Option (PPO)

This plan pays a more substantial benefit for services that are rendered with PMS and/or BCBSNM PPO Network providers and facilities. Office visits are subject to a co-payment. Any other services received during the office visit are subject to the deductible and co-insurance (e.g., diagnostic X-rays or lab work) (see Side-By-Side comparison in the Benefit Plan Summaries 2024 booklet). Out-of-network services are covered at a reduced amount and subject to Blue Cross Blue Shield of New Mexico's allowable cost.

Prescription Drug Coverage

All prescription drug coverage is provided through BCBSNM and our mail order provider Prime Mail. You may get your prescriptions filled at any participating retail pharmacy or use Prime Mail to order a 90-day supply to be delivered to your home. For questions regarding your prescription drug plan, please contact the following:

- **Blue Cross Blue Shield Member Services**: **800-432-0750 or bcbsnm.com**
- **Summary Document**: **See the benefits website**

Medical Plan Added Value Services

MDLive

Contact MDLive via 888-858-5074 or *MDLive.com/BCBSNM*. MDLive provides you and your covered dependents access to care for non-emergency medical issues and behavioral health needs through MDLive. Access to a board-certified doctor is available 24 hours a day, seven days a week. You can speak to a doctor immediately or schedule an appointment based on your availability. Virtual visits can be a better alternative than going to the emergency room or urgent care center. MDLive doctors or therapists can help treat the following conditions and more:

- General health
- Allergies
- Asthma
- Nausea
- Sinus infections
- Pediatric care
- Cold
- Flu
- Ear problems
- Pinkeye
- Behavioral health
- Anxiety/Depression
- Child behavior/Learning issues
- Marital problems

24/7 Nurse line 800-973-6329

The Nurse line can help you decide if you should call your doctor, go to the Emergency Room, an Urgent Care Center, or treat the problem yourself. This service could end up saving you money and time and is free for BCBSNM participants.

Blue Access for Members (BAM)℠

BAM allows you to access your claims data, order additional cards and access many value-added services. BAM is located at **bcbsnm.com**. You will have to register if this is your first website visit.

Identity Theft Protection Services

Employees (and their minor dependents) enrolled in BCBSNM medical insurance may enroll *at no cost* in identity theft protection through Experian. Services include credit monitoring, identity restoration, and up to $1 million in Identity Theft insurance.

To enroll, log in to your www.bcbsnm.com account, click on "Coverage", then Coverage & Benefits," then "Identity Protection" and follow the enrollment steps. Enrollment is annual, employees must re-enroll each year if they wish to continue the program.

Provider Finder®

Provider Finder from BCBSNM helps medical plan participants manage medical costs and quality of care by estimating provider and facility treatment costs and reporting quality rating information.

Use Provider Finder to:

- **Find** a network primary care physician, specialist or hospital.
- **Estimate the cost** of procedures, treatments and tests and gauge out-of-pocket expenses.
- **Determine** if a Blue Distinction Center for Specialty Care® is an option for treatment. Blue Distinction Centers can improve the quality-of-care employees receive by recognizing medical facilities that deliver better overall care. Blue Distinction Centers focus on high-volume, high-risk and high-cost areas of specialty care including cardiac, transplants, complex and rare cancers.
- **View** patient feedback or add a provider review.
- **Check** the quality, certifications and recognitions for doctors.

On **bcbsnm.com**, click on the Find a Doctors & Hospitals tab. PMS uses the PPO network.

Well on Target®

This BCBSNM site assists employees with health and wellness goals such as exercise programs, nutrition planning, smoking cessation, and disease management. Employees interested in a gym membership can access gym discounts through Well on Target and a free wellness app is available.

To access this site, log in to your www.bcbsnm.com account and click on "Wellness" then click on the Well on Target link to be taken to that website. Follow the instructions to get started.

Discounted Gym Memberships & Fitness Classes

Employees can access discounts on gym membership and fitness classes. To learn more and enroll, log in to your www.bcbsnm.com account and click on "Wellness" then click on the Fitness Program link to be taken to the Blue365 site. Follow the instructions to get started.

Blue365®

Blue365 offers members and covered dependents access to savings on many health care and wellness products and services including gym memberships, online and in-person fitness classes, online personal trainers, fitness equipment, fitness trackers, meal subscriptions, and hearing aids. To learn more, visit the **blue365deals.com/BCBSNM**.

Coverage Tier Options

When making your medical, dental, and vision benefit elections, you may choose from the following levels of coverage:

- **Employee only**
- **Employee plus one dependent**
- **Employee plus two or more dependents**

Your premium for coverage – including your contribution and PMS' contribution – will vary depending on which level of coverage you select.

SEMI-MONTHLY RATES: MEDICAL PLANS

Medical Blue Cross Blue Shield of NM
April 1, 2024 – March 31, 2025

Consumer Driven Health Plan (CDHP) + Health Reimbursement Arrangement (HRA)		
	Full-Time and Part-Time Grandfathered Premiums	Part-Time Premiums
Employee Only	$50.87	$173.61
Employee + 1 Dependent	$126.20	$355.40
Employee + 2 or more Dependents	$195.79	$476.99

Exclusive Provider Organization (EPO)		
	Full-Time and Part-Time Grandfathered Premiums	Part-Time Premiums
Employee Only	$96.48	$232.37
Employee + 1 Dependent	$214.98	$475.70
Employee + 2 or more Dependents	$305.17	$637.76

Preferred Provider Organization (PPO)		
	Full-Time and Part-Time Grandfathered Premiums	Part-Time Premiums
Employee Only	$160.36	$244.67
Employee + 1 Dependent	$333.09	$497.77
Employee + 2 or more Dependents	$494.67	$666.21

*Please refer to the Family Member Eligibility section of this book to determine who can be covered as a family member under the PMS benefits plans. For a list of network providers, visit **bcbsnm.com**.

Visit the benefits website at mybensite.com/pmsnm to obtain these important documents:

- Notice of Privacy Practices for PMS Group Health Plan
- BCBSNM Summary of Benefits and Coverage (SBC)
- Important Notice from Presbyterian Medical Services About Your Prescription Drug Coverage and Medicare
- Benefit Booklet for the CDHP + HRA plan, EPO, and PPO plans

PMS DENTAL PLAN

Eligibility Criteria

Employees at .50 FTE or above. Coverage is effective the first of the month after 60 days of continuous employment.

- Participating dentists bill Delta Dental directly. For covered services, subscribers are initially responsible only for co-payments and deductibles, if any.
- Pre-selection of a dentist is never required. Every member of the family may use a different dentist.
- The plan allows subscribers to visit a licensed dentist not participating in the plan, but costs are typically higher.

See the 2024 Benefit Plan Summaries booklet for detailed Dental plan provisions.

