NM OFFICE OF SUPERINTENDENT OF INSURANCE
FINAL ADOPTED RULE
F I L E D
07/21/2022 09:38:23 am

TITLE 13 INSURANCE
CHAPTER 10 HEALTH INSURANCE
PART 34 STANDARDS FOR ACCIDENT-ONLY, SPECIFIED DISEASE, HOSPITAL INDEMNITY, DISABILITY INCOME, SUPPLEMENTAL, AND NON-SUBJECT WORKER EXCEPTED BENEFITS

13.10.34.1 ISSUING AGENCY: New Mexico Office of Superintendent of Insurance ("OSI").
[13.10.34.1 NMAC - Rp, 13.10.34.1 NMAC, 07/01/2023]

13.10.34.2 SCOPE: This section identifies the excepted benefits and excepted benefits products that are subject to this rule, and applicable exceptions.

A. Subject products. This rule applies to these excepted benefits products:

(1) accident only;
(2) specified disease or illness;
(3) hospital indemnity;
(4) other fixed indemnity;
(5) disability income;
(6) supplemental; and
(7) insurance similar to workers' compensation (non-subject worker).

B. Extraterritorial plans. This rule applies to every subject individual, group and blanket contract of insurance, including any certificate, delivered in this state, and to any subject contract issued to a group located outside of this state, if any covered person resides in this state, except:

(1) a group plan, and certificates of insurance relating to that plan, issued to an out-of-state employer that employs 100 or fewer New Mexico residents at any time during the calendar year; or

(2) a group or blanket plan issued to an out-of-state entity that resides in a state whose laws offer protections that, in the discretion of the superintendent, are equivalent to or more protective than New Mexico law.

C. Grandfathered plans. This rule does not apply to:

(1) An individual or blanket plan issued prior to the effective date of these rules if:

(a) the plan is guaranteed renewable, non-cancellable, or guaranteed renewable through a specified age, or conditionally renewable in the case of disability income plans;

(b) the plan is continually in force without any lapse; and

(c) there are no material changes in the substantive provisions of the plan after the effective date of this rule. An annual rate change that does not exceed ten percent is not considered a material change in the substantive provisions of a grandfathered plan unless the plan was issued with a guaranteed rate.

(2) An employer group, labor union, credit union, or bona fide association, as defined at Subsection A of Section 59A-23G-2 NMSA 1978, if:

(a) the carrier began offering the plan through the employer, labor union, credit union, or association prior to the effective date of this rule;

(b) the plan is continually in force without any lapse;

(c) eligibility for the plan is limited to employees, labor union, credit union, or association members and their dependents;

(d) there are no material changes in the substantive provisions of the plan after the effective date of this rule. An annual rate change that does not exceed ten percent is not considered a material change in the substantive provisions of a grandfathered plan unless the plan was issued with a guaranteed rate. Incremental changes in fixed dollar coverage amounts or benefit limitations consistent with inflation, and changes in plan enrollment of employees and their dependents (whether newly hired or newly enrolled) are also not considered a material change.

D. Self-funded plans. This rule does not apply to a self-funded employer plan.
[13.10.34.2 NMAC - Rp, 13.10.34.2 NMAC, 07/01/2023]

13.10.34.3 STATUTORY AUTHORITY: Sections 59A-18, 59A-16 and 59A-23G-3 NMSA 1978.
[13.10.34.3 NMAC - Rp, 13.10.34.3 NMAC, 07/01/2023]

13.10.34.4 DURATION: Permanent.
[13.10.34.4 NMAC – Rp, 13.10.34.4 NMAC, 07/01/2023]

13.10.34.5 EFFECTIVE DATE: July 1, 2023, unless a later date is cited at the end of a section.
[13.10.34.5 NMAC - Rp, 13.10.34.5 NMAC, 07/01/2023]

13.10.34.6 OBJECTIVE: The purpose of this rule is to establish regulatory requirements for the subject excepted benefit plans. The rule will standardize and simplify the terms and coverages; facilitate public understanding and comparison of coverage; eliminate provisions that may be misleading or confusing in connection with the purchase and renewal of the coverages or with the settlement of claims and require disclosures in the marketing and sale of subject excepted benefit plans.
[13.10.34.6 NMAC - Rp, 13.10.34.6 NMAC, 07/01/2023]

13.10.34.7 DEFINITIONS: For definitions of terms contained in this rule, refer to 13.10.29 NMAC, unless otherwise noted below.

A. "Accident only plan" means an insurance agreement that conditions a fixed indemnity benefit on the occurrence of an injurious accident.

B. "Certificate" means a document that extends coverage under a group plan to a group member.

C. "Direct response insurer" means a carrier who does not sell its insurance products through producers.

D. "Disability income plan" means an insurance agreement that provides income protection benefits during a period of disability resulting from either sickness, pregnancy, injury or a combination of these.

E. "Domestic co-insured" means a spouse or domestic partner insured under the same plan or certificate.

F. "Hospital indemnity plan" means an insurance agreement that conditions a fixed indemnity benefit on the hospitalization, hospital-based treatment or hospice care of a covered person.

G. "Occupational accident plan" means an accident-only plan that pays a fixed indemnity benefit for injury that results from an occupational accident involving a covered subject worker.

H. "Other fixed indemnity" means a fixed cash benefit payable to a covered person on the occurrence of an event, circumstance or condition, other than or in addition to accident, injury, illness or disability.

I. "Plan" means any individual, group or blanket insurance subject to this rule provided through a standalone policy, certificate, contract or rider.

J. "Non-contributory" means that a covered person pays no premium, membership fee or dues to qualify for coverage or benefits under the plan.

K. "Non-subject worker plan" means an insurance agreement that provides benefits similar to workers' compensation benefits to a self-employed non-subject worker.

L. "Specified disease plan" means an insurance agreement that conditions a fixed indemnity benefit on the occurrence or diagnosis of a specific disease or illness that is either life-threatening or likely to cause a covered person to incur significant financial obligations.

M. "Supplemental plan" means an insurance agreement that provides benefits that supplement coverage under a group major medical, TRICARE or Champus plan.
[13.10.34.7 NMAC - Rp, 13.10.34.7 NMAC, 07/01/2023]

13.10.34.8 GENERALLY APPLICABLE PROVISIONS: A plan subject to this rule shall comply with these provisions:

A. Probationary periods. A plan shall not include a probationary or waiting period during which no coverage is provided for a covered benefit after the coverage effective date. A probationary period does not include an eligibility-waiting period during which no premium is paid, or an elimination period for a disability income plan.

B. Riders and other supplements. A rider, amendment, endorsement or other supplement shall explicitly state which benefits the carrier has amended or supplemented from the original plan.

C. Preexisting conditions. An individual plan, or plan sold through an association or group described in Paragraph (2) or (4) of Subsection A of Section 59A-23-3 NMSA 1978, shall not exclude coverage for a loss due to a preexisting condition unless the application or enrollment form includes a conspicuous notice about the scope and applicability of any such exclusion that will apply in the coverage, and that notice also appears in the plan document issued to the covered person at the start of the free look period.

D. Return of premium. A plan may include a return of premium or cash value benefit if authorized by the superintendent following an evaluation of the potential impact on the carrier's reserves and ability to service policy obligations. Nothing in this rule requires a carrier to seek authorization from the superintendent to return

premiums unearned through termination or suspension of coverage, retroactive waiver of premium paid during a medical condition, payment of dividends on participating policies, or experience rating refunds.

E. **Exclusions**. A plan shall not exclude any type, circumstance or cause of loss that would not otherwise be covered, and the plan exclusions shall not, individually or collectively, unreasonably or deceptively alter the scope of coverage. Subject to the foregoing, a plan may exclude coverage for the following conditions, circumstances and causes of loss:

(1) preexisting conditions;

(2) loss resulting from or contributed to by:

(a) war or act of war (whether declared or undeclared); participation in a felony, riot or insurrection; service in the armed forces or units auxiliary to it;

(b) suicide (sane or insane), attempted suicide or intentionally self-inflicted injury within two years of the effective date of coverage;

(c) aviation, other than travel as a fare paying passenger on a commercial carrier; or

(d) incarceration or detention due to illegal activity.

