A Guide to

Your Benefits

PNM Resources™

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An Introduction to Your Benefits

Benefits are an integral part of your total rewards at PNM Resources. Through programs like our medical, dental, life insurance and disability plans, you have valuable coverage if you get sick and your family is protected in the case of your disability or death. Our paid time off programs offer you the chance to spend much-needed time away from work — whether vacationing with friends and family or just relaxing. Our retirement and savings programs help you prepare for a sound financial future.

Whatever the benefit, it's important that you choose them wisely and know ho to use them properly. This guide is designed to help you do both. By reading it thoroughly and sharing it with your family, you'll be able to make smarter benefit decisions — ones that work for you.

It's important to us that you understand your benefits, know how to use them wisely and receive communication that will assist you. Please take a moment to complete the survey card at the end of this guide and return it to the Benefits Department at Mail Stop 2340.

Your Benefits at a Glance

PNM Resources offers a combination of company-provided and voluntary benefits. You are enrolled in company-provided benefits automatically, and PNMR pays the total cost. You choose whether or not to participate in voluntary benefits and you pay a portion or all of the cost.

Once you've enrolled as a new hire, your next opportunity to enroll or make changes is during Open Enrollment. You can enroll in or make changes to your medical, dental and vision coverage, life and AD&D insurance, and flexible spending accounts during Open Enrollment. This is also the time of year when you can sell a portion of the following year's PTO accrual or vacation and personal leave for IBEW represented employees. You cannot make changes to these benefits during the year (unless you have a qualified change in status, see page 21). You can enroll in or make changes to the Retirement Savings Plan at any time and you can enroll in the Employee Stock Purchase Plan during a stock option offering period once you become eligible.

The chart to the right gives a summary of your voluntary benefit choices. *You may choose to waive, or not participate, in any voluntary benefit. If you waive medical coverage you will be required to submit proof of other coverage. The Benefits Department will contact you for this information.*

If any of the information on your personal enrollment form is incorrect, call the Benefits Department right away at (505) 241-4919/ (800) 640-4692 or send an email to **benefitshelp@pnm.com**.

Summary of Voluntary Benefit Choices

Benefit	Coverage Choices
Medical	▪ BCBS Premium PPO Option ▪ BCBS Standard PPO Option ▪ BCBS Value PPO Option ▪ Presbyterian PPO Option (New Mexico only)
Dental	▪ Delta Dental of New Mexico
Vision	▪ VSP
Health Care FSA	▪ Maximum before-tax contribution amount of $5,000
Day Care FSA	▪ Maximum before-tax contribution amount of $5,000
Supplemental Life	▪ Coverage options of 1x, 2x, 3x, 4x, 5x or 6x your annual base pay
Supplemental AD&D	▪ Coverage options of 1x, 2x, 3x, 4x, 5x or 6x your annual base pay
Spouse Life	▪ Coverage of $25,000; $50,000; $75,000 or $100,000
Child Life	▪ Coverage of $2,000; $10,000; $15,000 or $25,000
Dependent AD&D	▪ Spouse only: 50% of your supplemental AD&D ▪ Spouse with dependent children: 40% of your supplemental AD&D for your spouse, 10% for each child ▪ Child only: 15% of your supplemental AD&D
PTO Sale	▪ Eligible employees can sell up to 50% of their following year's PTO allocation – dollar for dollar
Vacation, Personal Leave Sale	▪ Eligible employees can sell a portion of their following year's vacation accrual and/or a portion of their following year's Personal Leave accrual (for represented employees covered by these programs)

In addition to the benefits listed in the chart above, PNM Resources also offers:

- Basic Life and AD&D Insurance
- Educational Assistance
- Employee Assistance Program
- Employee Stock Purchase Plan
- Holiday Pay
- Jury Duty
- Long-Term Disability
- Paid Time Off
- Results Pay
- Retirement Savings Plan (401(k) Plan)
- Salary Enhancements
- Short-Term Illness/Injury
- Travel AD&D Insurance
- Wellness and Safety Programs
- Workers' Compensation

Medical

PNM Resources offers you the choice of four medical plan options, each designed to give you different levels of care. All options are administered through a Preferred Provider Organization (PPO), which pays a higher level of benefits when you use in-network providers. Your medical plan choices are:

- BCBS Premium Option
- BCBS Standard Option
- BCBS Value Option
- Presbyterian Health Plan Option (New Mexico only)

PNM Resources pays the majority of the cost of medical coverage — about 80% of the total premium for full-time employees.

Choosing a Plan

The benefit decisions you make can have a big impact on your family's well-being, both physically and financially. This is especially true when it comes to choosing a medical plan. Once you enroll as a new hire, you can change medical plans only during Open Enrollment each year or if you have a qualifying event (see page 21). But that's not the only reason to carefully consider the plan you've chosen. Your needs can change over time. For example, what's right for you when you're single may not be right when you have a family to consider.

All four of your medical plan options are PPOs — which means you can choose any doctor, hospital or specialist, but your benefits are highest when you use a preferred provider. The options differ in things like your bi-weekly contributions, deductibles, out-of-pocket maximums and coinsurance.

When you are choosing a plan, you may want to consider the following:

- **What are your estimated medical expenses for the following year?** If historically your expenses have been low, consider enrolling in a plan with a high deductible and out-of-pocket maximum to save on bi-weekly contributions.
- **How many office visits do you expect for the following year?** Review each plan's office visit copay. Consider choosing a plan with a higher copay if you do not expect many office visits in the upcoming year.
- **Are you anticipating any planned surgery or hospitalization?** Review each plan's hospitalization benefits. If you're not expecting any hospitalization, consider choosing a plan with lower benefits to save money on bi-weekly contributions.
- **Are you or your covered dependents planning on having a baby?** Review the maternity services for each of the plans to choose the right one for you.

These are just a few of the things you should consider when choosing your medical plan. Review the medical comparison chart on pages 5–7 and your SPD binder for more details. Remember, if you experience a catastrophic event during the year, you still have the protection of the plan's out-of-pocket maximum.

If you decide that a high deductible plan is right for you, your savings on bi-weekly contributions can be invested in the Retirement Savings Plan, which helps you save for your future.

How the Plan Works

With a PPO, you can receive care from any doctor, specialist or medical facility. This type of plan does not require that you choose a primary care physician. However, it's always a good idea to choose one doctor to coordinate your care. Benefits are higher, out-of-pocket expenses are lower and there are no claim forms to fill out when you use preferred providers who are in the PPO network.

Before you choose a medical plan, you may want to see what providers are considered "preferred" in each plan. You can access a list of BCBS and Presbyterian preferred providers by visiting their websites. (See back cover.)