Delta Dental of New Mexico
April 1, 2024 – March 31, 2025

	Full-Time and Part-Time Grandfathered Premiums	Part-Time Premiums
Employee Only	**$4.00**	**$8.00**
Employee + 1 Dependent	**$7.62**	**$15.25**
Employee + 2 or more Dependents	**$12.25**	**$24.50**

*Please refer to the Family Member Eligibility section of this book to determine who can be covered as a family member under the PMS benefit plans. For a list of network providers, visit **deltadentalnm.com**.

Visit the benefits website at mybensite.com/pmsnm to obtain these important documents:

- Delta Dental Benefit Handbook
- Summary of Benefits

PMS VISION PLAN

Eligibility Criteria

Employees at .50 FTE or above. Coverage is effective the first of the month after 60 days of continuous employment.

The PMS vision plan is voluntary coverage provided through Vision Service Plan (VSP). Participating employees pay the full premium.

The full-service VSP Vision plan offers a network of participating providers throughout the US. The plan allows you to obtain eye exams and glasses from a participating provider for a minimal co-payment. Benefits are also available from a non-participating provider with reimbursement for services based on an allowance. For a list of VSP Providers, visit www.vsp.com. VSP does not provide membership cards.

See the 2024 Benefit Plan Summaries booklet for detailed vision plan provisions.

Vision Service Plan (VSP)
April 1, 2024 – March 31, 2025

	Full-Time, Part-Time Grandfathered and Part-Time Premiums
Employee Only	**$4.92**
Employee + 1 Dependent	**$9.83**
Employee + 2 or more Dependents	**$15.84**

*Please refer to the Family Member Eligibility section of this book to determine who can be covered as a family member under the PMS benefits plans. For a list of network providers, visit **vsp.com**.

Visit the benefits website at mybensite.com/pmsnm to obtain these important documents:

- Group Vision Care Policy Evidence of Coverage
- Summary of Benefits

PRE-TAX VS. POST-TAX DEDUCTIONS – PREMIUM ONLY PLAN

Eligibility Criteria

Employees at .50 FTE or above. Coverage is effective the first of the month after 60 days of continuous employment.

The PMS Premium Only Plan is regulated by Section 125 of the Internal Revenue Code, which allows employees to pay their premium contributions for employer sponsored group insurance plans with pre-tax dollars. Medical, dental, and vision plan premiums are eligible for pre-tax deductions under this section. When you make your benefit selection, indicate your preference for pre-tax or post-tax deductions.

If you elect **pre-tax** deductions:

- You receive a reduction in your taxable income, thus decreasing the amount of your annual income taxes.
- You cannot drop or change medical, dental or vision insurance coverage until the next open enrollment period unless you experience a qualifying life event (QLE). See QLE info on page 5.

If you elect **post-tax** deductions:

- You can drop medical, dental or vision insurance coverage at the end of a calendar month during the plan year.
- You cannot make changes to medical, dental or vision insurance coverage until the next open enrollment period unless you experience a qualifying life event (QLE).

For more information on how to make these changes, go to **mybensite.com/pmsnm** or call the PMS benefits call center at 888-868-5530.

Visit the benefits website at mybensite.com/pmsnm to obtain these important documents:

- Premium Only Plan.
- Welfare Benefits Wrap Plan Summary Plan Description

BASIC LIFE, AD&D AND LONG-TERM DISABILITY

Eligibility Criteria

Employees at .50 FTE or above. Coverage is effective the first of the month after 60 days of continuous employment.

Eligible employees are automatically enrolled in **Basic Term Life Insurance** and **Accidental Death and Dismemberment (AD&D)** coverage through Mutual of Omaha. Full-time and part-time grandfathered employees receive coverage in the amount of two times their annual salary, rounded to the next higher thousand to a maximum of $200,000. The Designated Provider maximum is $400,000. Part-time employees receive coverage in the amount of one times their annual salary, rounded to the next higher thousand to a maximum of $100,000 with a Designated Provider maximum of $200,000. The full premium for this benefit is paid by PMS.

AD&D insurance provides specified benefits for a covered accidental bodily injury that directly causes dismemberment. In the event that death occurs from a covered accident, both the basic life and AD&D benefits would be payable.

The **Basic Life Insurance and AD&D** coverage amounts are reduced 50% once you reach age 70.

Eligible employees are automatically enrolled in **Long Term Disability** insurance. After a 180-day elimination period the benefit will provide income (when combined with Social Security disability income or Workers Compensation income) which is equal to 60 percent of your basic monthly earnings to a maximum of $13,500. The full premium for this benefit is paid by PMS.

As an added value, you have access to **Worldwide Travel Assistance** and **Will Preparation** services. Please see the fliers in the 2024 Benefit Plan Summaries booklet.

Visit the PMS benefits website at mybensite.com/pmsnm to obtain these important documents:

- Mutual of Omaha Basic Life and AD&D Certificate
- Mutual of Omaha Group Long Term Disability Certificate

To update your life insurance beneficiary information, go to **mybensite.com/pmsnm** or call the **benefit call center** at **888-868-5530**. It is important that you keep this information current. You may update/change your beneficiary at any time.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Eligibility Criteria

Employees at .50 FTE or above. Coverage is effective the first of the month after 60 days of continuous employment.

Eligible employees and eligible dependents are automatically enrolled in this valuable support program. The EAP is administered by Mutual of Omaha who has been providing EAP services for over 25 years. The EAP assists with personal or job-related concerns, including emotional well-being, family & relationships, legal & financial matters, healthy lifestyles and work/life transitions. Benefits include:

- Unlimited telephone access to EAP professionals 24/7
- Telephone assistance and referral
- Robust network of licensed mental health professionals
- Five face-to-face sessions* with a counselor (per household, per calendar year)
  * Face-to-face visits can also be used toward legal consultation
- Toll-free phone and web access 24/7
- Legal assistance and financial services
- Access to a library of educational articles, handouts, and resources

For more information or to access the benefits of the **EAP** go to **mutualofomaha.com/eap** or call **800-316-2796**.
An informative flyer is available on Staurolite 2.0 by clicking the "Benefits & You" link.

VOLUNTARY SUPPLEMENTAL BENEFITS

Eligibility Criteria

Employees at .50 FTE or above. Coverage is effective the first of the month after 60 days of continuous employment.

Identity Theft Protection

PMS offers employees the opportunity to purchase Identity Theft Protection through Norton LifeLock. Two plan options with two service levels are available.

Mutual of Omaha provides the following supplemental benefits:

Accident Insurance

24-hour Accident coverage provides cash benefits for out-of-pocket expenses associated with an accidental injury and can help protect hard-earned savings should an on- or off-the-job accidental injury occur. Benefits correspond with treatment for injuries including hospitalization, emergency treatment, intensive care, fractures and more.