(3) loss for which benefits are provided under Medicare or other governmental program (except Medicaid), a state or federal workers' compensation program, employers liability or occupational disease law, or motor vehicle no-fault law;

(4) participation in an illegal activity;

(5) voluntary intoxication by any legal or illegal drug, including alcohol;

(6) specifically named high-risk physical activities;

(7) international territorial limitations;

(8) occupational injury or disease;

(9) normal pregnancy or childbirth;

(10) foreign travel or residency; or

(11) any other type, circumstance or cause of loss if the carrier satisfies the superintendent that the exclusion promotes a legitimate underwriting or public policy objective or is required to comply with any state or federal law.

F. **Contracted providers**. A plan shall not condition a benefit or offer an enhanced benefit based on receipt of health care from any specific provider, provider network or facility, or based on the care methodology. A carrier shall not refer to a network or provider arrangement in any plan document or advertisement.

G. **Marketing of blanket or group coverages**. A carrier shall not sell any blanket coverage that is not described in Section 59A-23-2 NMSA 1978 or group coverage that is not identified or described in Section 59A-23-3 NMSA 1978.

H. **Arbitration provisions**. A plan shall not require a covered person or master policyholder to submit a dispute arising out of or relating to the plan to mediation or arbitration. A covered person or master policyholder may agree to participate in voluntary mediation or arbitration after the submission of a claim for benefits, or after a dispute arises.

I. **Legal compliance.** A covered person's rights under any plan shall be governed by the terms of the plan approved by the superintendent, and by applicable state and federal law. This rule does not limit the superintendent's authority to approve or disapprove a plan or plan provision as authorized by any other state or federal law.

J. **Telemedicine services**. A plan that provides a benefit conditioned on a covered person's receipt of a health care service shall provide that benefit if the service is delivered in-person or virtually. No plan may offer a telemedicine only benefit.

K. **Discrimination**. No carrier or plan shall discriminate in eligibility for coverage or benefits on the basis of sex, sexual orientation, gender, gender identity, race, religion, or national origin. A plan may differentiate on the basis of age in rating and age limits on coverage.

L. **Insurance cards**. A carrier shall not issue an insurance card or similar proof of coverage to a covered person.

M. **Direct reimbursement.** A carrier shall pay fixed indemnity benefits directly to a covered person unless the covered person assigns benefits after a covered loss occurs. A coercive assignment is unenforceable.

N. **Inducements.** Except as authorized by Section 59A-16-17 NMSA 1978, and these rules, a carrier shall not offer or provide monetary or other valuable consideration, engage in misleading or deceptive practices or make untrue, misleading, or deceptive representations in any plan document, advertising or sales presentation to induce enrollment.

O. Military service exclusion or suspension. If a plan contains a military service exclusion or a provision that suspends coverage during military service, the plan shall refund unearned premiums upon receipt of a written request for refund, or upon learning that a covered person has entered military service.

P. Individual noncancellable and guaranteed renewable policies. A "noncancellable," "guaranteed renewable," or "noncancellable and guaranteed renewable" individual plan shall not provide for termination of coverage of the domestic co-insured solely because of the occurrence of an event specified for termination of coverage of the covered person, other than nonpayment of premium. In addition, the plan shall provide that in the event of the covered person's death, the domestic co-insured of the covered person, if covered under the plan, shall become the policyholder.

(1) The terms "noncancellable" or "noncancellable and guaranteed renewable" may only be used in an individual excepted benefit plan if the covered person has the right to continue the coverage by timely paying premiums, until the age of 65 or until eligibility for Medicare, during which time the carrier has no unilateral right to change any provision of the plan.

(2) The term "guaranteed renewable" may only be used in a plan where the covered person has the right to continue in force, by timely paying premiums, until the age of 65 or until eligibility for Medicare, during which period the carrier has no unilateral right to change any provision of the plan, other than changes in premium rates by classes.

(3) In an individual plan covering domestic co-insureds, the age of the younger of the two shall be used as the basis for meeting the age and durational requirements of the definitions of "non-cancellable" or "guaranteed renewable." However, this requirement shall not prevent termination of coverage of the older of the two upon attainment of the stated age, so long as the plan may be continued in force as to the younger of the two to the age or for the durational period as specified in the plan.

Q. Dependent child. An individual excepted benefit plan's coverage for a child who is incapable of self-sustaining employment on the date the child would otherwise age out of coverage shall continue if the child depends on the covered person for support and maintenance. The plan may require that within 31 days of the date the company receives proof of the child's incapacity, the covered person may elect to continue the plan in force with respect to the child or insure the child under an approved conversion plan.

R. Continuous loss. A carrier shall not terminate a plan, except for non-payment of premium, during a period of continuous loss that commences during the period of coverage unless expressly limited by the duration of the benefit period, if any, or any maximum benefit limit.

S. Waivers. Where a waiver is required as a condition of plan issuance, renewal or reinstatement, a signed acceptance by the covered person is required. A waiver shall be limited to a specifically named or described disease, physical condition or activity.

T. Termination of coverage. A carrier may terminate a plan only for a reason specified in the agreement delivered to the covered person. A plan may authorize termination for:

(1) failure of the covered person or subscriber to pay the premiums and other applicable charges for coverage;

(2) material breach of a contractual obligation, or a prejudicial failure to satisfy a post-loss condition;

(3) fraud or misrepresentation affecting underwriting;

(4) expiration of term; or

(5) any reason that the superintendent determines is not substantively or procedurally unconscionable.

U. Notice required upon termination of coverage for individual plans. A carrier shall not terminate a plan unless it provides written notice to a covered person 30 days prior to the intended termination date. Notice of termination shall:

(1) be in writing and dated;

(2) state the reason for termination, with specific references to the clauses of the plan that justify the termination;

(3) state that a covered person's plan cannot be terminated because of health status, need for services, race, religion, national origin, gender, gender identity, age (except where allowed by law or rule), or sexual orientation of covered persons under the contract;

(4) state that a covered person who alleges that an enrollment has been terminated or not renewed because of the covered person's health status, need for health care services, race, religion, national origin, gender, gender identity, age or sexual orientation may file a complaint with the superintendent of insurance at www.osi.state.nm.us or 1-855-427-5674; and

(5) state that in the event of termination by either the covered person or the carrier, except in the case of fraud or deception, the carrier shall, within 30 calendar days, return to the covered person or subscriber the portion of the money paid to the carrier that corresponds to any unexpired period for which payment had been received together with amounts due on claims, if any.

V. Notice required upon termination of coverage for group plans. A group plan shall specify that either the carrier or the group master policyholder shall provide notice to the party responsible for providing notice to each group certificate holder of any plan expiration, lapse or termination at least 30 days in advance. Except where the group policyholder or the employer is replacing a group plan with another carrier's plan, a carrier shall not terminate a group plan unless it provides written notice to the party responsible for providing notice to each certificate holder 30 days prior to the certificate holder's intended termination date. The party responsible for providing notice to each certificate holder shall attest that notice was provided 30 days prior to the intended termination date. Notice of termination shall:

(1) be in writing and dated;

(2) state the reason(s) for termination, with specific references to the clauses of the plan that justify the termination; and

(3) state that in the event of termination by either the group policyholder or the carrier, except in the case of fraud or deception, the carrier shall, within 30 calendar days, return to the group policyholder the money paid to the carrier that corresponds to any unexpired period for which payment had been received.

W. Claim form. If a carrier requires submission of a claim form as a condition of payment, the carrier, upon receipt of notice of a claim, shall deliver the form to the covered person. If a carrier does not deliver a claim form within 15 days after notice of a claim, the claimant shall be deemed to have complied with any proof of loss requirement if a written notice of claim contains sufficient detail to determine that a covered loss occurred.

