TITLE 6 PRIMARY AND SECONDARY EDUCATION
CHAPTER 50 INSURANCE
PART 10 EMPLOYEE BENEFIT COVERAGE ENROLLMENT POLICY

6.50.10.1 ISSUING AGENCY: New Mexico Public School Insurance Authority.
[6.50.10.1 NMAC - Rp, 6.50.10.1 NMAC, 09/01/2014]
[The address of the New Mexico Public School Insurance Authority is 410 Old Taos Highway, Santa Fe, New Mexico 87501.]

6.50.10.2 SCOPE: This part applies to all school districts, charter schools, other educational entities, eligible employees, eligible retired employees, eligible dependents, eligible participating entity governing body members, and persons or entities authorized to participate in the authority's employee benefits coverages.
[6.50.10.2 NMAC - Rp, 6.50.10.2 NMAC, 09/01/2014]

6.50.10.3 STATUTORY AUTHORITY: Subsection D of Section 22-29-7 NMSA 1978 directs the authority to promulgate necessary rules, regulations and procedures for the implementation of the New Mexico Public School Insurance Authority Act, Section 22-29-1 et seq. NMSA 1978.
[6.50.10.3 NMAC - Rp, 6.50.10.3 NMAC, 09/01/2014]

6.50.10.4 DURATION: Permanent.
[6.50.10.4 NMAC - Rp, 6.50.10.4 NMAC, 09/01/2014]

6.50.10.5 EFFECTIVE DATE: September 1, 2014, unless a later date is cited at the end of a section.
[6.50.10.5 NMAC - Rp, 6.50.10.5 NMAC, 09/01/2014]

6.50.10.6 OBJECTIVE: The objective of this part is to establish the enrollment policy for all persons or entities authorized to participate in the authority's employee benefits coverage.
[6.50.10.6 NMAC - Rp, 6.50.10.6 NMAC, 09/01/2014]

6.50.10.7 DEFINITIONS:

A. "Actively at work" for life and disability coverage, means performing the material duties of your own occupation at your employer's usual place of business. You will also meet the actively at work requirement if you were absent from active work because of a regularly scheduled day off, holiday or vacation day or if you were capable of active work on the day before the scheduled effective date of your insurance or increase in your insurance.

B. "Employee" means full time employee as defined in Subsection X of 6.50.1.7 NMAC. This definition applies to the rules related to employee benefits coverage contained in 6.50.10 NMAC only.
[6.50.10.7 NMAC - Rp, 6.50.10.7 NMAC, 09/01/2014; A, 12/10/2024]

6.50.10.8 REQUIREMENTS FOR ENROLLMENT OF FULL TIME EMPLOYEES:

A. An employee shall be enrolled pursuant to their actual status at the time of enrollment. If a change in status of an employee occurs they must notify the employer within 31 calendar days of the change and complete any enrollment documents required by the authority.

B. An employee may enroll only themself. However, if the employee chooses to enroll one eligible dependent, the employee shall enroll all eligible dependents unless one or more eligible dependents have other coverage. If the dependent of an eligible employee participant is enrolled in another medical plan, the eligible employee participant may enroll in the authority's medical plan as a single and in the two-party or family coverage for other lines. Evidence of the other coverage is required.

C. New eligible employees may enroll under the conditions set forth by the authority as follows:

(1) New eligible employees shall enroll within 31 calendar days of hire or within 31calendar days of being upgraded to eligible employee. Evidence of upgrade is required.

(2) A new participating entity governing body member or new participating authority board member shall enroll within 31 days of being sworn in to office.

(3) Coverage is effective on the first day of the month following the day the employee applies, provided the employee authorizes in writing that the premium is to be withheld from their payroll check,

subject to the actively-at-work provision, and for self-payers, the first day of the month following receipt of the premium by the authority.

(4) Where an employee is on a payroll option, the employer shall deduct and remit from each payroll and shall remit the employer's contribution simultaneously.

(5) Where an employee seeks a transfer of benefits:

(a) the employee is covered until the end of the month for which coverage was paid at the school the employee is leaving;

(b) the employee shall enroll within 31 calendar days of hire at the school the employee is moving to; and

(c) participating entities shall coordinate the effective date to ensure duplicate premiums are not paid on behalf of the employee through the outgoing school as well as the incoming school.

(6) Eligible employees or dependents who involuntarily lose benefits coverage have a 31-day window to enroll in the authority. Supporting documentation showing the reason for the involuntary loss of benefits coverage, the date benefits coverage was lost, who was covered and what types of benefits coverage was lost must be submitted within 31 days from the date of loss of coverage. The effective date of new benefits coverage will be the first of the month following receipt by the authority of the documentation required and the necessary application or applications, provided that all enrollment rules of the authority are met.

(7) Eligible employee enrollment after the enrollment period shall be permitted to only enroll in the authority's long-term disability plan and the voluntary life insurance plan upon providing the required evidence of medical insurability and approval by the disability and life carrier. Late enrollments shall not be permitted for medical, dental or vision coverages.