Short-Term Disability Insurance

Short-Term Disability coverage provides weekly benefits for a period of up to 24 weeks when an employee is unable to work because of a covered sickness or off-the-job injury. You may choose a benefit amount up to $1,500 per week to a maximum of 60% of your monthly income.

Supplemental Term Life Insurance

Supplemental Term Life Insurance coverage is age-based and pays a lump sum benefit at the time of death. You may purchase coverage in multiples of $10,000 subject to a maximum amount equal to the lesser of $500,000 or five times your annual salary.

Voluntary Critical Illness Insurance

Critical Illness insurance provides a lump sum cash benefit to help cover expenses associated with a qualifying serious illness such as cancer, heart attack, stroke, organ transplant, end-stage renal failure and other ailments.

For a more detailed summary of the provisions of the voluntary benefits listed above, see the 2024 Benefit Plan Summaries booklet.

Visit the benefits website at mybensite.com/pmsnm for plan summaries.

To update your life insurance beneficiary information, go to **mybensite.com/pmsnm** or call the **benefits call center** at **888-868-5530**. It is important that you keep this information current. You may update/change your beneficiary at any time.

RETIREMENT PROGRAMS

PMS Discretionary Contribution Plan

Eligibility Criteria

Employees who are age 18 and above are eligible to participate after they have completed one year of service and have worked at least 1,000 hours during their first twelve consecutive months of employment. Employees enter the plan on either January 1st or July 1st (whichever occurs first) after meeting the eligibility requirements.

This is a type of qualified retirement plan commonly referred to as a discretionary contribution plan where PMS makes contributions to the plan on behalf of eligible employees. Eligible employees must be actively employed on the last day of the plan year (December 31st) in order to receive the employer contribution. This plan is 100% funded by PMS. Employer contributions are generally funded at the end of March for the previous year.

Employees are fully vested in the plan after six "Years of Service". To earn a "Year of Service," employees must be credited with at least 1,000 hours of service during any plan year.

Visit the benefits website at mybensite.com/pmsnm to obtain these important documents:

- *Presbyterian Medical Services Discretionary Contribution Plan Summary Plan Description.*

Update or change your beneficiary information at any time by contacting **The Newport Group** at **844-749-9981** or **newportgroup.com**. It is important that you keep this information current. You may update/change your beneficiary at any time.

403(b) Retirement Savings Plan

Eligibility Criteria

All employees, excluding temporary employees, are eligible to participate upon employment with no waiting period.

A 403(b) plan is a retirement savings plan that allows participating employees to defer a portion of their pay into individual plan accounts. PMS will make employee payroll deductions to the vendor of their choice – American Century, Mutual of America, or Vanguard. Plan participants can choose among various investment options that meet their tolerance level for risk and return. Investments include both **pre-tax** (Traditional) and **post-tax** (Roth) options.

For 2024, IRS regulations limit employee deferrals to a maximum of $23,000 per year. In addition, employees aged 50 or older can make catch-up contributions up to $7,500 higher than the standard limit.

The basic difference between a traditional and Roth 403(b) is when you pay the taxes.

Pre-tax (Traditional) deductions:

- The taxable income on each paycheck is reduced by the amount of the 403(b) deduction, so you get the tax break now.
- You will pay taxes when you start taking withdrawals at retirement.

Post-tax (Roth) deductions:

- Your 403(b) deduction is made with after-tax dollars meaning you are taxed on that current paycheck.
- Because you have already paid the taxes, Roth elective deferrals and any associated earnings are eligible for tax-free withdrawal if your Roth account has been open for at least 5 years and you are at least 59 ½ years of age.

You can begin taking normal distributions from a 403(b) plan at age 59½. In general, a distribution taken before age 59½ may be subject to a 10% penalty. You must begin taking distributions by April 1st of the year after you reach age 73 or retire, whichever is later. These distributions are commonly referred to as required minimum distributions (RMDs). After that, you must take distributions annually by December 31. If you don't take the RMDs on time, the IRS will assess you a penalty of 50% of the amount that should have been withdrawn.

Contact American Century, Mutual of America or Vanguard for additional information regarding how these accounts work, fees and to review account agreements.

Visit the benefits website at mybensite.com/pmsnm for information on how to enroll in the 403(b) Retirement Savings Plan:

Note: The 403(b) Retirement Savings Plan is a **non-ERISA** benefit and is offered as a courtesy to PMS employees. Any questions regarding these benefits should be directed to your selected vendor – **American Century**, **Mutual of America** or **Vanguard**.

PAID & UNPAID LEAVE PROGRAMS

PMS provides several different paid and unpaid leave programs to allow you time to enjoy with your friends and family as well as to care for them and yourself.

Paid-Time Off (PTO)

The PTO plan is designed to ensure that individuals employed by PMS have periods of rest and relaxation which contribute to their quality of life by maintaining an equitable balance between work and family/personal time.

Eligibility Criteria

Employees who are classified at a .50 FTE or greater are eligible for PTO leave.

Waiting Period:

Eligible employees can request PTO upon employment and can use PTO when it is available in the payroll system.

PTO Hours Provided:

PTO hours are provided to eligible employees in accordance with one of the following three PTO schedules: Non-Exempt, Exempt or Designated Clinician.

PTO Carryover:

Employees are allowed to carry over a maximum number of unused PTO hours into the next calendar year per the applicable schedules below. Any unused hours above the maximum carryover limit will be forfeited by the employee.

NON-EXEMPT EMPLOYEE PTO SCHEDULE			
YEARS OF SERVICE	ANNUAL # OF DAYS	ANNUAL MAX # OF HOURS	PTO CARRYOVER
Less than 1	16	128	192
1 to less than 5	19	152	228
5 to less than 10	22	176	264
10 or More	25	200	300

EXEMPT EMPLOYEE PTO SCHEDULE			
YEARS OF SERVICE	ANNUAL # OF DAYS	ANNUAL MAX # OF HOURS	PTO CARRYOVER
Less than 1	19	152	228
1 to less than 5	22	176	264
5 to less than 10	25	200	300
10 or More	28	224	336

*Non-exempt LPN's and RN's will accrue PTO leave based upon the exempt employee schedule.