X. Grace periods. A carrier shall grant a premium payment grace period of at least 10 days for a monthly premium plan and at least 31 days for a plan billed less frequently.

Y. Variability. A carrier who offers an individual plan with variable benefit types and levels shall submit for approval the outline of coverage and benefits that illustrates the plan design that would be available to a prospective covered person. A carrier who offers coverage to eligible covered persons under a group plan shall submit for approval an outline of coverage or certificate that corresponds with the plan design ultimately offered to those covered persons. A carrier shall comply with the variability guidance posted on the OSI website, including mapping requirements. Each distinct outline of coverage, or certificate shall be subject to a filing fee as specified in statute.

Z. Treatment trigger. Except as expressly authorized in this rule, no accident only or specified disease plan shall condition a benefit on a covered person's receipt of health care or offer a fee for service benefit.

AA. Portability. A portability or continuation provision in an employer group plan shall not allow a person whose group eligibility ends to continue group coverage for more than nine months. A portability or continuation provision in any other type of group plan shall not allow a covered person to continue coverage for more than three months. In the event of the death of a covered group member, coverage for a domestic co-insured of the decedent insured may continue for two years, until one-year after any minor dependent insured obtains the age of majority, and for one-year after circumstances creating dependency end for any other dependent insured.

BB. Subrogation. A carrier who offers or pays a fixed indemnity benefit shall not claim, assert or pursue subrogation.

CC. Benefit minimums. The superintendent may, after conducting a public hearing, issue an order mandating, or reducing mandated, benefit minimums for any type of subject plan. A non-contributory plan is not subject to any benefit minimum mandated by this rule. Benefit minimums are not applicable to the non-contributory portion of a plan that has both contributory and non-contributory portions.

DD. Value added product or service. A carrier shall not provide or offer a value added product or service in connection with a subject plan if any part of the cost of providing the product or service is included in the plan rates. A carrier who proposes to offer a value added product or service must provide actuarial certification of compliance with this rule.

[13.10.34.8 NMAC - Rp, 13.10.34.8 NMAC, 07/01/2023]

13.10.34.9 ADDITIONAL REQUIREMENTS FOR DISABILITY INCOME PLANS: A disability income plan is subject to these additional requirements:

A. Benefit reduction. A disability income plan may provide that benefits shall decrease by up to fifty percent if the covered person is or attains the age of 62 during the period of disability.

B. Disability limitation. A disability income plan shall only provide benefits for disability resulting from injury, sickness, pregnancy or combination of these causes.

C. Partial disability. A disability income plan shall consider an individual to be partially disabled if the individual:

(1) is unable to perform one or more but not all of the substantial and material duties or words of similar import, of the individual's employment or existing occupation or work a specified percentage of time, or a specified number of hours, or earn a specified amount of compensation; and

(2) remains engaged in work for wage or profit.

D. Residual disability. A disability income plan shall consider "residual disability" in relation to the individual's reduction in earnings and may be related either to the inability to perform some part of the "major," "important" or "essential duties" of employment or occupation or to the inability to perform all usual business duties for as long as is usually required. A disability income plan that provides for residual disability benefits may require a qualification period, during which the covered person must be continuously totally disabled before residual disability benefits are payable. The qualification period for residual benefits may be longer than the elimination period for total disability. In lieu of the term "residual disability," a disability income plan may use "proportionate disability" or other term of similar import that, in the opinion of the superintendent, adequately and fairly describes the benefit.

E. Total disability. A disability income plan shall not define "total disability" more restrictively than a definition requiring that an individual who is totally disabled not be able to perform the duties of any employment or occupation for which he or she is or becomes qualified by reason of education, training, or experience; and is not, in fact, engaged in any employment or occupation for wage or profit.

(1) Total disability may be defined in relation to the inability of the insured to perform duties, and may include a reduction in earnings requirement, but may not be based solely on an insured's inability to:

(a) Perform any occupation whatsoever, any occupational duty, or any and every duty of his or her occupation; or

(b) Engage in a training or rehabilitation program.

(2) A disability income plan may require the covered person to have complete inability to perform all of the substantial and material duties of his or her regular occupation, or words of similar import.

(3) If the covered person is not employed at the onset of disability, a disability income plan shall not define total disability more restrictively than the inability to perform three or more activities of daily living, as certified by a physician.

(4) A carrier may require proof of disability or care to be provided by a physician other than the insured of a member of the insured's immediate family.

F. Independent examination. A carrier may require a covered person to undergo an independent examination to evaluate disability as often as reasonably necessary.

G. Elimination period. A disability income plan shall not include an elimination period greater than 30 days in the case of coverage providing a benefit duration of one year or less; 60 days in the case of coverage providing a benefit duration of greater than one year and no more than two years; 90 days in the case of coverage providing a benefit duration of greater than two years and no more than three years; 180 days in the case of coverage providing a benefit duration of greater than three years and no more than five years; or 365 days in all other cases. For purposes of this provision, the benefit duration shall disregard reduced benefit durations based on age. If a plan provides both full and partial disability, only one elimination period is allowed. The requirements of this section do not apply to a short term disability plan.

H. Minimum benefit period. After the elimination period, a disability income plan shall not have a benefit duration of less than three months, or until the disability ends, whichever is less.

I. Recurrent disabilities. Unless a disability income plan provides for a benefit payable to a certain age limit, a provision relating to recurrent disabilities shall not specify that a recurrent disability be separated by a period greater than six months.

[13.10.34.9 NMAC - Rp, 13.10.34.9 NMAC, 07/01/2023]

13.10.34.10 ADDITIONAL REQUIREMENTS FOR ACCIDENT-ONLY PLANS: An accident-only plan is subject to these additional requirements.

A. Plan definitions. An accident-only plan:

(1) shall not define "accident" more narrowly than an injurious event during the coverage period that was unexpected and unintended from the standpoint of the covered person.

(2) shall not define "injury" more narrowly than physical or mental harm that results from an accident, no matter the degree of harm or when it manifests.

B. Coverage requirements. An accidental death benefit in an accident-only plan shall be no less than $5,000 for a named covered person and any domestic co-insured. Dependent coverage for accidental death shall be no less than $2,500 for each dependent. The death benefit amount may vary for each specifically identified life insured under the policy or certificate. A dismemberment benefit shall be at least $2,500 for loss of an arm or leg. The benefit amount for partial dismemberment and loss of a non-limb body part shall be no less than $250 for each covered loss.

C. Basis of compensation. An accident-only plan shall only compensate for losses on a fixed-indemnity basis.

D. Specified accident. Specified accident insurance coverage shall only be sold as blanket coverage pursuant to Section 59A-23-2 NMSA 1978, or as nonrenewable individual coverage with a term not to exceed 30 days. Specified accident coverage shall only be offered in a designated specified accident plan.

E. Occupational accident plan. An occupational accident plan:

(1) shall only be issued to an individual or group member who is a worker engaged in employment subject to New Mexico workers' compensation law protections.

(2) shall only pay benefits conditioned on the covered person sustaining a work-related injury.

(3) shall not coordinate with workers' compensation benefits.

(4) shall include this notice, displayed on a cover page or on the first page of the plan in bold 14-point type:

YOUR PURCHASE OF THIS PLAN DOES NOT RELEASE YOUR EMPLOYER FROM ANY LEGAL DUTY TO PROVIDE WORKERS' COMPENSATION COVERAGE. TO LEARN MORE ABOUT YOUR RIGHTS TO WORKERS' COMPENSATION COVERAGE PLEASE CONTACT:

STATE OF NEW MEXICO
WORKERS' COMPENSATION ADMINISTRATION
2410 CENTRE AVE SE
ALBUQUERQUE, NM 87106
505-841-6000
www.workerscomp.nm.gov

THIS PLAN ONLY PROVIDES BENEFITS IF YOU ARE INJURED WHILE ENGAGED IN EMPLOYMENT SUBJECT TO NEW MEXICO WORKERS' COMPENSATION LAWS. IF YOU ARE NOT ENGAGED IN SUCH EMPLOYMENT OR CEASE TO BE ENGAGED IN SUCH EMPLOYMENT, CONTACT US AT [INSERT NUMBER] AND WE WILL CANCEL THIS PLAN AND REFUND ANY UNEARNED PREMIUM.