You will receive medical ID cards for you and each enrolled dependent approximately two weeks after you enroll. Be sure to keep that ID card with you at all times. Your medical ID cards do not expire, so if you don't change plans during Open Enrollment, you will not receive new cards.

Quick Definitions

Annual Deductible — The amount of money that you must pay in any given year before the plan starts paying coinsurance.

Coinsurance — The percentage of covered expenses you or the plan pays. If a covered health service is covered at "90%," you pay 10% of the cost and the plan pays 90% of the cost after you have met your deductible.

Copay — the flat dollar amount you pay for certain medical services at the time of visit (such as doctor's office visits).

Out-of-Pocket Maximum — The maximum amount you will pay in *coinsurance* for all of your covered medical expenses combined in any calendar year.

Tips for Using Your Medical Benefits

- Use preferred providers
- Use your plan's wellness benefits and programs
- Use generic drugs and mail-order
- Visit your plan's website for useful articles and tools
- Call BCBS or Presbyterian for pre-approval if you are unsure if a service is covered

The Cost for Coverage

You and the company share in the cost of your coverage, with the company paying approximately 80% of the total cost. Your contributions are taken out of your pay before taxes are calculated, which saves you money.

Medical Plan Summary of Coverage

The charts on the following pages compare the benefits and prescription drug coverage under the four medical plans. Review these charts to see the different amounts you pay when you receive care. To review coverage information for services not listed below, please see your Summary Plan Description.

Note: The charts below and on pages 6–7 are a small sample of services offered. Please refer to your Summary Plan Description for a complete list.

Prescription Drugs	You Must Use Preferred/In-Network Pharmacies — All Plans No Benefits for Non-Preferred/Out-of-Network Pharmacies (except emergencies) BCBSNM Premium Option	BCBSNM Standard Option	BCBSNM Value Option	Presbyterian Health Plan Option
Generic Up to 30-day supply	$7 copay	$7 copay	$7 copay	$7 copay
Brand name when generic is available Up to 30-day supply	$7 copay plus cost difference between brand and generic	$7 copay plus cost difference between brand and generic	$7 copay plus cost difference between brand and generic	$7 copay plus cost difference between brand and generic
Brand name when generic is not available ▪ Brand name on Formulary list ▪ Brand name not on Formulary list Up to 30-day supply	▪ $30 copay ▪ $50 copay	▪ $40 copay ▪ $60 copay	▪ $40 copay ▪ $60 copay	▪ $30 copay ▪ $50 copay
Mail-order Up to 90-day supply	2 x above amounts	2 x above amounts	2 x above amounts	2 x above amounts
Pre-packaged items Presbyterian Health Plan option only	Not applicable	Not applicable	Not applicable	1 x above amounts
Immunosuppresive drugs and specialty pharmaceuticals* Presbyterian Health Plan option only	Not applicable	Not applicable	Not applicable	You pay 15% (up to a maximum copay of $250 per prescription)

Special Notes for the BCBSNM program: There is a $5,000 lifetime maximum for prescription drugs related to infertility treatment. For covered non-prescriptions enteral nutritional products and special medical foods, the copay is 50%.

** Includes immunosuppressive drugs following transplant surgery. Specialty pharmaceuticals are a list of drugs including injectibles and oral or inhalation forms. It includes, but is not limited to, growth hormones, low molecular weight heparins, immunologic agents and anti-tumor necrosis factors.*

Medical Plan Summary of Coverage *(continued)*

	Blue Cross and Blue Shield of New Mexico			
	Premium Option		Standard Option	
Plan Features				
Annual Deductible ▪ Individual ▪ Family	 $150 $450		 $400 $1,200	
Out-of-Pocket Maximum ▪ Individual ▪ Family	 $1,500 $3,000		 $3,000 $6,000	
Lifetime Maximum Benefit	Unlimited		Unlimited	
	Preferred Provider	**Non-Preferred Provider[1]**	**Preferred Provider**	**Non-Preferred Provider[1]**
Doctor's Office Visit Includes regular office visits, as well as covered diabetes education, family planning and gynecological services and prenatal visits	PPP*: 100% after a $15 copay No deductible Other Preferred Providers and Specialists: 100% after $20 copay No deductible	70%	PPP*: 100% after a $20 copay No deductible Other Preferred Providers and Specialists: 100% after $25 copay No deductible	60%
Emergency Room/Observation Room – Facility Charges, Emergency Only	100% after $100 copay No deductible	100% after $100 copay No deductible	100% after $125 copay No deductible	100% after $125 copay No deductible
Urgent Care	100% after $20 copay No deductible	70%	100% after $35 copay No deductible	60%
Wellness Visits ▪ Annual physical ▪ Annual OB/GYN ▪ Well-child care ▪ Adult and child immunizations ▪ Mammogram ▪ Colon exams Up to $600/year	100% after $15 copay No deductible	70%	100% after $20 copay No deductible	60%
Allergy Injections, Tests, Serum	90%	70%	80%	60%
Infertility [2, 3] – Physician/Facility Up to $5,000 lifetime	Based on services	70%	Based on services	60%
Maternity Services ▪ Including delivery and routine pediatrician care for covered newborns Initial visit may require a copay.	90%	70%	80%	60%
Mental Health – Outpatient [2] $3,500/calendar year maximum for preferred providers only	90% No deductible	Not covered	80% No deductible	Not covered
Mental Health – Inpatient [2, 3] 30 days per calendar year maximum for preferred providers	90% No deductible	Not covered	80% No deductible	Not covered
Spinal Manipulation/Chiropractic $1,500/calendar year maximum	90%	Not covered	80%	Not covered

	Presbyterian Health Plan Option		
Value Option			
$2,000 $4,000		$150 $450	
$4,000 $8,000 Unlimited		$1,500 $3,000 Unlimited	
Preferred Provider	**Non-Preferred Provider[1]**	**In-Network**	**Out-of-Network**
PPP*: 100% after a $25 copay No deductible Other Preferred Providers and Specialists: 100% after $50 copay No deductible	50%	100% after a $15 copay No deductible Specialists: 100% after $20 copay No deductible	70%
100% after $150 copay No deductible	100% after $150 copay No deductible	100% after $100 copay No deductible	100% after $100 copay No deductible
100% after $50 copay No deductible	50%	100% after $20 copay No deductible	70%
100% after $25 copay No deductible	50%	100% after $15 copay No deductible	70%
75%	50%	90%	70%
Based on services	50%	Based on services	70%
75%	50%	90%	70%
75% No deductible	Not covered	90% No deductible	Not covered
75% No deductible	Not covered	90% No deductible	Not covered
75%	Not covered	Spinal Manipulation: 90% Office Visit: 100% after a $20 copay No deductible	Not covered

** A PPP is a BCBSNM preferred provider in one of the following specialties: Family Practice, General Practice, Internal Medicine, Obstetrics/Gynecology, Gynecology and Pediatrics.*

[1] *Percentage shown for non-preferred providers are the percentage of covered charges payable after deductible.*

[2] *Certain services are not covered if prior approval is not obtained. See your Summary Plan Description for a complete list of specific expenses, surgeries and procedures that require prior approval.*

[3] *Admission review is required for inpatient admissions or financial penalties apply. Some services, such as transplants and physical rehabilitation, require additional approval or benefits may be denied entirely. See your Summary Plan Description for details.*

Dental

Oral health is critical to your overall well-being. Studies show that periodontal disease is linked to such health issues as diabetes, heart disease and respiratory infection. Therefore, it is important to maintain your oral health by receiving routine dental care.