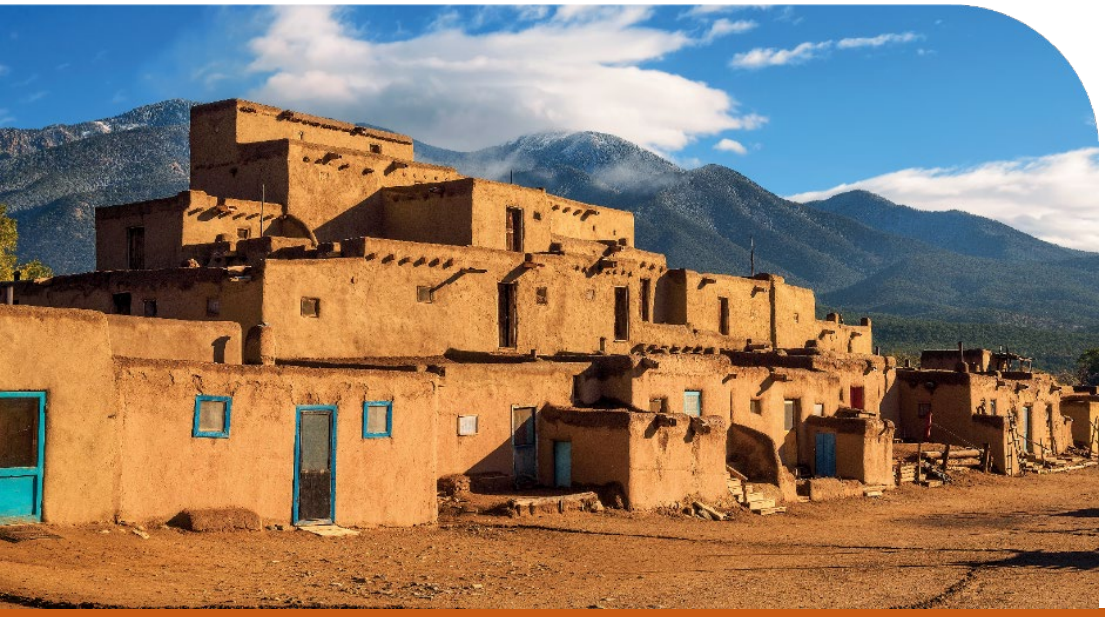
DESIGNATED CLINICIAN SCHEDULE: (Physicians, Psychiatrists, Dentists, Physician Assistants, Nurse Practitioners, Prescribing Psychologists, Psychiatric & Mental Health Nurse Practitioners)			
YEARS OF SERVICE	**ANNUAL # OF DAYS**	**ANNUAL MAX # OF HOURS**	**PTO CARRYOVER**
Less than 5	**25**	**200**	**300**
5 or More	**28**	**224**	**336**

New Mexico Healthy Workplace Act:

The PMS PTO policy complies with all provisions of the New Mexico Healthy Workplace Act and any other applicable state sick leave laws. For more information, see PMS policy 208.001 Paid Time Off.

PTO Payout:

Upon termination of employment, eligible employees who have completed six months of continuous employment and who have given appropriate written notice of two weeks (fourteen calendar days) for most non-exempt; four weeks (twenty-eight calendar days) for exempt and non-exempt nurses; will be paid out their PTO balance at 75% of the total value.



PAID HOLIDAY LEAVE

Standard Holidays

Eligibility Criteria

Employees at **.50 FTE or above**, effective upon employment.

PMS recognizes seven holidays per year:

- New Year's Day
- President's Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day
- Christmas Day

Float and Birthday Holidays

Eligibility Criteria

Employees at **.5 FTE or above**, effective upon employment.

PMS grants two additional holidays for personal use – a floating holiday and a birthday holiday which may be taken any time during the calendar year but must be taken by December 31st.

Bereavement (Funeral) Leave

Eligibility Criteria

Employees at **.75 FTE or above**, effective upon date of hire.

PMS recognizes the importance of family and the difficulties employees face following the loss of a loved one. For eligible employees, PMS provides up to three days of paid leave (prorated to the employee's FTE level), following the loss of an employee's immediate family member.

"Immediate Family" is defined as the employee's parent, spouse, child, brother, sister, grandparent, grandchild or corresponding step or in-law relationship, whether related by blood, adoption or marriage.

Professional Continuing Education Leave

Eligibility Criteria

All regular status licensed clinical professionals who must maintain licensure as a condition of employment, at a .50 FTE or above and at least six months of continuous service with PMS at the time of the request for continuing education leave, are eligible for this leave.

Eligible licensed professionals may be granted paid continuing education leave, prorated to FTE level. Licensed professionals include those employees who must maintain State of New Mexico licensure or certification as a condition of employment. Physicians, dentists, and advanced practitioners are eligible for up to 40 hours per calendar year, prorated to FTE level; and all other eligible licensed professionals are eligible for up to 20 hours per calendar year, prorated to FTE level.

OTHER LEAVE PROGRAMS

These and other policies are available on Staurolite 2.0.

- **Domestic Abuse Leave** – Refer to the Domestic Abuse Leave policy
- **Family and Medical Leave of Absence (FMLA)** – Refer to the FMLA policy
- **Paid Sick Leave For Part-Time Employees** – Refer to the Paid Sick Leave For Part-Time Employees policy, for employees who are less than 0.5 FTE
- **Jury Duty Leave** – Refer to the Civic Responsibility Leave policy
- **Leave of Absence (LOA)** – Refer to the Leave of Absence policy
- **Military Leave of Absence** – Refer the Military Leave of Absence policy
- **Voting Leave** – Refer to the Civic Responsibility Leave policy

Contact the Human Resources Administrator at *hradministrator@pmsnm.org* if you have questions regarding these leaves.

ADDITIONAL BENEFITS

Educational Assistance

Eligibility Criteria

Employees at .75 FTE or above who have completed at least one year of continuous employment.

Eligible employees may be reimbursed for courses of study that PMS determines are directly related to the employee's present job or that will enhance the employee's potential for advancement to a position within PMS and which the employee has a reasonable expectation of attaining. PMS reimburses approved expenses including tuition, books, and fees at the rate of 75%, up to a maximum of $1,500 per calendar year. Educational assistance requests must be received and approved by the Human Resources Department prior to the start of the class.

Malpractice Insurance

Eligibility Criteria

All licensed professionals are provided with 100% occurrence-based paid professional malpractice insurance in the amounts of $1 million/$9 million in coverage. Licensed employees are eligible for this coverage upon employment.

Professional Stipend

Eligibility Criteria

Licensed professionals, employed at .50 FTE or above, after six months of continuous employment. Licensed professionals are provided with a stipend to offset the cost associated with continuing education expenses, professional fees and licensure. The amount of payment is based upon specific licensure type and is prorated to FTE level. Payment is provided annually in two installments paid to active employees on June 30th and December 31st.

IMPORTANT RIGHTS & LEGAL REQUIREMENTS

COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) provides for continued coverage for a certain period of time at applicable monthly COBRA rates if you, your spouse, or your dependents lose group medical, dental, or vision because you terminate employment (for reason other than gross misconduct); your work hours are reduced below the eligible status for these benefits; death, divorce, legal separation, or if you are on your spouse's medical plan and your spouse becomes entitled to Medicare A or B or both; or your child ceases to be an eligible dependent.