(5) shall not reduce or eliminate any benefit because a covered person receives, or is entitled to receive, workers' compensation benefits.

(6) shall not exclude activities or accidents inherent to the covered person's occupation.

(7) shall not require a covered person to waive rights to workers' compensation coverage or benefits.

(8) shall be cancellable at any time.

(9) shall not be conditioned on a covered person receiving workers' compensation benefits.

(10) shall provide benefits for any injury that results during a covered person's work hours at the covered person's work location, subject to any authorized exclusion and to the going-and-coming rule. An injury to a traveling worker shall be covered if the injury results while the worker is traveling for the employer and is being compensated for the travel.

F. Sickness benefit. An accident-only plan shall not offer a benefit for any sickness or disease that is not caused by a covered accident. Sickness or disease benefits shall be limited to illness that arises within 90 days of the accident. Sickness benefits may include coverage for mental health care or nervous disorders that result from an accident.

G. Other Fixed Indemnity Benefits: An accident-only plan may offer other fixed indemnity benefits in compliance with Section 13.10.34.12.

H. Income replacement benefit. An accident-only plan may offer income replacement benefits only for disability resulting from a covered accident.

I. Accidental cause variation. An accident only plan that provides benefits, or benefit amounts, that vary depending on the accident cause, place, time or manner shall prominently set forth in the outline of coverage the circumstances under which different benefits or amounts are payable. A plan that includes accidental cause variation may be deemed a specified accident plan subject to the specified accident provisions of this rule.

J. Exclusion consistency. A carrier shall not suggest or imply that an accident only plan applies to injury that results from an excluded activity.

K. Death and dismemberment. An accident-only plan may offer a death and dismemberment benefit. When accidental death and dismemberment coverage is part of an individual plan, the covered person shall have the option to include all covered persons under the coverage and not just the principal covered person.

L. Delayed loss. Accident-only benefits shall be payable if a covered loss was caused by a covered accident during the period of coverage even if the loss first manifests after the period of coverage, provided notice of loss is provided within five years of the covered accident

M. Fractures or dislocations. A plan that provides coverage for fractures or dislocations shall provide benefits for full and partial fractures or dislocations.

[13.10.34.10 NMAC - Rp, 13.10.34.10 NMAC, 07/01/2023]

13.10.34.11 ADDITIONAL REQUIREMENTS FOR HOSPITAL INDEMNITY PLANS: A hospital indemnity plan is subject to these additional requirements.

A. Benefit minimum. A hospital indemnity plan shall pay a minimum lump-sum of no less than $1,500 upon initial confinement. A plan may offer additional lump-sum or daily benefits for additional periods of confinement as defined by the plan, subject to the provisions contained in this rule.

B. Continuous hospital confinement. A hospital indemnity plan shall treat consecutive days of in-hospital service received as an inpatient, and successive inpatient confinement for treatment of the same condition within 30 days of prior discharge, as a single period of confinement. A carrier shall not combine confinements that result from medically distinct causes. A plan may exclude benefits for any calendar day period of confinement that does not result in billed charges by a hospital.

C. Basis of compensation. A hospital indemnity plan shall provide benefits only on a fixed indemnity basis.

D. Hospital indemnity benefit limitations. A hospital indemnity plan shall only offer benefits conditioned on a covered person being hospitalized, or receiving hospice, convalescent or extended care, hospital-treatment related ambulatory surgical center services, ambulance service to or from a covered confinement, hospital-affiliated outpatient services, anesthesia, surgery, emergency care leading to a hospital, convalescent or hospice confinement, lost wages during a period of hospital confinement, or expenses to travel to or from a hospital confinement. These benefits shall not be offered as a separate rider.

E. Confinement defined. A hospital indemnity plan shall define “confinement” as any consecutive 24-hour period during which medical observation or services are provided on a continuous basis in a licensed medical facility, each immediately successive such period, and any period of time less than 24-hours on the date of discharge from any such confinement.

F. Convalescent or extended care. A plan that provides a benefit conditioned on a covered person receiving convalescent or extended care following hospitalization shall provide such benefits if the admission to the convalescent or extended care facility is within 14-days after discharge from the hospital.

[13.10.34.11 NMAC - Rp, 13.10.34.11 NMAC, 07/01/2023]

13.10.34.12 OTHER FIXED INDEMNITY: Other fixed indemnity benefits are subject to these additional requirements.

A. Benefits. Other fixed indemnity benefits shall be no less than $50 per triggering event, circumstance or condition. The aggregate amount of all other fixed indemnity benefits offered shall not exceed $10,000.

B. Limitations. A carrier shall not offer or sell a person a plan, or combination of plans, that provide more than ten other fixed indemnity benefits. A carrier shall not sell a plan that includes other fixed indemnity benefits if that would result in the customer having coverage for more than ten other fixed indemnity benefits under one or more plans. An application for a plan that offers other fixed indemnity benefits shall inquire whether a prospective insured has other excepted benefits coverage, and about the number and type of other fixed indemnity benefits covered by a prospective insured’s other coverage, if any. A carrier that offers more than five other fixed indemnity benefits must do so in a manner which is not ambiguous, deceptive, or misleading, or which suggests that the package of fixed indemnity benefits is a substitute for or constitutes major medical insurance.

C. Other fixed indemnity benefit types. Unless otherwise limited by this rule, the other fixed indemnity benefits shall be limited to hospitalization, outpatient services, ambulance and other transportation services, behavioral health services, laboratory and imaging services, in-home care, durable medical equipment, home, work or vehicle modifications to accommodate disability, therapy services, treatment-related lost wages, health care related lodging, pet care and daycare services, or cosmetic services relating to a covered accident or illness. Other fixed indemnity benefits may be offered as a stand-alone policy or certificate of insurance or as a rider to an excepted benefit subject plan. A stand-alone other fixed indemnity plan shall include all notices required by this rule at an appropriate reading level which is understandable to a prospective insured.

D. Treatment trigger. Other fixed indemnity benefits may be conditioned upon a covered person receiving medical care given in a medically appropriate location. A carrier shall not condition payment for any such benefit on prior approval of treatment or on medical necessity.

[13.10.34.12 NMAC - Rp, 13.10.34.12 NMAC, 07/01/2023]

13.10.34.13 ADDITIONAL REQUIREMENTS FOR SPECIFIED DISEASE PLANS: A specified disease plan is subject to these additional requirements.

A. General requirements.

(1) A plan covering a single specified disease or combination of specified diseases shall not be sold or offered for sale other than as a specified disease plan.

(2) A specified disease plan that conditions payment upon a pathological diagnosis shall also provide that if the pathological diagnosis is not medically feasible, a clinical diagnosis will be accepted.

(3) A specified disease plan shall pay a lump-sum upon medical diagnosis of the specified disease, or for any form or variation of a specified disease that is covered by the plan.

(4) An individual specified disease plan shall be guaranteed renewable.

(5) A specified disease plan shall not be sold to a person covered by any Title XIX program (Medicaid, Centennial Care or any similar name). An individual specified disease plan shall contain a statement above the signature line of an individual applicant or covered person attesting that the person seeking to be covered for a specified disease is not covered by Medicaid. The statement may not be combined with any other statement for which the carrier may require the applicant or covered person's signature. For group plans, the carrier shall provide a notice in any enrollment materials of the above prohibition of sale of a specified disease plan to persons covered by Title XIX programs.

(6) Any benefit that is conditioned on repeated care for a specified disease shall begin with the first day of care even if the diagnosis is made at some later date.

(7) A specified disease plan shall provide benefits only on a fixed indemnity basis.