(8) If an eligible employee participant obtains dependent coverage for any eligible dependent from the authority, then the employee is required to enroll all eligible dependents in such coverage unless one or more eligible dependents have proof of other coverage. As an example: If an eligible employee participant is divorced, and the divorce decree states that medical coverage will be provided by the ex-spouse for one or more dependents of the eligible employee participant, the employee is permitted to enroll as a single in the medical and in the two party or family coverage for other lines of coverage.

(9) An employee is prohibited from having duplicate coverage from the authority for any line of coverage. An employee is also prohibited from having employee coverage and dependent coverage at the same time from the authority for any line of coverage. In the event of duplicate coverage, only one benefit will be paid. In those cases where an employee and their spouse or domestic partner are both eligible employees, either one may enroll into the coverage and the other be treated as an eligible dependent.

(10) An eligible employee is not permitted to enroll for a particular line of coverage unless the minimum participation level as determined by the authority is met.

(11) The participant shall only be permitted to switch from one plan to another plan within the same line of coverage during an established switch enrollment period and then only under the terms and conditions permitted by the authority. Open enrollment is allowed annually to add a line of coverage under the terms and conditions provided by the authority.

(12) An employee may drop any line of coverage at any time at the employee's discretion, provided, however, any provision with respect to prohibition against dropping any lines of coverage shall be enforced as determined by the member. In divorce situations, a divorced eligible employee may not drop eligible dependents based on a change in status until a court-endorsed divorce decree is provided to the member and processed by the authority. When a domestic partnership is terminated, the employee may not drop eligible dependents based on a change in status until the authority receives written notice from the employee that the domestic partnership is terminated in the form of an affidavit terminating domestic partnership provided to the member and processed by the authority. If the employee drops the line of coverage(s), the employee cannot re-enroll except as this part permits.

(13) Proper documentation, including evidence of medical insurability where required, must be provided by the eligible employee seeking coverage within 31 calendar days of the qualifying event. Coverage may be rejected where adequate proof and documentation satisfactory to the authority is not submitted in a timely manner.

(14) Eligibility for employee basic life requires the employee to be a benefits-eligible employee working a minimum of 15 hours or more per week, or as determined by the member.

[6.50.10.8 NMAC - Rp, 6.50.10.8 NMAC, 09/01/2014; A, 12/10/2024]

6.50.10.9 REQUIREMENTS FOR ENROLLMENT OF PART-TIME EMPLOYEES:

A. Part-time employees who work less than 20 hours a week but 15 hours per week or more are eligible for employee benefits if the member has passed a part-time resolution agreeing to provide employee benefits to part-time employees. A part-time resolution must be renewed in May of each year by the member and approved by the authority board in order for its part-time employees to remain eligible for employee benefits.

B. Part-time employees who work less than 15 hours per week are not eligible for employee benefits.

C. Part-time employees eligible for employee benefits may also enroll their dependents.The requirements for enrollment for full-time employees under 6.50.10.8 NMAC also apply to part-time employees.

D. Eligibility for employee basic life requires the employee to be a benefits-eligible employee working a minimum of 15 hours or more per week or as determined by the member.

[6.50.10.9 NMAC - N, 09/01/2014; A, 12/10/2024]

6.50.10.10 REQUIREMENTS FOR ENROLLMENT OF EMPLOYEE DEPENDENTS:

A. Eligible employee participants may enroll their eligible dependents during the enrollment period established by the authority. If the employee is enrolled in family medical coverage, a newborn dependent of an employee parent is covered from the date of birth under the same lines of family coverage in which the employee parent is enrolled at the time of the newborn's birth. In cases where the employee is not enrolled in family medical coverage but has family coverage for other lines of employee benefits, the employee parent must enroll the newborn dependent within 31 calendar days from the date of birth to be covered from the date of birth special enrollment. In cases where there is a change of status in premium (i.e., single to two-party, single to family, or two-party to family) due to the addition of a newborn dependent, the employee parent must enroll the newborn dependent within 31 calendar days from the date of birth to be covered from the date of birth. Certification of information from the official state publicly filed birth certificate or a state-filed birth certificate registration certification must accompany the enrollment form, or if the birth certificate or certification is not available, it must be submitted within 61 calendar days from the first day of the month following the newborn dependent's date of birth. Adopted dependents of an employee are eligible for coverage from the date of placement by a licensed state agency, a governmental agency or a court of competent jurisdiction. Supportive documentation of such placement is required with the change of status application within 61 calendar days of the date of placement.

B. The employee participant shall enroll the new eligible dependent within 31 calendar days of becoming an eligible dependent, except for newborns when family medical coverage is in effect at the time of the newborn's birth. Those persons considered to be a new eligible dependent are a newborn child, a new spouse, a domestic partner newly established by affidavit to be verified by the employer, a new legally adopted child, legal guardianship and other similar situations where the dependent becomes a new family member and is otherwise an eligible dependent pursuant to a court order. Supportive documentation in the form of copies of publicly filed marriage certificates, certificate of birth certificate information, guardianships, placement or adoption decrees and affidavits of domestic partnership shall be submitted along with the enrollment application.