PNM Resources offers dental coverage through Delta Dental Plan of New Mexico. When you choose dental coverage, you have access to one of the nation's largest national networks, with three out of four dentists participating nationwide.

How the Plan Works

When you elect dental coverage, you can receive care from any dentist you choose. However, the amount you pay will depend on the network, if any, in which your dentist participates. Your dentist will be considered one of the following:

- Advantage PPO Dentist
- DeltaPremier Dentist
- Non-Participating Dentist

Benefits are highest when you choose an Advantage dentist, but Delta offers these dentists only in New Mexico. Benefits are lowest when you use a non-participating dentist. However, you can receive care from any dentist at any time.

Delta dentists have agreed to an allowable fee for payment of services. When you use an Advantage PPO dentist or a DeltaPremier dentist, there are no claim forms for you to fill out. Your dentist will complete any necessary paperwork and Delta Dental will submit payment directly to the dentist.

If you use a non-participating dentist, you are responsible for paying the dentist and then filing a claim for reimbursement. In addition to your deductible and coinsurance, you will be responsible for paying any charges over Delta Dental's Allowable Fee.

To find a participating dentist, visit Delta's website at **www.deltadental.com** or **www.deltadentalnm.com** (New Mexico only). There are no identification cards for the plan. When you receive services, simply tell your dentist that you are a member of the Delta Dental plan. Claims should be filed with Delta Dental of New Mexico.

Tips for Using Your Dental Benefits

- Use Delta Dentists
- Get cleanings twice a year — they are covered at 100%

The Cost for Coverage

You and the company share in the cost of your coverage. Your contributions are taken our of your pay before taxes are calculated, which saves you money.

Dental Plan Summary of Coverage

Dental Plan Highlights	Advantage PPO Dentist (New Mexico Only)	DeltaPremier Dentist (Nationwide)	Non-Participating Dentist (Nationwide)
Plan Features			
Annual Deductible			
▪ Individual	None	$50	$50
▪ Family	None	$150	$150
Benefits Maximums			
▪ Annual – per individual; applies to all expenses except orthodontia		$1,500	
▪ Lifetime Orthodontic – per individual; applies only to orthodontic benefits		$2,500	
Covered Expenses			
Preventive Services	100%	100%	100%*
▪ Cleanings (Prophylaxis) or Periodontal Cleaning – up to twice each calendar year	No deductible applies	No deductible applies	No deductible applies
▪ Fluoride, topical application – only for children under age 19; up to twice each calendar year			
▪ Oral exams, routine – up to twice each calendar year			
▪ Palliative treatment (emergency treatment for pain)			
▪ Space maintainers			
▪ X-rays, bitewing – up to twice each calendar year			
▪ X-rays, full-mouth – once every five years			
Restorative and Basic Services	90%	80%	80%*
▪ Anesthesia, general	No deductible applies	After deductible	After deductible
▪ Extractions and other oral surgery			
▪ Fillings and regular restorative services			
▪ Gum treatments (periodontics)			
▪ Prescription drugs – only when dentally necessary. You must pay up front and file a claim for reimbursement.			
▪ Root canals (endodontics)			
▪ Sealants – only for children under age 19 and only to unrestored molars and bicuspids. Up to one treatment per tooth per calendar year and no more than two treatments per tooth per lifetime			
Major Services	60%	50%	50%*
▪ Bridges, fixed or removable	No deductible applies	After deductible	After deductible
▪ Crowns and cast restorations			
▪ Dentures, full or partial			
▪ Implants			
Orthodontic Services	50%	50%	50%*
▪ For children under age 19	No deductible applies	After deductible	After deductible
▪ For adults age 19 and over – only when dentally necessary, needed for future dental health and not cosmetic in nature			

** With a non-participating dentist, you are responsible for paying your coinsurance amount, if any, as well as any amount billed by the dentist that is over Delta Dental's Allowable Fee. With a Delta Advantage PPO or DeltaPremier dentist, you are NOT responsible for paying amounts over the Allowable Fee.*

Vision

Good vision is essential to conducting activities of daily living. But vision care is often one of the most overlooked components of preventive care. PNM Resources offers vision coverage through VSP, a nationwide network of vision care providers. The vision plan offers routine eye exams, as well as coverage for eyeglasses, contacts, laser vision correction and more.

How the Plan Works

You can choose any provider for your vision care. However, benefits are highest and you pay less when you use a VSP participating provider. When you use a VSP provider, there are no claim forms to fill out and submit — your provider does it for you.

The chart to the right is a summary of your coverage when you receive routine vision care.

To find a VSP provider, visit VSP's website at **www.vsp.com**. There are no identification cards for the VSP plan. When you receive services, simply tell your provider that you are a member of the VSP plan.

VSP Discounts

In addition to the covered services shown on the chart to the right, the VSP offers discounts on some additional services and expenses, including:

- Contact lens exams
- Annual supplies of certain brands of contacts
- The purchase of non-covered/additional pairs of glasses (such as prescription sunglasses) within 12 months of your last eye exam
- Prescription glasses in addition to your contact lenses

These discounts are only available when you use VSP providers. See your VSP provider for the latest discounts.