(8) A specified disease plan may offer other fixed indemnity benefits in compliance with 13.10.34.12.

B. Minimum benefits. The following minimum benefits standards apply to all specified disease coverages:

(1) No less than an aggregate amount of $5,000 per triggering diagnosis. The OSI may approve product filings that allow a lower aggregate amount for a variant or subtype of a covered specified disease that requires minimally invasive treatment or are non-life-threatening. OSI may also approve plan designs for more extensive coverage for dependents.

(2) Dollar benefit limits shall be offered for sale only in even increments of $1,000 unless for dependent extended coverage riders, in which case this extended coverage may be offered for sale only in even increments of $500.

(3) Where coverage is advertised or otherwise represented to offer generic coverage of a disease or diseases, the same dollar amounts shall be payable regardless of the particular variant or subtype of the disease, unless lower aggregate amounts have otherwise been approved under Paragraph (1) of this subsection.

C. Reductions in benefits. A specified disease plan shall not eliminate or reduce benefits based on the occurrence of specified events or attaining a certain age.

D. Overinsurance. No carrier or producer shall offer or sell a specified disease plan, or combination of such plans, that apply to more than eight specified diseases. Except for group specified disease plans offered by an employer, no carrier or producer shall sell a specified disease plan if that would result in the customer having coverage for more than eight specified diseases under plans issued by different carriers. Except for group specified disease plans offered by an employer, a specified disease plan application shall inquire whether a prospective insured has other specified disease coverage, and about the number and type of diseases covered by a prospective insured's other coverage, if any. A specified disease plan may provide benefits for all medically diagnosed and

commonly recognized forms or variations of each specified disease or illness without having each variation count against the eight disease limit. A carrier shall not sell to an individual a specified disease plan if such coverage would result in the individual being covered by more than one specified disease plan for the same specified disease.
[13.10.34.13 NMAC - Rp, 13.10.34.13 NMAC, 07/01/2023]

13.10.34.14 ADDITIONAL REQUIREMENTS FOR HOSPICE CARE BENEFITS: A hospital indemnity plan that provides hospice coverage, separately or in conjunction with other hospital indemnity coverage, is subject to these additional requirements.

A. Scope. The hospice benefit shall apply to care received in a facility or through an in-home program, licensed, certified or registered in accordance with state law that provides a formal program of care that is:

(1) for terminally ill patients whose life expectancy is less than six months;
(2) provided on an inpatient or outpatient basis; and
(3) directed by a physician.

B. Benefits trigger. Hospice benefits shall be payable when the attending physician of the covered person provides a written statement that the covered person has a life expectancy of six months or less, and the person is receiving hospice care as described in this rule.

C. Hospice benefit. A hospice care benefit shall be no less than a lump-sum of $2,500.
[13.10.34.14 NMAC - Rp, 13.10.34.14 NMAC, 07/01/2023]

13.10.34.15 SUPPLEMENTAL PLAN: A supplemental plan is subject to these additional requirements.

A. Group coverage limitation. A carrier shall only offer or issue a supplemental plan to a person who is covered under a primary group major medical, TRICARE or Champus plan.

B. Plan design. A supplemental plan must be specifically designed to fill gaps in the primary coverage. This requirement is satisfied if the coverage is designed to fill gaps in cost-sharing in the primary coverage, such as coinsurance or deductibles, or the coverage is designed to provide benefits for items and services not covered by the primary coverage and that are not essential health benefits as defined under section 1302(b) of the Patient Protection and Affordable Care Act in the New Mexico benchmark plan, or the coverage is designed to both fill such gaps in cost-sharing under, and cover such benefits not covered by, the primary coverage.

C. No coordination. A supplemental plan shall not include a coordination-of-benefits provision but may condition payment of benefits on the covered person becoming obligated to pay a cost-sharing obligation under the primary coverage.

D. Indemnity. A supplemental plan shall not offer fixed indemnity benefits.

E. Filing requirement. For each supplemental plan filed with the superintendent, the carrier shall also file a separate document specifically identifying any offered benefits that are not covered by group major medical coverage and are not essential health benefits.

F. Exclusions. A supplemental plan shall include a provision that guarantees the plan will not impose an exclusion that does not appear in the covered person's group major medical plan.
[13.10.34.15 NMAC - Rp, 13.10.34.15 NMAC, 07/01/2023]

13.10.34.16 NON-SUBJECT WORKER PLAN: A non-subject worker plan is subject to these additional requirements.

A. Eligibility. A non-subject worker plan shall only be offered or sold to a person who is self-employed and not subject to New Mexico workers' compensation law protections. A carrier shall investigate and evaluate the self-employment status of each applicant for an individual non-subject worker plan, and of each person who applies to enroll in a group non-subject worker plan. An attestation of self-employment by an applicant shall not relieve a carrier from these duties. 1099 income, standing alone, is insufficient proof of self-employment.

B. Notice. An application for individual coverage, and an enrollment form for group coverage, shall include this notice, printed in 14-point type:

THE INSURANCE YOU ARE APPLYING FOR IS NOT A MAJOR MEDICAL INSURANCE PLAN. THE INSURANCE YOU ARE APPLYING FOR DOES NOT OFFER ANY BENEFIT FOR MEDICAL CARE YOU REQUIRE FOR AN OFF-WORK INJURY OR ILLNESS.

TO LEARN IF YOU ARE ELIGIBLE FOR A MAJOR MEDICAL PLAN, PLEASE VISIT WWW.BEWELLNM.COM. OR CALL 1-833-862-3935. PREMIUM DISCOUNTS, FINANCIAL ASSISTANCE, MEDICAID OR OTHER MAJOR MEDICAL COVERAGE OPTIONS MAY BE AVAILABLE.

C. **Benefit requirements.** The benefits provided under a non-subject worker plan are limited to medical expense reimbursement, wage loss replacement and lump-sum payment for permanent or temporary disability (full or partial) sustained by a covered person as a result of an on-the-job injury or occupational disease. A subject plan may provide any combination of such benefits, subject to the benefit levels rule.

D. **Benefit levels.** The benefits offered under a non-subject worker plan shall be no less than what a covered person would be entitled to receive if that person's self-employment was subject to New Mexico workers' compensation laws. A subject plan may provide lower benefit levels, and omit some such benefits, provided the carrier offers an applicant a plan that would provide workers' compensation equivalent benefits, and the covered person rejects that offer in writing. The rejection document shall include the following attestation printed in 14-point type:

[CARRIER] OFFERED APPLICANT AN INSURANCE PLAN THAT INCLUDED BENEFITS EQUIVALENT TO WHAT APPLICANT WOULD BE ENTITLED TO IF THE APPLICANT'S SELF-EMPLOYMENT WAS SUBJECT TO NEW MEXICO WORKERS' COMPENSATION LAWS. THE MONTHLY PREMIUM FOR THAT COVERAGE WOULD BE [$XX]. APPLICANT ELECTED TO PURCHASE THIS PLAN WHICH PROVIDES LESS COVERAGE THAN WOULD BE AVAILABLE TO A SUBJECT WORKER UNDER THE NEW MEXICO WORKERS COMPENSATION LAWS. THE MONTHLY PREMIUM FOR THIS PLAN IS [$XX]. [CARRIER] OFFERED APPLICANT A CHART SHOWING THE DIFFERENCES BETWEEN THIS PLAN AND THE FULL COVERAGE PLAN AND OFFERED TO EXPLAIN THOSE DIFFERENCES.

I ATTEST THAT THE STATEMENT ABOVE IS TRUE AND CORRECT:

____ ____________________
[APPLICANT NAME] DATE

E. **Notice to Workers' Compensation Administration.** Upon the sale of any non-subject worker plan, the carrier shall file a disclosure notice with the New Mexico Workers' Compensation Administration Employer Compliance Bureau. The notice shall contain the following information:

(1) name of covered person;
(2) covered person's occupation;
(3) name, address, and telephone number of any group sponsor of the plan; and
(4) effective dates of the plan.