If you experience a Qualifying Event, you must notify the PMS Benefits Call Center within the proper deadlines as detailed on page 5 of this booklet.

Genetic Information Nondiscrimination Act (GINA)

Group health plans are prohibited from adjusting premiums or contribution amounts for a group on the basis of genetic information. A health plan is also prohibited from requiring an individual or his/her family member to undergo a genetic test, although the plan may request that a voluntary test be taken for research purposes.

Medicare Part D

If you have Medicare or will become eligible for Medicare in the next 12 months a Federal law gives you more choices about your prescription drug coverage. Visit the PMS Employee Benefits Website at **mybensite.com/pmsnm** to obtain the document entitled **Important Notice from Presbyterian Medical Services About Your Prescription Drug Coverage and Medicare**.

Mental Health Parity Act

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) generally applies to Employers that employ more than 50 employees and its health plan provides for mental health and substance abuse benefits. These group health plans must cover mental health and substance abuse in a manner equal to their coverage of predominant medical and surgical services.

Financial and treatment limits for mental health/substance abuse, such as deductibles, co-payments, coinsurance and out-of-pockets expenses, days of coverage, limited networks for services, and other similar limits on dollars, scope, or duration of treatment may not be substantially more limited than for medical/surgical benefits. For example, a plan may not apply separate deductibles for treatment related to mental health or substance abuse use disorders and medical or surgical benefits-they must be calculated as one limit.

To the extent that non-grandfathered small group plans are required to provide essential health benefits, including mental health and substance abuse disorder benefits for plan years beginning on or after July I, 2014, such benefits will comply with final rules under the MHPAEA.

Newborns and Mothers' Health Protection Act

MATERNITY BENEFITS

Under Federal and state law you have certain rights and protections regarding your Maternity benefits under the Plan.

Under federal law known as the **"Newborns' and Mothers' Health Protection Act of 1996" (Newborns' Act)** group health plans and health insurance issuers generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Under New Mexico law, if your Plan provides benefits for obstetrical services your benefits will include coverage for postpartum services. Coverage will include benefits for inpatient care and a home visit or visits, which shall be in accordance with the medical criteria, outlined in the most current version of or an official update to the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists or the "Standards for Obstetric-Gynecologic Services" prepared by the American College of Obstetricians and Gynecologists. Coverage for obstetrical services as an inpatient in a general Hospital or obstetrical services by a Physician shall provide such benefits with durational limits, deductibles, coinsurance factors, and copayments that are no less favorable than for physical Illness generally.

Social Security Numbers for Dependents

The Mandatory Insurer Reporting Law (Section 111 of Public Law 110-173) requires group health plan insurers to report Social Security numbers for Medicare to coordinate payments with other insurance benefits. The law was enacted in late 2007 and became effective on January 1, 2009. As a subscriber (or spouse or family member of a subscriber) to a PMS Group Health Plan Arrangement, the Social Security numbers of enrolled employees and dependents must be furnished to meet the requirements of this law. Please make sure your information is up to date with the Human Resources Department and your dependent information is up to date with the PMS Benefits Call Center or Website.

Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment no later than 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment no later than "31 days" after the marriage, birth, adoption, or placement for adoption.

Effective April 1, 2009, if either of the following two events occur, you will have 60 days after the date of the event to request enrollment in your employer's plan:

- Your dependents lose Medicaid or CHIP coverage because they are no longer eligible.
- Your dependents become eligible for a state's premium assistance program.

To take advantage of special enrollment rights, you must experience a qualifying event and provide the employer plan with timely notice of the event and your enrollment request. Proper documentation is required for approval of the qualifying event.

To request special enrollment or obtain more information, contact the PMS Benefits Call Center at 888-868-5530.

State of New Mexico Contractor Health Coverage Requirement

Pursuant to Executive Order 2007-049, PMS is required to advise employees of the availability of State publicly financed health care coverage programs. To obtain additional information about these plans please visit: www.insurenewmexico.state.nm.us/.

Summary of Benefits and Coverage and Uniform Glossary of Terms

Under the law, insurance companies and group health plans will provide consumers with a concise document detailing, in plain language, simple and consistent information about health plan benefits and coverage. This summary of benefits and coverage document will help consumers better understand the coverage they have and, for the first time, allow them to easily compare different coverage options. It will summarize the key features of the plan or coverage, such as the covered benefits, cost-sharing provisions, and coverage limitations and exceptions. People will receive the summary when shopping for coverage, enrolling in coverage, at each new plan year, and within seven business days of requesting a copy from their health insurance issuer or group health plan.

Consumers will also have a new resource to help them understand some of the most common but confusing jargon used in health insurance. Insurance companies and group health plans will be required to make available upon request a uniform glossary of terms commonly used in health insurance coverage such as "deductible" and "co-payment". To help ensure the document is easily accessible for consumers, the Departments of Health and Human Services (HHS) and Labor will also post the glossary on the new health care reform website www.HealthCare.gov and www.dol.gov/ebsa/healthreform.

Waiver of Annual Dollar Amounts

The Patient Protection and Affordable Care Act (PPACA) generally prohibits health plans from imposing lifetime and annual limits on the dollar value of essential health benefits.

Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act of 1998 (WHCRA) requires group health plans to make certain benefits available to participants who have undergone a mastectomy. In particular, a plan must offer mastectomy patients benefits for:

- All stages of reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance

- Prostheses
- Treatment of physical complications of the mastectomy, including lymphedema

Our plan complies with these requirements. Benefits for these items generally are comparable to those provided under our plan for similar types of medical services and supplies. Of course, the extent to which any of these items is appropriate following mastectomy is a matter to be determined by the patient and her physician. Our plan neither imposes penalties (for example, reducing or limiting reimbursements) nor provides incentives to induce attending providers to provide care inconsistent with these requirements. If you would like more information about WHCRA required coverage, you can contact the PMS Benefits Call Center at 888-868-5530.

W-2 Reporting Requirement for Employer Sponsored Group Health Plans

PPACA requires employers to include the cost of employer-sponsored group health plan coverage on employees' W-2 forms. This reporting to you is for information purposes only and does not impact your taxable income.

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Presbyterian Medical Services Plan
Notice of Privacy Practices
April 1, 2024

The Presbyterian Medical Services plans maintain a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you have questions about the Plan's Notice of Privacy Practices, please contact your Benefits Administrator at **benefits@pmsnm.org** or **505-443-1125**.

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), you have certain rights with respect to your Protected Health Information ("PHI"), including the right to know how your PHI may be used by a group health plan.