Plan Feature	VSP Providers	Non-VSP Providers
Annual Deductible	None	None
Examinations (once every 12 months)	Plan pays 100% after $15 copay	Plan pays up to $35 after $15 copay
Lenses (once every 12 months)	Plan pays 100% after $25 copay (includes single vision, bifocal, trifocal and progressive)	Plan pays (after $25 copay): ▪ Single vision – up to $25 ▪ Bifocal – up to $40 ▪ Trifocal – up to $55 No coverage for Progressive
Frames (once every 24 months)	Plan pays up to $145 frame allowance (one $25 copay applies to both lenses and frames)	Plan pays up to $45 (one $25 copay applies to both lenses and frames)
Contact Lenses (once every 12 months, you may receive one pair of contact lenses instead of all other lens and frame benefits)	Plan pays: ▪ Elective – up to $145 ▪ Medically necessary (if vision cannot be corrected by eyeglasses) – 100% after $25 copay	Plan pays: ▪ Elective – up to $105 ▪ Medically necessary (if vision cannot be corrected by eyeglasses) – up to $210 after $25 copay
Laser Vision Correction	Plan pays: ▪ Screening – 100% ▪ Surgery (including pre- and post-operative care) – plan provides discount on fees (typically 15%)	No Coverage
Low Vision Services and Supplies (must be approved by VSP in advance; maximum benefit of $1,000 every 24 months for all services and materials)	Plan pays: ▪ Supplemental testing – 100% ▪ Supplemental aids – 75% of pre-approved amount	Plan pays: ▪ Supplemental testing – up to $125 ▪ Supplemental aids – up to 75% of pre-approved amount

Flexible Spending Accounts (FSAs)

The flexible spending accounts (FSAs) save you money by letting you pay for eligible expenses with before-tax dollars. There are two plans — the Health Care FSA and the Day Care FSA — and you can choose to participate in either or both.

Health Care FSA

The PNM Resources medical, dental and vision plans are designed to cover the majority of your health care costs when you use participating providers. However, items like coinsurance, copays, deductibles and other eligible expenses not covered can lead to some out-of-pocket expenses for you. The Health Care FSA lets you set aside money to pay for these expenses — before taxes are taken out of your paycheck. That means the taxes you pay are less. You can contribute up to $5,000 each year in your Health Care FSA.

How the Plan Works

When you have an eligible expense, such as a doctor's office copay, you pay for the expense when it's due. Then, you file a claim and are reimbursed from your Health Care FSA. When you use your SmartFlex card, you do not have to file a claim (see page 12).

The following is a sample list of expenses eligible for reimbursement through the Health Care FSA. A complete list of health care expenses that the IRS considers eligible are described in IRS Publication 502, Medical and Dental Expenses, at www.irs.ustreas.gov/formspubs/index.html.

Eligible Expenses

Professional Services

- Christian Science Practitioners
- Midwives
- Oculists
- Podiatrists
- Practical and other nonprofessional nurses for medical services only

Medicines

- Over-the-counter medicines for treatment of medical conditions (e.g., antacids, allergy medicines, pain relievers, cold and flu medicines)
- Prescription drugs – cost not reimbursed by any other plan (not all prescriptions are eligible)

Eligible Expenses (continued)

Equipment and Supplies

- Abdominal supports
- Arches
- Autoette (auto device for handicapped person), but not if used to travel to job or business
- Air conditioning where necessary primarily for relief from an allergy or for relieving difficulty in breathing and provided that the device does not become a permanent part of the dwelling and may be removed to other quarters
- Back supports
- Contact lenses and cleaning solution
- Crutches (purchase or rental)
- Eyeglasses
- Fluoridation unit in home on advice of dentist
- Hearing aids
- Heating devices
- Invalid chair
- Orthopedic shoes – excess cost over normal shoes
- Reclining chair if prescribed by doctor
- Special telephone equipment for the deaf, and its repair
- Special mattress and plywood bed boards for relief of arthritis of spine
- Wheelchairs and other necessary equipment for the disabled
- Wig to cover hair loss due to medical reasons

Medical Treatments

- Acupuncture – cost not reimbursed by any other plan
- Diathermy
- Experimental surgery
- Healing services
- Hearing exams and fitting of hearing aids
- Hydrotherapy (water treatments)
- Hypnosis for treatment of illness
- Laser surgery for vision correction
- Navajo healing ceremonies
- Private duty nursing
- Sterilization
- Whirlpool baths

Miscellaneous

- Birth control pills or other birth control items prescribed by your doctor
- Braille books – excess cost over regular editions
- Childbirth classes
- Convalescent home – for medical treatment only
- Fees paid to health institute for treatment prescribed by a physician to alleviate a physical or mental defect
- Guide dog or other animal assistant, and its maintenance, for the blind, hearing-impaired or disabled
- Hair transplant surgery
- Learning disability tutoring
- Legal fees to authorize treatment for mental illness
- Nurse's board and wages, including Social Security taxes paid on wages
- Organ donor expenses
- Sanitarium and similar institutions
- Smoking cessation programs, including prescription drugs used in the programs
- Special school costs for physically and mentally handicapped children
- Telephone or teletype costs and television adapter for the hearing-impaired
- Transportation to receive medical care – based on IRS guidelines
- Wages of a guide for a blind person

The following expenses are ineligible for reimbursement from the plan:

Ineligible Expenses

- Antiseptic diaper service
- Athletic club expenses to keep you physically fit
- Bottled water
- Cosmetic surgery, except for correction of birth defects, accidental disfigurement or reconstruction following surgery
- Cosmetics, toiletries, toothpaste and other sundries
- Divorce, even if recommended by a therapist
- Domestic help, even if recommended by a doctor
- Electrolysis
- Funeral and burial expenses
- Health insurance premiums
- Health programs offered by resort hotels, health clubs or gyms
- Licensed practical nurse (LPN) for care of a newborn
- Marriage counseling fees
- Maternity clothes
- Over-the-counter drugs for general well-being, rather than for treatment of an illness (e.g., some vitamins, herbal medicines)
- Scientology fees
- Social activities, such as dance lessons or classes, even with a doctor's recommendation
- Special food or beverage substitutes – but allergy patients may claim the excess cost of chemically uncontaminated foods over ordinary foods
- Transportation costs to take a disabled person to and from work
- Tuition for special school for a child with discipline or emotional problems
- Veterinary fees
- Weight reduction programs undertaken for general health, not for treatment of specific ailments

Using the SmartFlex Card

When you enroll in the Health Care FSA, you automatically will receive a SmartFlex card. If you are enrolled each year, you will receive a new card every three years. The SmartFlex card, similar to an ATM card, can be used for eligible health care expenses. When you pay for items like office visit copays or prescription drugs, the money is taken directly from your account. This means there are no claim forms for you to complete and submit.

In some instances, you may need to submit a receipt, so it's important that you keep them in a safe place. If you receive a letter from the FSA administrator asking for documentation of a medical or dental expense, your best option is to provide the Explanation of Benefits (EOB) from BCBS, Presbyterian or Delta Dental. The EOB will have all of the information that is needed. For other expenses, such as vision, prescription drugs and over-the-counter medications, you will have to submit a copy of your receipt.

Go to **www.smartflex.com** to check your account balance, the status of your claims and view your transactions. You also can view a list of eligible expenses.

Walgreens Makes it Easier

Walgreens and the government have teamed up to make using your SmartFlex card even easier. Simply present your card when making a purchase at a Walgreens store — your eligible items will be deducted from your card automatically and you will be asked for another form of payment for ineligible items. It's that easy!