[13.10.34.16 NMAC - Rp, 13.10.34.16 NMAC, 07/01/2023]

13.10.34.17 FORM AND RATE FILING AND APPROVAL REQUIRED:

A. **Prior approval of forms required**. A carrier shall not issue, deliver or use a form associated with a plan, unless and until such form has been filed with and approved by the superintendent.

B. **Prior approval of rates required**. A carrier shall not use rates or modified rates for an individual or group plan unless and until such rates are filed with and approved by the superintendent, except for rates for a plan issued to eligible members of an out-of-state group policyholder defined by 59A-23-3(A)(1). A carrier shall not offer a group coverage plan to New Mexico residents that are members of a group not defined in 59A-23-3(A)(1) under a plan issued to an out-of-state group policyholder unless the plan complies with Subsections D and G of this Section. Projected loss ratios for new plans or products shall be filed prior to sales and be based on credible data.

C. **Rate filing requirements**. The superintendent shall post on its website requirements for filing actuarial memorandums and rates for rate filing requests.

D. **Minimum loss ratios for group plans.** A group product subject to this rule shall be subject to the following actual minimum loss ratios, adjusted for low or high average premium forms:

(1) **Definitions of renewal clause.** The following definitions shall be applied to the table:

Type of Coverage:	OR	CR	GR	NC
Medical Expense	65%	60%	60%	55%
Loss of Income and Other	65%	60%	55%	50%

(a) **OR- Optionally Renewable:** renewal is at the option of the insurance company;

(b) **CR- Conditionally Renewable:** renewal can be declined by class; by geographic area or for stated reasons other than deterioration of health;

(c) **GR- Guaranteed Renewable:** renewal cannot be declined by the insurance company for any reason, but the insurance company can revise rates on a class basis;

(d) **NC- Non-Cancelable:** renewal cannot be declined nor can rates be revised by the insurance company.

(2) **Low average premium forms.** For a plan form, including riders and endorsements, under which the actual average annual premium per certificate is low (as defined below), the appropriate ratio from the table above should be adjusted downward by the following formula:

$$RN = R \times \frac{(I \times 500) + X}{(I \times 750)}$$

where: R is the table ratio;
RN is the resulting guideline ratio;
I is the consumer price index factor; and
X is the average annual premium, up to a maximum of I x 250.

The factor I is determined as follows:

$$I = \frac{\text{CPI-U, Year (N-1)}}{\text{CPI-U, (1982)}} = \frac{\text{CPI-U, Year (N-1)}}{97.9}$$

where:

(a) (N-1) is the calendar year immediately preceding the calendar year (N) in which the rate filing is submitted in the state;

(b) CPI-U is the consumer price index for all urban consumers, for all items, and for all regions of the U.S. combined, as determined by the U.S. Department of labor, bureau of labor statistics based on the 1982=100 basis;

(c) the CPI-U for any year (N-1) is taken as the value of September. For 1982, this value was 97.9;

(d) hence, for rate filings submitted during calendar year 1983, the value of I is 1.00.

(e) Low average annual premium is defined as average annual premium less than or equal to I x 250.

(f) High average annual premium is defined as average annual premium more than or equal to I x 1500.

(3) **High average premium forms**. For a plan form, including riders and endorsements, under which the actual average annual premium per certificate is high (as defined above), the appropriate ratio from the table above should be adjusted upward by the following formula:

$$RN = R \times \frac{(I \times 4000) + X}{(I \times 5500)}$$

where: R is the table ratio
RN is the resulting guideline ratio
I is the consumer price index factor (as defined in Paragraph (2) above)
X is the average annual premium, not less than I x 1500.

In no event, however, shall RN exceed the lesser of:
(a) R + 5 percentage points, or
(b) 68%.

(4) **Determination of average premium.** A carrier shall determine the average annual premium per form based on the distribution of business by all significant criteria having a price difference, such as age, sex, amount, dependent status, rider frequency, etc., except assuming an annual mode for all certificates (i.e., the fractional premium loading shall not affect the average annual premium or anticipated loss ratio calculation).

E. Individual plan minimum loss ratio. An individual plan subject to this rule shall be subject to the following actual minimum loss ratios, adjusted for low or high average premium forms:

Type of Coverage:	OR	CR	GR	NC
Medical Expense	60%	55%	55%	50%
Loss of Income and Other	60%	55%	50%	45%

(1) Definitions of renewal clause. The following definitions shall be applied to the table:

(a) **OR- Optionally Renewable:** renewal is at the option of the insurance company;

(b) **CR- Conditionally Renewable:** renewal can be declined by class, by geographic area or for stated reasons other than deterioration of health;

(c) **GR- Guaranteed Renewable**: renewal cannot be declined by the insurance company for any reason, but the insurance company can revise rates on a class basis;

(d) **NC- Non-cancelable:** renewal cannot be declined nor can rates be revised by the insurance company.

(2) **Low average premium forms.** For a plan form, including riders and endorsements, under which the actual average annual premium per certificate is low (as defined below), the appropriate ratio for the table above should be adjusted downward by the following formula:

$$RN = R \times \frac{(I \times 500) + X}{(I \times 750)}$$

where: R is the table ratio;
RN is the resulting guideline ratio;
I is the consumer price index factor; and
X is the average annual premium, up to a maximum of I x 250.

The factor I is determined as follows:

$$I = \frac{\text{CPI-U, Year (N-1)}}{\text{CPI-U, (1982)}} = \frac{\text{CPI-U, Year (N-1)}}{97.9}$$

where:

(a) (N-1) is the calendar year immediately preceding the calendar year (N) in which the rate filing is submitted in the state;

(b) CPI-U is the consumer price index for all urban consumers, for all items, and for all regions of the U.S. combined, as determined by the U.S. Department of labor, bureau of labor statistics, based on the 1982=100 basis;

(c) the CPI-U for any year (N-1) is taken as the value of September. For 1982, this value was 97.9;

(d) hence, for rate filings submitted during calendar year 1983, the value of I is 1.00.

(3) **High average premium forms.** For a plan form, including riders and endorsements, under which the actual average annual premium per certificate is high (as defined above), the appropriate ratio from the table above should be adjusted upward by the following formula:

$$RN = R \times \underline{(I \times 4000) + X}$$

where: R is the table ratio
RN is the resulting guideline ratio
I is the consumer price index factor (as defined in Paragraph (2) above)
X is the average annual premium, not less than I x 1500.

In no event, however, shall RN exceed the lesser of:

(a) R + 5 percentage points, or
(b) 63%.

(4) **Determination of average premium.** A carrier shall determine the annual premium per

form based on an anticipated distribution of business by all significant criteria having a price difference, such as age, sex, amount, dependent status, rider frequency, etc., except assuming an annual mode for all certificates (i.e., the fractional premium loading shall not affect the average annual premium or anticipated loss ratio calculation). The value of X should be determined on the basis of rates being filed. Thus, where this adjustment is applicable to a rate revision under Paragraph G, rather than to a new form, X should be determined on the basis of anticipated average size premium immediately after the revised rates have fully taken effect.

F. **Rate revisions.** The following requirements shall apply to rate revision requests:

(1) With respect to filing rate revisions for a previously approved form, or a group of previously approved forms combined for experience, benefits shall be deemed reasonable in relation to premiums provided the revised rates meet the most current standards applicable to rate filings; and

(2) Carriers are urged to review their experience periodically and to file rate revisions, as appropriate, in a timely manner to avoid non-compliance with this rule.

G. **Annual rate certification filing procedures.** Carriers not filing new or updated premium rates in any given plan year shall file an actuarial memorandum demonstrating that minimum loss ratios have been met for all products.

(1) **General requirement.** Carriers shall meet the minimum loss ratio ("MLR") established, and in the manner calculated, under this section of the rule.

(2) **Aggregation.** Loss ratios shall be calculated on a consolidated level across policies with the same product type and benefit design.