This Notice of Privacy Practices ("Notice") covers the following group health plans (collectively referred to as the "Plan"):

- Medical
- Dental
- Vision
- EAP

The Plan is required by law to maintain the privacy of your PHI and to provide this Notice to you pursuant to HIPAA. This Notice describes how your PHI may be used or disclosed to carry out treatment, payment, health care operations, or for any other purposes that are permitted or required by law. This Notice also provides you with the following important information:

- Your privacy rights with respect to your PHI;
- The Plan's duties with respect to your PHI;
- Your right to file a complaint with the Plan's Privacy Officer and/or to the Secretary of the Office of Civil Rights of the U.S. Department of Health and Human Services; and
- The person or office to contact for further information about the Plan's privacy practices.

PHI is health information (including genetic information) in any form (oral, written, electronic) that:

- Is created or received by or on behalf of the Plan;
- Relates to your past, present or future physical or mental condition, or the provision of health care services to you, or the payment for those health care services; and
- Identifies you or from which there is a reasonable basis to believe the information can be used to identify you.

Health information your employer receives during the course of performing non-Plan functions is not PHI. For example, health information you submit to your employer to document a leave of absence under the Family and Medical Leave Act is not PHI.

Section 1. USES AND DISCLOSURES OF YOUR PHI

Under HIPAA, the Plan may use or disclose your PHI under certain circumstances without your consent, authorization or opportunity to agree or object. Such uses and disclosures fall within the categories described below. Note that not every permissible use or disclosure in a category is listed; however, all the ways in which the Plan is permitted to use or disclose PHI will fall within one of the categories.

General Uses and Disclosures

Treatment. The Plan may use and/or disclose your PHI to help you obtain treatment and/or services from providers. Treatment includes the provision, coordination or management of health care and related services. It also includes, but is not limited to, consultations and referrals between one or more of your providers. For example, the Plan may disclose to a treating orthodontist the name of your treating dentist so that the orthodontist may ask for your dental x-rays from the treating dentist. The Plan may also disclose information about your prior prescriptions to a pharmacist to determine if any medicines contraindicate a pending prescription.

Payment. The Plan may use and/or disclose your PHI in order to determine your eligibility for benefits, to facilitate payment of your health claims and to determine benefit responsibility. Payment includes, but is not limited to billing, claims management, subrogation, plan reimbursement, reviews for medical necessity and appropriateness of care and utilization review and preauthorization's. For example, the Plan may tell a doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan. The Plan may also disclose your PHI to another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate payment of benefits.

Health Care Operations. The Plan may use and/or disclose your PHI for other Plan operations. These uses and disclosures are necessary to run the Plan and include, but are not limited to, conducting

quality assessment and improvement activities, reviewing competence or qualifications of health care professionals, underwriting, premium and other activities relating to Plan coverage. It also includes cost management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general Plan administrative activities. For example, the Plan may use your PHI in connection with submitting claims for stop-loss coverage. The Plan may also use your PHI to refer you to a disease management program, project future costs or audit the accuracy of its claims processing functions. However, the Plan is prohibited from using or disclosing PHI that is an individual's genetic information for underwriting purposes.

Business Associates. The Plan may contract with individuals or entities known as Business Associates to perform various functions on the Plan's behalf or to provide certain types of services. In order to perform these functions or to provide such services, the Business Associates will receive, create, maintain, use and/or disclose your PHI. For example, the Plan may disclose your PHI to a Business Associate to administer claims or provide pharmacy benefit management services. However, Business Associates will receive, create, maintain, use and/or disclose your PHI on behalf of the Plan only after they have entered into a Business Associate agreement with the Plan and agree in writing to protect your PHI against inappropriate use or disclosure and to require that their subcontractors and agents do the same.

Plan Sponsor. For purposes of administering the Plan, the Plan may disclose your PHI to certain employees of Presbyterian Medical Services. However, these employees will only use or disclose such information as necessary to perform administration functions for the Plan or as otherwise required by HIPAA, unless you have authorized further disclosures. Your PHI cannot be used for employment purposes without your specific authorization.

Required By Law. The Plan may disclose your PHI when required to do so by federal, state or local law. For example, the Plan may disclose your PHI when required by public health disclosure laws.

Health or Safety. The Plan may disclose and/or use your PHI when necessary to prevent a serious threat to your health or safety or the health or safety of another individual or the public. Under these circumstances, any disclosure will be made only to the person or entity able to help prevent the threat.

Special Situations

In addition to the above, the following categories describe other possible ways that the Plan may use and disclose your PHI without your consent, authorization or opportunity to agree or object. Note that not every permissible use or disclosure in a category is listed; however, all the ways in which the Plan is permitted to use or disclose PHI will fall within one of the categories.

Public Health Activities. The Plan may disclose your PHI when permitted for purposes of public health actions, including when necessary to report child abuse or neglect or domestic violence, to report reactions to drugs or problems with products or devices, and to notify individuals about a product recall. Your PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition.

Health Oversight. The Plan may disclose your PHI to a public health oversight agency for oversight activities authorized by law. Oversight activities can include civil, administrative or criminal actions, audits and inspections, licensure or disciplinary actions (for example, to investigate complaints against providers); other activities necessary for appropriate oversight of government benefit programs (for

example, to investigate Medicare or Medicaid fraud); compliance with civil rights laws and the health care system in general.

Lawsuits, Judicial and Administrative Proceedings. If you are involved in a lawsuit or similar proceeding, the Plan may disclose your PHI in response to a court or administrative order. The Plan may also disclose your PHI in response to a subpoena, discovery request or other lawful process by another individual involved in the dispute, provided certain conditions are met. One of these conditions is that satisfactory assurances must be given to the Plan that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or were resolved in favor of disclosure by the court or tribunal.

Law Enforcement. The Plan may disclose your PHI when required for law enforcement purposes, including for the purposes of identifying or locating a suspect, fugitive, material witness or missing person.

Coroners, Medical Examiners, and Funeral Directors. The Plan may disclose your PHI when required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the descendent.

Workers' Compensation. The Plan may release your PHI for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

National Security and Intelligence. The Plan may release PHI to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Military and Veterans. If you are a member of the armed forces, the Plan may disclose your PHI as required by military command authorities. The Plan may also release PHI about foreign military personnel to the appropriate foreign military authority.

Organ and Tissue Donations. If you are an organ donor, the Plan may disclose your PHI to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Research. The Plan may disclose your PHI for research when the individual identifiers have been removed or when the institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the requested information and approves the research.

Required Disclosure to Secretary

The Plan is required to disclose your PHI to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining the Plan's compliance with HIPAA.