Tips for Using Your Health Care FSA

- Keep all receipts and documentation in a safe place
- File your claims on a timely basis
- Visit **www.smartflex.com** often to track your account
- Use your SmartFlex card
- Get prescriptions and over-the-counter drugs at Walgreens

Day Care FSA

If you work and you have a dependent child or spouse that needs care during the day, the Day Care FSA may be right for you. Daycare can be very expensive, but the Day Care FSA lets you take money out of your check before taxes are deducted to pay for eligible expenses.

You can contribute up to $5,000 per year in your Day Care FSA. However, $5,000 is a household maximum, so if your spouse participates in a Day Care FSA at his or her work, your combined contributions cannot be more than $5,000.

Day Care FSA or Child Care Tax Credit?

You can participate in the Day Care FSA or take a Child Tax Credit on your income tax return — but not both. Which one is better for you depends on your personal tax situation. You may want to consult a tax professional for advice.

How the Plan Works

You can use your Day Care FSA to pay for expenses of an eligible person. An eligible person is someone who meets one of the following criteria:

- A dependent child under age 13 for whom you have custody
- Your spouse, if physically or mentally incapable of self-care
- Your dependent of any age who is physically or mentally incapable of self-care, even if you cannot claim an exemption for the person for income tax purposes

For daycare to be eligible for reimbursement under the plan, it must allow you and your spouse (if not physically or mentally incapable) to work or actively look for work. In addition, the care cannot be provided by your minor child or another dependent claimed on your income taxes.

Consider the following when deciding how much to save in your FSAs:

- What have your average health care and daycare expenses been over the past several years?
- Are you expecting any unusual expenses next year, such as a planned surgery or the birth of a child?
- Do you expect to pay for work-related dependent daycare next year?

How Much Should You Contribute to Your FSAs?

When deciding how much to contribute to your FSAs, it's important to plan carefully. The following worksheets are designed to help you estimate how much is right for you to save.

Health Care FSA — Estimating Your Health Care Expenses

Follow the steps below to estimate your health care expenses and determine how much you should contribute to the Health Care FSA. Remember, the maximum you can contribute for the year is $5,000 and all expenses must be incurred between January 1 of the year you elect to contribute and March 15 of the following year.

Step 1 — Estimate your copayments

After you choose a medical plan, estimate your doctor and specialist's office, emergency room/urgent care and prescription drug copays. Use the chart on pages 5–7 for copay amounts.

Office Visits No._____ x copay _____ = total _____

Emergency Care No._____ x copay _____ = total _____

Prescription Drugs No._____ x copay _____ = total _____

Step 2 — Estimate your deductibles

If your service does not require a copayment, you pay expenses up to the deductible. Use the chart on pages 5–7 for a list of deductibles for each plan. Each member of your family must meet the individual deductible, but if your family has three or more covered persons you'll never pay more than the family deductible. Remember, you may not reach your deductible maximum so estimate carefully.

Deductible

No. persons _____ x deductible _____ = total _____

(continued on page 14)

Step 3 — Estimate your coinsurance

Once you meet your deductible, the remaining share of your medical expenses is your coinsurance. Coinsurance varies by plan and whether or not you use preferred providers. Use the chart on pages 5–7 to estimate any coinsurance you might have to pay.

Coinsurance total _____

Step 4 — Estimate other expenses

Other than your medical expenses, dental and vision expenses, as well as some over-the-counter drugs, are eligible for reimbursement through the Health Care FSA. The amount of coverage you get from the dental plan depends on what kind of dentist you use. Use the dental chart on page 9 to estimate your dental expenses. In addition, even if you don't elect vision coverage, expenses for eyeglasses, contacts and exams are eligible for reimbursement.

Dental coinsurance and deductibles total _____

Vision expenses total _____

Over-the-counter drugs total _____

Other (use the chart on page 11 to help estimate) total _____

Total Estimated Expenses **$_____**

Day Care FSA — Estimating Your Day Care Expenses

You can contribute up to $5,000 per year in the Day Care FSA. Care must be provided between January 1 to December 31 to be eligible for reimbursement.

Step1 — Calculate your weekly daycare expenses

Weekly daycare expense $_____

Step 2 — Calculate the number of weeks you need care

Don't include weeks where you won't need daycare, such as vacations and holidays.

Number of weeks of care _____
(max 52)

Step 3 — Calculate your total daycare expenses

Weekly daycare expenses x number of weeks of care $_____

It's Important to Plan Carefully

An IRS rule known as "use it or lose it" requires you to forfeit any money left in your Day Care FSA at the end of the year. There is a 2 1/2 month extension for the Health care FSA before the "use it or lose it" rule applies — see below. By carefully calculating how much to set aside each year, you can enjoy the tax advantages of the FSAs without forfeiting any money.

Health Care FSA Extension

If you participate in the Health care FSA, you can be reimbursed for expenses you incur up to 2 1/2 months after the end of the year. After that, you will forfeit any money remaining in your account. For example, if you set aside $1,000 in your Health Care FSA for 2007 and only use $900 by the end of the year, you can still apply eligible expenses you incur up to March 15, 2008 to the remaining amount in your 2007 Health care FSA. You can not use your SmartFlex card for expenses you want to apply to a previous year's account — you must file a manual claim form.

Filing a Health Care FSA Claim

If you do not use your SmartFlex card, you will need to file a claim for reimbursement. To file a claim for your Health Care FSA, attach documentation that identifies the provider, type of service, date you received service and the amount of your expense. If your claim is for medical or dental expenses, include a copy of your plan's explanation of benefits (EOB). For other expenses, such as vision expenses and prescription drugs, be sure to include a copy of your receipt.

Filing a Day Care FSA Claim

To file a claim for your Day Care FSA, have your daycare provider complete the claim form or you can simply attach a bill or provider-signed statement showing the provider's name and address, the dates of service, the charges and your dependent's name. The provider's taxpayer identification number is required unless the provider is a non-profit, religious, charitable or educational organization (Social Security number is acceptable if the provider is an individual). Canceled checks are not an acceptable form of documentation.

How to File a Claim

Follow these easy steps to file an FSA claim:

- Get a claim form online from NetSource or use the claim form included in your FSA information kit, which you will receive when you enroll
- Complete your form, include the required documentation, and send to:

  Aon Consulting
  7325 Beaufont Springs Drive, Suite 300
  Richmond, VA 23225

You have until March 31 of each year to file claims for reimbursement from the previous year's Day Care FSA. For example, the claims administrator must receive any claims you want to apply to your 2007 day care flexible spending account no later than March 31, 2008. You have until May 31 of each year to file claims for reimbursement from the previous year's Health Care FSA.

Call Aon at (800) 481-5224 if you have questions about filing claims.