C. An eligible dependent has no greater coverage than the eligible employee participant and the eligible dependent can maintain coverage only to the extent that the eligible employee participant maintains his coverage, except as otherwise specifically provided in this rule or to the extent federal law may grant broader rights.

D. An eligible employee participant may drop any line of coverage for their eligible dependent at any time at the employee's discretion. However, any provision with respect to prohibition against dropping any lines of coverage shall be enforced as determined by the employer. If the employee drops the line of coverage, that employee cannot re-enroll the eligible dependent except as this rule permits. If the employee drops one dependent from a line of coverage, the employee must drop coverage on all eligible dependents except an employee may drop a dependent 18 years or above without dropping the other eligible dependents with supporting documentation or proof of application. In divorce situations, a divorced eligible employee may not drop eligible dependents based on a change in status until a court-endorsed divorce decree or mutual written court-endorsed stipulation is provided is filed with the authority. When a domestic partnership is terminated, the employee’s ex-domestic partner may not drop eligible dependents based on a change in status until the authority receives written notice that the domestic partnership is terminated in the form of an affidavit terminating domestic partnership.

E. Proper documentation (together with application for coverage) including evidence of medical insurability where required, must be provided by the employee for the person seeking coverage within 31 calendar days of the qualifying event. Coverage may be rejected where adequate proof and documentation satisfactory to the authority is not submitted in a timely manner.

F. An eligible retired employee and eligible dependents enrolled in a voluntary life plan prior to retirement and the retiree is less than age 70, shall be permitted to enroll in voluntary life prior to life coverage expiring. The retiree shall be responsible for submitting enrollment paperwork and the first month’s premium prior

to active coverage expiring to ensure no break in premium or coverage occurs. The retiree shall be responsible for premium payments for any monthly premiums. Retiree voluntary life coverage will extend through the last day of the month the retiree reaches age 70.

G. The established enrollment period allowed by the authority for active participating entity board members and eligible dependents is 31 calendar days after the board member has taken oath.

[6.50.10.10 NMAC - N, 09/01/2014; A, 10/1/2015; A, 12/10/2024]

6.50.10.11 SPECIAL EVENTS ENROLLMENT: In cases of "special events" as defined in Subsection GGG of 6.50.1.7 NMAC, enrollment shall be allowed.

[[6.50.10.11 NMAC - N, 09/01/2014]

6.50.10.12 REPORTING REQUIREMENT: Authority insurance providers depend on timely reporting of dismissals, resignations, change in status, reports of new employees and eligible dependents and those dropping coverages. The only source of this information is from the participating entity. Participating entities shall report this information on or before the 15th day following notification from the employee of the event. In the event they fail to so timely report, the responsible participating entity shall be liable for any losses an eligible employee or dependent may incur as a result of the failure to timely report.

[6.50.10.12 NMAC - N, 09/01/2014]

6.50.10.13 ENROLLMENT AND ELIGIBILITY CONFLICTS:

A. In the event there is a conflict between a carrier's contract with the authority and this part regarding enrollment and eligibility, the carrier's contract shall prevail.

B. In the event there is a conflict between a carrier's contract with the authority and the policies of a participating entity regarding enrollment and eligibility, the carrier's contract shall prevail.

C. In the event there is a conflict between the policies of a participating entity policy and this part regarding enrollment and eligibility, this part shall prevail.

D. All disputes between a participating entity and an employee or part-time employee in determining eligibility shall be resolved at the participating entity level.

E. As to questions of enrollment and eligibility, if miscommunication to an employee or part-time employee by the participating entity has allegedly occurred, the participating entity shall provide a written statement to the authority indicating the party or parties who allegedly miscommunicated to the employee or part-time employee and the circumstances in which the alleged miscommunication occurred.

F. As to questions of enrollment and eligibility, disputes not resolved between an employee or part-time employee, the participating entity and the authority or its contractors shall be resolved according to the procedures of 6.50.16 NMAC of these rules. Paid premiums are to be determined by the employer.

G. As to all other conflicts between the authority and carriers, the relevant conflict provisions of the agreements between them shall control with regard to conflict resolutions.

[6.50.10.13 NMAC - N, 09/01/2014; A, 12/10/2024]

HISTORY OF 6.50.10 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives under:

NMPSIA 86-200, Employee Benefit Coverage Enrollment Policy, filed 10/31/1986.
NMPSIA 88-200, Employee Benefit Coverage Enrollment Policy, filed 11/4/1988.
NMPSIA Rule 93-13, Employee Benefit Coverage Enrollment Policy, filed 3/22/1993.
NMPSIA Rule 94-1, Employee Benefit Coverage Enrollment Policy, filed 5/20/1994.

History of Repealed Material:

6.50.10 NMAC, Employee Benefit Coverage Enrollment Policy, filed 7/1/2004 - Repealed effective 09/01/2014.