Disclosures to Family Members and Personal Representatives

The Plan may disclose your PHI to family members, other relatives and your close personal friends but only to the extent that it is directly relevant to such individual's involvement with a coverage, eligibility or payment matter relating to your care, unless you have requested, and the Plan has agreed not to disclose your PHI to such individual. The Plan will disclose your PHI to an individual authorized by you, or to an individual designated as your personal representative, provided the Plan has received the appropriate authorization and/or supporting documents. Your personal representative will be

required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- A power of attorney for health care purposes, notarized by a notary public:
- A court order of appointment of the person as the conservator or guardian of the individual; or
- An individual who is the parent of a minor child.

However, the Plan will not disclose information to an individual, including your personal representative, if it has a reasonable belief that:

- You have been, or may be, subjected to domestic violence, abuse or neglect by such person or treating such person as your personal representative could endanger you; and
- In the exercise of professional judgment, it is not in your best interest to disclose the PHI.

This also applies to personal representatives of minors.

Authorization

Any uses or disclosures of your PHI not described above will be made only with your written authorization. Most disclosures involving psychotherapy notes will require your written authorization. In addition, the Plan generally cannot use your PHI for marketing purposes or engage in the sale of your PHI without your written authorization. You may revoke your written authorization at any time, so long as the revocation is in writing. Once the Plan receives your authorization, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

Section 2. RIGHTS OF INDIVIDUALS

You have the following rights with respect to your PHI:

Right to Request Restrictions on PHI Uses and Disclosures. You may request in writing that the Plan restrict or limit its uses and disclosures of your PHI to carry out treatment, payment, or health care operations, or to limit disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. For example, you could request that the Plan not use or disclose specific information about a specific medical procedure you had. However, the Plan is not required to agree to your request.

Right to Request Confidential Communications. You have the right to request that the Plan communicate with you about medical matters in a certain way or at a certain location. For example, you may ask that we only contact you at work or by mail. The Plan will not ask you the reason for your request, which must specify how or where you wish to be contacted. The Plan will accommodate all reasonable requests to receive communications of PHI by alternative means if you clearly provide information that the disclosure of all or part of your PHI could endanger you.

Right to Inspect and Copy PHI. You have a right of access to inspect and obtain a copy of your PHI (including electronic PHI) contained in the Plan's "designated record set," for as long as the PHI is

maintained by the Plan in a designated record set. If you request a copy of the information, the Plan may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request.

"Designated Record Set" includes the medical records and billing records about an individual maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used in whole or in part by or for the covered entity to make decisions about the individual. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set.

If your request is granted, the requested information will be provided to you within 30 days after the receipt of your request in the form and format requested, if it is readily producible in such form and format, or if not, in a readable hard copy form (or a readable electronic form and format in the case of PHI maintained in designated records sets electronically) or such other form and format as agreed upon by you and the Plan. If the Plan is unable to comply with request within the 30-day deadline, a one-time 30-day extension is permissible. In such case, you will receive notification of the need for an extension within the initial 30-day period.

Please note that your right does not apply to psychotherapy notes or information compiled in reasonable anticipation of a legal proceeding. The Plan may deny your request to inspect and copy your PHI in very limited circumstances. If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

Right to Amend PHI. If you believe that the PHI the Plan has about you is incorrect or incomplete, you have the right to request in writing that the Plan amend your PHI or a record contained in a designated record set for as long as the PHI is maintained by the Plan in the designated record set. The Plan has 60 days after the request is made to act on the request. However, a single 30-day extension is allowed if the Plan is unable to comply with the deadline.

The Plan may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, the Plan may deny your request if you ask for the amendment of information that: (1) is not part of the medical information kept by or for the Plan; (2) was not created by the Plan, unless the person or entity that created the information is no longer available to make the amendment; (3) is not part of the information that you would be permitted to inspect or copy; or (4) is already accurate and complete. If the request is denied in whole or in part, the Plan must provide you with a written denial that explains the basis for the denial. You have the right to file a written statement of disagreement and any future disclosures of the disputed information will include your statement.

The Right to Receive an Accounting of PHI Disclosures. You have the right to receive a list of disclosures of your PHI that have been made by the Plan on or after April 14, 2003 (or January 1, 2011 in the case of disclosures of your PHI from electronic health records maintained by the Plan, if any) over a period of up to six years (three years in the case of disclosures from an electronic health record) prior to the date of your request. Certain disclosures are not required to be included in such accounting of disclosures, including but not limited to disclosures made by the Plan (1) for treatment, payment or health care operations (unless the disclosure is made from an electronic health record), or (2) in

accordance with your authorization. If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

The Right to Receive a Paper Copy of This Notice Upon Request. You have the right to receive a paper copy of this Notice even if you have agreed to receive this Notice electronically.

To exercise any of your HIPAA rights described above, you or your personal representative must contact the HIPAA Privacy Officer in writing at 1422 Paseo de Peralta, Santa Fe, NM 87501 or by calling 505-982-5565. You or your personal representative may be required to complete a form required by the Plan in connection with your specific request.

Section 3. THE PLAN'S DUTIES

Notice of Privacy Practices. The Plan is required by law to provide individuals covered under the Plan with notice of its legal duties and privacy practices. The Plan is required to comply with the terms of this Notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan prior to that date. In the event of any material change to this Notice, a revised version of this Notice will be distributed to all individuals covered under the Plan within 60 days of the effective date of such change by first-class U.S. mail or with other Plan communications.

Breach Notification. The Plan has a legal duty to notify you following the discovery of a breach involving your unsecured PHI.

Minimum Necessary Standard. When using or disclosing PHI, the Plan will use and/or disclose only the minimum amount of PHI necessary to accomplish the intended purposes of the use or disclosure. However, the minimum necessary standard will not apply in the following situations:

Disclosure to or requests by a health care provider for treatment:

- Uses or disclosures made to you; and
- Uses or disclosures that are required by law.

Section 4. COMPLAINTS

If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the appropriate regional office of the Office for Civil Rights of the U.S. Department of Health and Human Services. To file a complaint with the Plan, contact the HIPAA Privacy Officer in writing at 1422 Paseo de Peralta, Santa Fe, NM 87501 or by calling 505-982-5565.

You will not be penalized or in any other way retaliated against for filing a complaint with the Office for Civil Rights or with the Plan.

Section 5. ADDITIONAL INFORMATION

If you have any questions regarding this Notice or the subjects addressed in it, you may contact the HIPAA Privacy Officer in writing at 1422 Paseo de Peralta, Santa Fe, NM 87501 or by calling 505-982-5565.