Life and AD&D

Life and Accidental Death and Dismemberment (AD&D) insurance provides financial protection to your survivors if you die. It can pay for things like funeral expenses and estate taxes, as well as offer future income to a spouse or provide educational expenses for your children. It's important to plan carefully when deciding how much life insurance you need. Although you want to make sure you have enough to fully protect your loved ones, you don't want to pay for coverage that you don't need. Review your options and your personal circumstances carefully before enrolling.

Basic Life and AD&D Insurance

The company offers full-time employees basic life coverage of one times base pay. This coverage is automatic and the company pays the entire cost. In addition to basic life, the company offers AD&D coverage of one and one-half times base pay. Part-time employees receive a basic life insurance benefit of $10,000. Part-time employee are not eligible for basic AD&D.

What is Life and AD&D Coverage?

Life Insurance pays a benefit to your beneficiary if you die. AD&D pays a benefit to your beneficiary if your death is a result of an accident. This coverage is in addition to your life benefit. If you are severely injured, such as losing a limb or an eye in an accident, you may be eligible to receive a percentage of your total AD&D benefit through the AD&D Plan.

Maximum Employee Life Insurance Amounts

(combined basic, supplemental, management and service life)

- Total Life Insurance — $1.5 million (with coverage from $1 million to $1.5 million subject to evidence of insurability (EOI), see page 16)
- Total AD&D Insurance — $2 million

Supplemental Life and AD&D Insurance

In addition to basic life and AD&D coverage provided by the company, you can purchase supplemental life insurance or AD&D insurance for yourself. You pay the full cost of premiums and they are taken out of your paycheck on a before-tax basis. You can elect from one to six times your base pay in either or both plans, in increments of one (rounded up to the nearest $1,000).

Your Life Insurance Options	
Basic Life (automatic)	1 x base pay
Basic AD&D (automatic)	1.5 x base pay
Supplemental Life	1, 2, 3, 4, 5, 6 x base pay
Supplemental AD&D	1, 2, 3, 4, 5, 6 x base pay

Dependent Life and AD&D Insurance

You also can purchase dependent life and/or AD&D coverage for your spouse and/or children. Family coverage under AD&D insurance covers all eligible members of your family. You pay the full cost of premiums. Premiums for dependent life are deducted on an after-tax basis and premiums for dependent AD&D are deducted on a before-tax basis.

Your coverage options for dependent life are:

Life Insurance	
Coverage for Your Spouse	Coverage for Each Child
$25,000	$2,000
$50,000	$10,000
$75,000	$15,000
$100,000	$25,000

AD&D benefits for family coverage are paid as follows:

AD&D Insurance	
Spouse only	50% of your supplemental AD&D coverage
Spouse with dependent children	40% of your supplemental AD&D coverage for spouse and 10% of your supplemental AD&D coverage for each child
Child only	15% of your supplemental AD&D coverage

When you elect child life insurance coverage each child is covered, regardless of how many children you have. Children are eligible for coverage from age 14 days to age 19, or to age 25 if they are full-time students.

Evidence of Insurability

When you elect certain levels of life insurance, you may have to provide proof of good health through a physical examination, questionnaire or some other form. This is called evidence of insurability. You must provide evidence of insurability if:

For Yourself

- You previously waived coverage and you want to elect coverage at any level during Open Enrollment
- You are increasing your supplemental life coverage by more than one level. For example, you currently have coverage of two times base pay and you want to increase it to four times base pay or more
- You want to elect five or six times base pay of coverage
- You elect supplemental life coverage that takes your total life coverage above $1 million. This includes coverage from Basic life, Management life, Service life and Supplemental life. Refer to your SPD binder for more information on these other life coverages

For Your Spouse

- You previously waived coverage and you want to elect coverage at any level during Open Enrollment
- You elect more than $50,000 of coverage
- You are increasing your spouse's coverage by more than one level

For Your Child

- You previously waived coverage and you want to elect coverage at any level during Open Enrollment
- You are increasing your child(ren)'s coverage by more than one increment

AD&D does not require EOI at any level.

Paid Time Off

Time away from work is essential to relax and rejuvenate. Studies have shown that employees are more productive when they take some form of time off during the year. At the same time, it's important that you have paid time away from work when you are ill, a loved one is sick or if you have other personal matters that need your attention.

PNM Resources offers a generous paid time off (PTO) program that's designed to give you time away from work when you need it. Here's how the plan works:

- Each year, you are allocated a PTO "bucket" based on your years of service. As your years of service increase, you receive more PTO.
  - If you are a full-time employee, see NetSource for your allocation
  - If you are a part-time employee, you receive 100 hours each year
  - If you are a new hire, you receive your annual allocation as a pro-rated amount based on your date of hire. See the chart below.

New Hire First Year PTO Allocation

	Full-time	Management (P15-P18)
Month Hired	PTO Allocation on Date of Hire	PTO Allocation on Date of Hire
January	128.00 hrs	168 hrs
February	117.33 hrs	154 hrs
March	106.67 hrs	140 hrs
April	96.00 hrs	126 hrs
May	85.33 hrs	112 hrs
June	74.67 hrs	98 hrs
July	64.00 hrs	84 hrs
August	53.33 hrs	70 hrs
September	42.67 hrs	56 hrs
October	32.00 hrs	42 hrs
November	21.33 hrs	28 hrs
December	10.67 hrs	14 hrs

- During the year, you can use your PTO for vacation, incidental sick time, personal time or any other reason approved by your supervisor. Full-time employees do not use PTO for company holidays, jury duty, funeral leave, military leave, voting time or employee doctor appointments up to three hours.
- If you have PTO left at the end of the year, you can carry forward up to 100 hours. You forfeit any hours over 100.

For employees represented by the IBEW, refer to your local contract for more information about vacation and personal leave.

Selling Time During Open Enrollment

During Open Enrollment, you have the opportunity to sell up to 50% of your allocation for the following year. If you decide to sell time, you will receive a lump sum payment in the last quarter of the following year. Open Enrollment is the only time that you can sell PTO for the following year. You can only have up to 100 hours in your PTO bucket at the end of the year, so it's important to keep track of your PTO time carefully.

During Open Enrollment, you can sell up to 50% of your following year's PTO. Employees represented by the IBEW have the option of selling vacation and/or personal leave.

Tips for Using Your PTO

- Plan carefully and sell any extra time you don't think you'll use
- Plan your vacations and time off throughout the year — don't wait until December and try to take 200 hours
- Talk to your supervisor about the best time for you to take time away from work

The maximum hours you can have in your PTO bucket at the end of the year is 100.

Disability Plans

If you are ill or injured and not able to work, it's important to know that you're able to meet your financial obligations. That's why PNM Resources offers full-time employees the Short-Term Illness/Injury plan and the Long-Term Disability plan at no cost to you.