(3) **Measurement period.** Compliance with the minimum loss ratio shall be measured over all years of issue combined and for each calendar year of experience utilized in the rate determination process (but never less than the last three years). A filing for a new pool shall be based on credible data from generally recognized industry sources. Separate filings shall be made for separate rating pools.

(4) **Frequency.** Actual loss ratios shall be calculated annually by carriers that issue excepted benefits products specified in this rule, beginning in 2023.

(5) **Timeline.** The evidence of compliance with the minimum loss ratio requirements shall be filed with the superintendent on the anniversary date when the product or the product's most recent rate filing was approved.

(6) **Methodology.** Actual loss ratios shall be calculated using company claim data including an estimate for claims incurred but not reported. The claims will be reported for all years of issue combined and for each calendar year of experience utilized in the rate determination process (but never less than the last three years after the third year of experience is available). The actual accumulated loss ratio over the measurement period (A) will be compared to original pricing accumulated loss ratios over the measurement period (E) as a method of justifying the minimum loss ratio is being met or showing the need for remedial action if (A)/(E) is below the threshold specified in Paragraph (8) of this subsection.

(7) **Waiver.** For noncredible blocks of business on a nationwide basis, the company may request a waiver of the requirement. The request shall be made annually and must be accompanied by a letter indicating the nature of the filing, the type of product, and the reason for the request.

(8) **Compliance with minimum loss ratios.** Each carrier shall submit to the superintendent an exhibit showing the calculation of the applicable loss ratios and:

(a) a statement signed by a qualified actuary that the minimum loss ratio requirements have been met; or

(b) a rate filing to justify the rates, revise rates, modify benefits through a benefit endorsement or to return excess premium, if the actual accumulated loss ratio divided by the expected accumulated loss ratio (A/E) over the measurement period is below eighty-five percent.

(9) The superintendent may require a plan to return excess premiums or increase benefits proportionately if the ratio of the actual accumulated experience to the expected accumulated experience (A/E) is below eighty percent.

(10) A carrier shall not return excess premiums per the above guidelines, until the carrier files a refund plan and calculation with and obtains approval of the plan by the superintendent.

H. **Disapproval of forms and rates.** The superintendent shall disapprove a form:

(1) if the benefit provided therein is unreasonable in relation to the premium charged; or

(2) that misrepresents the benefits, advantages, conditions or terms of any plan or that unfairly characterizes the plan as more favorable to the covered person than the actual terms of the plan, such as naming coverage for specific diseases whose primary forms of treatment are then listed as exclusions;

(3) that uses any false or misleading statements;

(4) that uses any name or title of any plan or class of plans misrepresenting the true nature thereof, including misrepresenting the plan as major medical coverage; or

(5) that is contrary to law, discriminatory, deceptive, unfair, impractical, unnecessary or unreasonable.

I. Variable MLR. A carrier shall not offer a plan subject to this rule to any person unless each possible plan design selectable by that person meets the MLR requirements as reflected in an approved rate filing. For variable forms, a carrier cannot satisfy MLR requirements with average premiums for the form as a whole. The carrier must base MLR calculations on the average premium for each possible combination of benefits and levels offered by demographics used for underwriting. The superintendent reserves the right to reject a plan that has no meaningful difference from another plan offered by the same carrier. The requirements of this rule do not apply to a non-contributory plan.

J. Premium increases. A carrier shall not increase a covered person's premium under any plan, other than a disability income plan, during the first two years that the covered person's coverage is in force except in cases where one or more persons are added to the policy as covered persons during this two year period. The new premium resulting from the addition of a covered person(s) shall not change for the first two years the policy with the added lives is in force.

[13.10.34.17 NMAC - Rp, 13.10.34.15 NMAC, 07/01/2023]

13.10.34.18 REQUIRED DISCLOSURES AND NOTICES:

A. General notice requirement. An application for an individual plan or plan sold through an association or group described in Paragraphs (2) or (4) of Subsection A of 59A-23-3 NMSA 1978, other than a disability income plan, shall contain in bold, 14-point type, directly above the applicant signature line the following notice:

NOTICE TO BUYER: PLEASE REVIEW THIS PLAN CAREFULLY. IT ONLY PROVIDES LIMITED BENEFITS, AND IT DOES NOT ON ITS OWN OR IN COMBINATION WITH OTHER LIMITED BENEFITS POLICIES CONSTITUTE MAJOR MEDICAL INSURANCE. BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES.

TO LEARN IF YOU ARE ELIGIBLE FOR A MAJOR MEDICAL PLAN, PLEASE VISIT [WWW.BEWELLNM.COM] OR CALL [1-833-862-3935]. PREMIUM DISCOUNTS, FINANCIAL ASSISTANCE, OR OTHER MAJOR MEDICAL COVERAGE OPTIONS MAY BE AVAILABLE.

B. Renewal provision. A plan shall include a renewal, continuation or nonrenewal provision. The language or specification of the provision shall be consistent with the type of plan to be issued. The provision shall be appropriately captioned, shall appear on the first page of the plan, and shall clearly state the duration of coverage and renewal terms.

C. Riders. A rider, endorsement, or supplement added to a plan after its effective date that reduces or eliminates benefits or coverage shall not be effective unless signed by the covered person. Signature may include electronic signature or voice signature, however, this signature must be recorded by the carrier and time-stamped. This signature requirement does not apply to certificates issued to covered persons in a group plan. A signature shall not be required if the rider, endorsement or supplement reflects a change to the plan that is required by law.

D. Additional premium for riders, endorsements or supplement. If an additional premium is charged for benefits specified in a rider, endorsement or supplement, the plan or certificate shall specify the premium.

E. Preexisting conditions. If a plan includes any preexisting condition exclusion or limitation, the plan or certificate shall include a separate section labeled "Preexisting Conditions, Exclusions and Limitations."

F. Right of return/Free look. A plan shall include a prominent notice, printed on or attached to the first page of the plan, stating that the covered person has the right to return the plan, and cancel any associated voluntary group membership enrolled in contemporaneous with the plan enrollment, within 30 days of its delivery, and to have the premium and membership fees refunded in full if the covered person is not satisfied for any reason.

G. Age factors. If age is a factor that reduces aggregate benefits, that factor shall be prominently set forth in the outline of coverage.

H. Conversion privilege. If a plan includes a conversion privilege, the provision shall be captioned, "Conversion Privilege." The provision shall specify who is eligible for conversion and the circumstances that govern

conversion, or may state that the conversion coverage will be as provided in an approved plan form used by the carrier for that purpose.

I. Medicare supplement notice.

(1) The outline of coverage delivered with an accident-only, specified disease, hospital indemnity, supplemental or non-subject plan shall contain the following notice in bold 14-point type:

THIS IS NOT A MEDICARE SUPPLEMENT PLAN. IF YOU ARE ELIGIBLE FOR MEDICARE, ASK FOR INFORMATION ABOUT MEDICARE SUPPLEMENT POLICIES.

(2) A carrier shall deliver to persons eligible for Medicare any notice required under 13.10.25 NMAC.

J. Outline of coverage requirements. Each subject plan and certificate shall include the outline of coverage that provides a basic overview of the plan's purpose, benefits, coverage minimums and maximums.

(1) The outline of coverage shall include the following notice, printed in bold 14-point type:

READ YOUR PLAN CAREFULLY – THIS OUTLINE OF COVERAGE PROVIDES A VERY BRIEF DESCRIPTION OF THE IMPORTANT FEATURES OF YOUR COVERAGE. THIS IS NOT THE INSURANCE CONTRACT AND ONLY THE ACTUAL PLAN PROVISIONS WILL DETERMINE THE TERMS OF COVERAGE. THE PLAN ITSELF SETS FORTH IN DETAIL THE RIGHTS AND OBLIGATIONS OF BOTH YOU AND YOUR INSURANCE COMPANY. IT IS, THEREFORE, IMPORTANT THAT YOU READ YOUR PLAN CAREFULLY!

(2) The outline of coverage shall provide contact information for the OSI consumer assistance bureau.