CHIPRA/CHIP Notice

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility -

ALABAMA – Medicaid	CALIFORNIA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
ALASKA – Medicaid	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442
ARKANSAS – Medicaid	**FLORIDA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	MASSACHUSETTS – Medicaid and CHIP
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
INDIANA – Medicaid	**MINNESOTA – Medicaid**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
IOWA – Medicaid and CHIP (Hawki)	**MISSOURI – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KANSAS – Medicaid	**MONTANA – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
KENTUCKY – Medicaid	**NEBRASKA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
LOUISIANA – Medicaid	**NEVADA – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900

MAINE – Medicaid	NEW HAMPSHIRE – Medicaid
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
NEW JERSEY – Medicaid and CHIP	**SOUTH DAKOTA - Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW YORK – Medicaid	**TEXAS – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493
NORTH CAROLINA – Medicaid	**UTAH – Medicaid and CHIP**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH DAKOTA – Medicaid	**VERMONT– Medicaid**
Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825	Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access (https://dvha.vermont.gov/members/medicaid/hipp-program) Phone: 1-800-250-8427
OKLAHOMA – Medicaid and CHIP	**VIRGINIA – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
OREGON – Medicaid	**WASHINGTON – Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
PENNSYLVANIA – Medicaid and CHIP	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) (https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx) CHIP Phone: 1-800-986-KIDS (5437)	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
RHODE ISLAND – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: http://www.eohhs.ri.gov/	Website:

Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA – Medicaid	**WYOMING – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20220 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137. MB Control Number 1210-0137 (expires 1/31/2023)

Non-Discrimination Notice

Presbyterian Medical Services (PMS) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. PMS does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

PMS:

1. Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    a. Qualified sign language interpreters
    b. Written information in other formats (large print, audio, accessible electronic formats, other formats)
2. Provides free language services to people whose primary language is not English, such as:
    a. Qualified interpreters

b. Information written in other languages

If you need these services, contact your clinic Site Administrator or the PMS Benefits Administrator at (505) 443-1125.

If you believe that PMS has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Presbyterian Medical Services
PO 2267
Santa Fe, NM 87504
(505) 443-2596
Email: benefits@pmsnm.org

You can file a grievance in person or by phone, mail or email. If you need help filing a grievance, the clinic Site Administrator or Benefits Administrator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Ave., SW, Rm. 509F, HHH Bldg.
Washington, D.C. 20201
(800) 368-1019
(800) 537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Presbyterian Medical Services (PMS) cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. PMS no excluye a las personas ni las trata de forma diferente debido a su origen étnico, color, nacionalidad, edad, discapacidad o sexo.

Presbyterian Medical Services (PMS) bik'ehgo hójił'ínígíí bidadeeti'ígíí Wáashindoon t'áá át'é bilá'ashdla'ii bee bá ádahaazt'i'ígíí bibee haz'ąąnii dóó doo ak'íjį' nitsáhákees da díí ninahjį' ał'ąą dadine'é, dine'é bikágí át'ehígíí, binááhai'ígíí, nazhnitł'ago da, éí doodaii' asdzání dóó diné át'ehígíí.

LANGUAGE ASSISTANT SERVICES	
English	ATTENTION: If you speak English, assistance services for deaf/hard of hearing, free of charge, are available to you. Call your clinic or the PMS Quality Department at (505) 237-4081. (TTY: 711)
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (844) 663-6191, prensa 1. (TTY: 711)
Navajo	D77 baa ak0 n7n7zin: D77 saad bee y1n7[ti'go **Diné Bizaad**, saad bee 1k1'1n7da'1wo'd66', t'11 jiik'eh, 47 n1 h0l=, koj8' h0d77lnih (844) 663-6191, Press 2. (TTY: 711)
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số (844) 663-6192, báo chí 5. (TTY: 711)
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: (844) 663-6191, presse 4. (TTY: 711)
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 (844) 663-6192, 新聞 1。(TTY: 711)
Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم (844)

	).7 اضغط ،6191-663TTY(711 :
Korean	주의: 한국어를 사용하는 경우 언어 지원 서비스를 무료로 사용할 수 있습니다. (844) 663-6192를 누른 다음 3을 누릅니다. (TTY: 711)
Tagalog-Filipino	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (844) 663-6192, pindutin 7. (TTY: 711)
Japanese	注意事項：日本語を話す人には無料の言語サポートが利用できます。 電話（844）663 - 6192、ダイヤル4。(TTY: 711)
French	ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le (844) 663-6191, appuyez sur 3. (TTY: 711)
Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero (844) 663-6191, premere 5. (TTY: 711)
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. (844) 663-6191, нажмите 6. (TTY: 711)
Hindi	ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। कॉल (844) 663-6192, प्रेस 2. (TTY :711)
Farsi	**توجه**: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با (844) 663-6191، 8 مطبوعات تماس بگیرید.(TTY: 711)
Thai	เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร (844) 663-6192 กด 6 (TTY: 711)

IMPORTANT DISCLAIMER

For plans governed by the Employee Retirement Income Security Act (ERISA), this Employee Benefits Guidebook serves as a Summary of Material Modifications (SMM) to the Presbyterian Medical Services (PMS) Health and Welfare Benefit Plans. PMS reserves the right to amend or discontinue any benefit plans at any time. If there is a conflict between this summary and the terms of the plan documents, the plan documents govern.

This document does not constitute a guarantee of plan coverage or benefits. Particular rules and eligibility requirements must be met before benefits can be received. Presbyterian Medical Services intends to continue the benefits described here indefinitely; however, the benefits of all employees and plan beneficiaries are subject to change or termination at the time of contract renewal or at any other time by the authority of Presbyterian Medical Services.

Presbyterian Medical Services also reserves the right to determine new premiums, employer contributions, and monthly costs at any time. Health and Welfare benefits are not accrued or vested benefit entitlements. Presbyterian Medical Services' contributions toward the monthly cost of the coverage are determined by Presbyterian Medical Services and may change or stop altogether.

Presbyterian Medical Services is an equal opportunity employer in conformance with applicable law, and Presbyterian Medical Services' policy. Nothing herein shall be deemed to constitute a contract of employment.

NOTE: If you do not have access to the benefits website at mybensite.com/pmsnm, please contact the benefits administrator at 505-443-1125 or benefits@pmsnm.org to obtain a hard copy of requested documents.

HOW TO ENROLL

Go to mybensite.com/pmsnm
Click “Enroll now”

Complete the step-by-step enrollment process
Accept terms and conditions

Save your changes
Email or print the confirmation statement for your records

Or complete your enrollment over the phone
The benefits call center is open Monday – Friday 6:00am – 7:00pm. 888.868.5530. *Se habla Español*

Thank you for completing your enrollment!

HUMAN RESOURCES BENEFITS ADMINISTRATION
1422 Paseo de Peralta, Santa Fe, NM 87501
505-443-1125 **benefits@pmsnm.org**