Short-Term Illness/Injury

If you are ill or injured and unable to come to work after seven days, you may be eligible for Short-Term Illness/Injury (STI) benefits. STI provides you with a benefit equal to 100% of your base pay for days eight through 90 of your disability, and then 60% of your base pay for days 91 through 180 of your disability. This program does not apply to employees represented by the IBEW unless your specific contract provides for participation.

Long-Term Disability

Long-Term Disability (LTD) provides coverage if you are unable to work for more than 180 days due to an illness or injury. LTD benefits are paid as a percentage of your base pay. A 90 day waiting period for benefits applies to employees represented by the IBEW.

Retirement Savings Plan (RSP)

The Retirement Savings Plan (RSP) is a 401(k) plan, which means you can voluntarily contribute a percentage of your pay — before taxes are taken out — to an account set up in your name. Because these "before-tax" contributions reduce the taxes taken out of your pay, you can save for the future with less effect on your take home pay than you might expect.

You can contribute up to 100% of your eligible pay to the RSP on a before-tax basis, subject to IRS maximums. For 2006, this maximum is $15,000. But, if you will be age 50 or older during 2006, you can contribute an additional $5,000. This is called a "catch-up" contribution. These limits are changed annually by the IRS and are communicated to employees at the end of each year. In addition to before-tax contributions, you can save from one to 10% of your eligible pay on an after-tax basis. You have 30 days after your date of hire to make an election in the RSP. If you haven't actively enrolled by 30 days after your date of hire, you will be enrolled automatically at a before-tax contribution rate of 3%.

In addition to your contributions, the company offers a generous company match and age-based contributions.

Company Match

After three months of service, you are eligible for the company match. If you are saving with before-tax dollars, the company will match your contributions with 75 cents for each $1 you save, up to 6% of your pay. For example, if you contribute $3,000 to your RSP and this is 6% of your pay, PNM Resources will contribute an additional $2,250.

Company Age-based Contributions

After three months of service, you are eligible to receive company age-based contributions. These contributions go into your account automatically — regardless of whether or not you're saving in the plan. The amount of your contribution is based on your age, as shown below:

Your Age	Company Contribution (as a percent of eligible pay)
Under 40	3%
40–44	5%
45–49	6%
50–54	8%
55 and over	10%

Accessing Your Account

It's easy to access your RSP account. To check your account balance, change your investment elections or contribution percentage, simply call Vanguard at (800) 523-1188 or log on to **www.vanguard.com**.

With the PNMR RSP, you are in charge. You choose how much to save and you choose how your savings are invested.

Why You Need to Save Aggressively

Inflation takes a bite. Inflation may seem tame today, but consider this: Just a 3% annual inflation rate will cut your purchasing power in half in 24 years. In other words, the cost of food, fuel, clothing and everything else you need could double during your retirement years.

How much should you be saving? Here's a general rule of thumb. If you're a younger worker just starting to save, you should be saving at least 10%–20% of your pay, including any company contributions. If that's not possible, start with 6% and gradually increase a percentage point or two until you reach the maximum allowed by the plan.

But remember, PNM Resources contributes to your account and helps you reach your retirement goals. The example below illustrates how you can reach the 10%–20% without contributing the entire amount yourself.

Retirement Example	
Your Contribution Rate	6%
Company Match	4.5% (.75 of your contributions)
Company Contribution	3% (under age 40)
Total Contribution	**13.5%**

Other Benefits

In addition to the benefits detailed in this booklet, the company provides a variety of other valuable programs and services. For more details on these programs, visit NetSource or see your Summary Plan Description binder.

Educational Assistance

Thinking of going back to school? PNM Resources offers educational assistance to employees after completing six months of service. You may be eligible for up to $5,250 annually for degree courses and $1,100 annually for non-degree courses.

Employee Stock Purchase Plan (ESPP)

After six months of service, you can start participating in the ESPP during the next offering period. Enjoy a 5% discount on PNMR stock purchases.

Holidays and Other Time Away From Work

PNM provides full-time employees with nine paid holidays each year. These holidays are in addition to PTO or vacation. In addition, time away from work is provided for funeral leave, jury duty, voting time, military leave and medical, dental and vision appointments for employees.

Business Travel Accident

Business Travel Accident and Life Insurance can provide you with a benefit up to a maximum of $250,000 if you are seriously injured or die in an accident while traveling on company business.

Results Pay/Incentive Plans

The Results Pay and other incentive programs reward you for target workgroup performance and company or business unit performance. The programs offer varying levels of payouts for different levels of performance.

Wellness Programs

The company offers a number of wellness programs, such as stress management and weight loss classes, health fairs, a cardiovascular room, aerobics and yoga.

Important Tips and Reminders

After you enroll as a new hire, you only can make changes to your benefits during Open Enrollment or if you have a qualified change in status. When you enroll, you are choosing benefits for an entire calendar year — January 1 through December 31. So, it's important to make informed decisions.

There are some important things to consider when you're choosing your benefits and coverage:

Waiving Coverage

Your medical, dental and vision coverage offers you preventive benefits to keep you and your family healthy. These plans also protect you financially when you need additional care. However, if you have coverage through another plan, such as your spouse's plan, you may elect to waive coverage in the PNMR plans.

If you'd like to waive coverage, you must complete a Waiver of Coverage Certification Form. When you enroll and elect to waive coverage, a form will be sent to your Mail Stop. Be sure to complete the form and return it by the required due date or you will default automatically into employee only coverage for medical in the BCBS Standard option, employee only coverage in the dental plan and no coverage in the vision plan.

If You Don't Enroll

It's important to review your benefits and be sure you are making the best choices for you and your family. If you don't enroll, you'll have the following coverages:

	You Are Enrolling During Open Enrollment	You Are Enrolling as a New Hire
Medical, Dental, Vision, Supplemental Life and AD&D, Dependent Life and AD&D	Your prior year elections will carry forward to the following year	▪ BCBS Standard Option – employee only ▪ Delta Dental Coverage – employee only ▪ No other optional coverage
Flexible Spending Accounts	You will not participate – your prior year elections do not carry forward to the following year	You will not participate
PTO, Vacation and Personal Leave Sale	You will not participate – even if you sold time in the prior year, you will not sell any time unless you make an active election to sell	Not eligible

Adding or Dropping Dependents

It's important to review your covered dependents each year to make sure they are still eligible for coverage. If your dependent loses eligibility during the year, be sure to notify the Benefits Department within 31 days of the dependents' loss of eligibility.

When you add a dependent for the first time, you may be asked for documentation, such as a marriage certificate if you added a spouse or birth certificate if you added a child. If you do not return the documentation in the time required, your dependents will be dropped from coverage and will not be eligible to re-enroll until the next Open Enrollment period.