K. Delivery of plan documents. A carrier shall not bind coverage for any subject plan without delivering all plan documents to a prospective insured and allowing the prospective insured 30 calendar days to review those materials. Nothing in this subsection precludes a carrier from making coverage retroactive to the date that the plan documents were delivered to the prospective insured. The carrier shall maintain proof of compliance with this requirement for each sale for five years from the coverage effective date. For a group plan, either the carrier or the group master policyholder may satisfy the delivery requirement, but the carrier shall remain responsible for any failure to do so by the master policyholder. In the case where the group master policyholder delivers the plan documents to the prospective policyholders, the carrier shall require the group master policyholder to attest to the compliance with the requirements of this section and to provide documents that clearly support the attestation. The carrier shall not bind coverage until it has received the master policyholder's attestation.
[13.10.34.18 NMAC - Rp, 13.10.34.16 NMAC, 07/01/2023]

13.10.34.19 REQUIREMENTS FOR REPLACEMENT OF INDIVIDUAL PLAN COVERAGE:

A. Required questions. An application for an individual plan or a plan sold through an association or group described in Paragraphs (2) or (4) of Subsection A of 59A-23-3 NMSA 1978 shall ask whether the insurance requested will replace any other plan subject to this rule.

B. Notice requirement. Upon determining that a sale will involve replacement of a plan, a carrier, other than a direct response carrier, or its agent, shall furnish the applicant, prior to issuance or delivery of the plan, the notice described in Subsection C below. A direct response carrier shall deliver to the applicant, upon issuance of the plan, the notice described in Subsection D below. No notice is required for the solicitation of accident-only or single premium nonrenewal policies. The carrier shall retain proof of notice for five years from the coverage effective date.

C. Non-direct response carrier notice:

NOTICE TO APPLICANT REGARDING REPLACEMENT
OF LIMITED BENEFIT HEALTH INSURANCE

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing insurance and replace it with a plan to be issued by [insert company name] Insurance company. For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new plan.

(1) Health conditions that you may presently have, (preexisting conditions) may not be immediately or fully covered under the new plan. This could result in denial or delay of a claim for benefits under the new plan, whereas a similar claim might have been payable under your present plan.

(2) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present plan. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.

(3) If, after due consideration, you still wish to terminate your present plan and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your plan had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

____
(Date)

____
(Applicant's Signature)

D. Direct response carrier notice:

NOTICE TO APPLICANT REGARDING REPLACEMENT
OF LIMITED BENEFIT HEALTH INSURANCE

According to [your application] [information you have furnished] you intend to lapse or otherwise terminate existing insurance and replace it with the plan delivered herewith and issued by [insert company name] Insurance company. Your new plan provides 30 days within which you may decide without cost whether you desire to keep the plan. For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new plan.

(1) Health conditions that you may presently have, (preexisting conditions) may not be immediately or fully covered under the new plan. This could result in denial or delay of a claim for benefits under the new plan, whereas a similar claim might have been payable under your present plan.

(2) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present plan. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.

(3) [To be included only if the application is attached to the plan]. If, after due consideration, you still wish to terminate your present plan and replace it with new coverage, read the copy of the application attached to your new plan and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to [insert company name and address] within 10 days if any information is not correct and complete, or if any past medical history has been left out of the application.

[COMPANY NAME]

[13.10.34.19 NMAC - Rp, 13.10.34.17 NMAC, 07/01/2023]

13.10.34.20 COORDINATION OF BENEFITS, BUNDLING AND VARIABILITY:

A. Noncoordination of benefits. Benefits under a plan shall:

(1) be provided under a separate plan, certificate, or contract of insurance;

(2) have no coordination with the benefits offered under a health plan; and

(3) pay benefits regardless of any benefits provided under a health plan.

B. No bundling. No carrier, directly or through an affiliated producer, shall market or sell a bundled combination of accident-only, specified disease, hospital indemnity and non-subject worker plans. An application that is used in connection with more than one type of plan subject to this rule shall include a conspicuous notice that the applicant cannot purchase more than one type of plan from the carrier using the same application. This provision

does not preclude the same carrier from selling more than one product type to a single purchaser as long as each policy is available at its own stated premium rate, independent of the other product types.
A carrier shall not offer or provide memberships or discounts relating to health care services or products. The provisions of this subsection shall not apply to a plan sold through a group identified in Paragraphs (1) or (3) of Subsection A of 59A-23-3 NMSA 1978, or to a bona fide association.

C. **Major medical coverage requirement.** Accident-only, specified disease, hospital indemnity and non-subject worker plans, excluding blanket coverage compliant with Section 59A-23-2 NMSA 1978 and group plans described in Paragraph (1) of Subsection A of 59A-23-3 NMSA 1978, shall only be issued to persons who acknowledge that the plan is not major medical or comprehensive health insurance. For purposes of this requirement, short-term, limited-duration insurance shall not be considered major medical coverage.

(1) An application or enrollment form for a plan subject to this subsection shall include an attestation by the applicant affirming that the applicant understands that the individual is not purchasing major medical insurance at the time of application. An application for a hospital indemnity plan, or plan offering other fixed indemnity benefits, shall also include any disclosure required by federal law. The attestation shall be in writing and signed by the applicant before coverage becomes effective. The carrier may retroactively apply coverage to the date of application.

(2) A sale of a plan subject to this subsection is unauthorized if an applicant fails to sign or deliver the attestation described in this rule.

(3) A carrier shall retain a copy of the attestation for at least five years.

(4) If a carrier of a plan subject to this subsection learns, directly or through an agent, that a covered person's major medical coverage has lapsed or was canceled, the carrier shall send the person the following notice:

YOUR MAJOR MEDICAL COVERAGE MAY HAVE RECENTLY LAPSED. YOUR POLICY WITH [IDENTIFY COMPANY] IS NOT MAJOR MEDICAL HEALTH INSURANCE. THE BENEFITS PROVIDED BY [IDENTIFY COMPANY] DO NOT COVER ALL MEDICAL EXPENSES.

TO LEARN IF YOU ARE ELIGIBLE FOR A MAJOR MEDICAL PLAN, PLEASE VISIT WWW.BEWELLNM.COM. OR CALL 1-833-862-3935. PREMIUM DISCOUNTS, FINANCIAL ASSISTANCE, MEDICAID OR OTHER MAJOR MEDICAL COVERAGE OPTIONS MAY BE AVAILABLE.

D. **Matrix forms**. The coverages governed by this rule are subject to prohibitions on matrix forms as otherwise specified in New Mexico law.
[13.10.34.20 NMAC - Rp, 13.10.34.18 NMAC, 07/01/2023]

13.10.34.21 **PENALTIES:** The sale of any plan that does not comply with this rule is unlawful. In addition to any applicable suspension, revocation or refusal to continue any certificate of authority or license under the New Mexico Insurance Code, a penalty for any material violation of this rule may be imposed against a health care insurance carrier or insurance producer by the superintendent. The actions of any producer or third-party administrator relating to the sale of a plan subject to this rule, or a claim under any such plan, shall be deemed the actions of the plan issuer.
[13.10.34.21 NMAC - Rp, 13.10.34.19 NMAC, 07/01/2023]

13.10.34.22 **SEVERABILITY:** If any section of this rule, or the applicability of any section to any person or circumstance, is for any reason held invalid by a court of competent jurisdiction, the remainder of the rule, or the applicability of such provisions to other persons or circumstances, shall not be affected.
[13.10.34.22 NMAC - Rp, 13.10.34.20 NMAC, 07/01/2023]

History of 13.10.34 NMAC:
13.10.34 NMAC - Standards For Accident Only, Specified Disease Or Illness, Hospital Indemnity, And Related Excepted Benefits, filed 10/01/2020 was repealed and replaced by 13.10.34 NMAC - Standards For Accident-Only, Specified Disease, Hospital Indemnity, Disability Income, Supplemental, And Non-Subject Worker Excepted Benefits, effective 07/01/2023.