It's Important to Drop Ineligible Dependents

When you cover ineligible dependents, it costs you and the company. It's important to review your covered dependents frequently to make sure they are still eligible. If you fail to drop your ineligible dependent from coverage within 31 days that he or she becomes ineligible, your dependent may lose the right to continue coverage under COBRA and you will be required to pay for any claims reimbursed after he or she became ineligible.

Full-time Student Verification

Children ages 19–25 who are full-time students are eligible for dependent coverage under our plans. However, you must submit proof of your child's status for him/her to be covered.

If you are enrolling for the first time and you are electing coverage for a child between ages 19 and 25, you must provide verification of full-time student status when you enroll. In addition, if you are covering a child who turns age 19 during the year, you must provide verification of full-time student status at that time. In either case, the Benefits Department will notify you and give you the form to complete and submit.

The Benefits Department confirms full-time student status each August. If you are covering a child who is a full-time student, look for a Student Certification Form in your Mail Stop around this time. You must complete and submit that form before the due date or your child will be dropped from coverage.

Making Changes During the Year

There are certain instances where you can make changes during the year. These are called qualified changes in status. When you have a qualified change in status, you must notify the Benefits Department ***within 31 days of your change***. If you do not, you cannot make changes until the next Open Enrollment period.

Changes you make to your benefits must be consistent with your change in status. For example, if you have a newborn or adopted child you can add that child to your medical plan, but you cannot add your spouse or change plans (until the next Open Enrollment period). Examples of qualified changes in status include:

- You get married, divorced, become legally separated or get an annulment
- You add a new dependent child through birth, adoption, permanent legal guardianship or foster care
- Your dependent's employment status changes (he/she begins a new job or loses a job)
- Your dependent no longer meets the definition of an eligible dependent (for example, your 23-year old full-time student graduates from college)
- Your spouse or child dies
- Your dependent loses coverage elsewhere
- You switch employment status (full-time to part-time or vice versa)

If Both You and Your Spouse Work For PNM Resources

If you and your spouse both work for PNM Resources, you have two coverage options for enrolling in medical, dental and vision:

- You both can enroll as "employee only"
- One of you can enroll as "employee plus spouse" and the other can waive coverage

You cannot enroll as an employee and be covered as a dependent by your spouse. In addition, only one of you may enroll your child(ren) in medical, dental and vision coverage.

For dependent life insurance and AD&D, you and your spouse may elect coverage for each other. However, only one of you can elect coverage for your eligible children.

Using NetSource

Visit NetSource for a variety of important information, including Summary Plan Descriptions, plan details, forms, contact information and more.

Disclaimer

This benefits guide highlights the key features of the PNM Resources' benefits program. While efforts have been made to ensure the accuracy of the information in this booklet, the official plan documents and insurance contracts govern if there is an error, omission or conflict. PNM Resources expects to continue the plans indefinitely. However, subject to its collective bargaining obligations and applicable law, PNM Resources, Inc. reserves the right to amend, modify or terminate the plans or any component program, in whole or in part — or to transfer the plan to its successor(s) — at any time, for any or no reason and without prior notice.

In the event of a plan change, merger or consolidation, a plan's assets or debts may be transferred to another plan. If a plan is changed or terminated, the Company may or may not decide to establish a different plan providing similar benefits. For health care benefits, the Company may change the amounts you or the Company contributes to a plan. In addition, benefits for services received after the effective date of any plan modification or termination are payable in accordance with the revised provision.

This booklet is not an implied contract and does not guarantee benefits or employment.

For further information about any of the benefit plans, refer to your Summary Plan Descriptions binder. If you need help enrolling, contact the Benefits Department at (505) 241-4919 or (800) 640-4692 or email at benefitshelp@pnm.com.

PNM Resources — Employee Benefits

We'd like you to take a moment to tell us more about benefit communications at PNMR. Please complete this survey and return it to Mail Stop 2340.

1. How much communication do you receive about your benefits?
   - ☐ Too much
   - ☐ Not enough
   - ☐ Just the right amount

2. What is the best way to communicate with you and your family about PNMR benefits and programs? *(please rank, with 1 being the best method)*
   - ☐ Mailing to home
   - ☐ Materials at work
   - ☐ On Netsource
   - ☐ Live meetings

3. Do you share information about your benefits with your family?
   - ☐ Always
   - ☐ Never
   - ☐ Sometimes
   - ☐ Not applicable

4. Who makes benefits decisions in your house?
   - ☐ Me
   - ☐ We do it as a family
   - ☐ My spouse

5. If you have a question about benefits, who are you most likely to contact?
   Benefits Department: ☐ by phone ☐ by email
   - ☐ Vendor (BCBS/Presbyterian/Aon/Delta)

6. Rank the value of the following communications:

	Excellent	Good	Poor	N/A
Summary Plan Descriptions	☐	☐	☐	☐
NetSource Information	☐	☐	☐	☐
HealthSense	☐	☐	☐	☐
Total Rewards Statement	☐	☐	☐	☐
Quarterly RSP Statement (401(k))	☐	☐	☐	☐
Open Enrollment Materials	☐	☐	☐	☐
Investment Classes	☐	☐	☐	☐
Wellness Seminars	☐	☐	☐	☐

Other_____

7. What do you want to learn more about in 2007?
   - ☐ Health Plans
   - ☐ Life Insurance
   - ☐ Wellness Programs
   - ☐ RSP (401(k))
   - ☐ FSA Plans
   - ☐ Disability Plans (STI/LTD)

   Other_____

8. What suggestions do you have for future educational communications such as seminars, presentations or written communications?

   _____

   _____

   _____

Thank you for participating — your opinion is very important.

This panel is 4 3/4 x 11
Perf along the 11 inch side so that it can be torn off.

Your Opinion Counts

Important Contacts

Medical		
Blue Cross and Blue Shield of New Mexico	(888) PNM-BCBS (888) 766-2227	www.bcbs.com www.bcbsnm.com
Presbyterian Health Plan	(800) 356-2219 (505) 923-5678	www.phs.org
Dental		
Delta Dental of New Mexico	(877) 395-9420 (505) 855-7111	www.deltadental.com www.deltadentalnm.com
Vision		
VSP	(800) 877-7195	www.vsp.com
Life and AD&D		
Minnesota Life	(800) 843-8358	
Flexible Spending Accounts		
Aon Consulting	(800) 481-5224	www.smartflexcard.com
STI/FMLA		
MetLife	(888) 601-2073	
Employee Assistance Plan		
Corporate Health Resources	(800) 348-3232 (505) 816-6790	
Retirement Savings Plan		
Vanguard	(800) 523-1188	www.vanguard.com
PNM Resources Benefits Department		
Questions	(800) 640-4692 (505) 241-4919	benefitshelp@pnm.com