TITLE 13 INSURANCE
CHAPTER 10 HEALTH INSURANCE
PART 35 MINIMUM STANDARDS FOR LIMITED SCOPE DENTAL AND VISION PLANS

13.10.35.1 ISSUING AGENCY: Office of Superintendent of Insurance ("OSI").
[13.10.35.1 NMAC - N, 05/01/2021]

13.10.35.2 SCOPE: This rule applies to individual and group limited scope dental and vision benefit plans that are offered separately from a health benefits plan ("plan"); however pediatric dental and vision plans may be embedded in qualified health benefits plans. This rule applies to a contract of insurance, and to coverage extended to an individual member of a group located outside of this state, if a covered person resides in this state.
[13.10.35.2 NMAC - N, 05/01/2021]

13.10.35.3 STATUTORY AUTHORITY: Section 59A-23G-1 et seq. NMSA 1978.
[13.10.35.3 NMAC - N, 05/01/2021]

13.10.35.4 DURATION: Permanent.
[13.10.35.4 NMAC - N, 05/01/2021]

13.10.35.5 OBJECTIVE: Establish minimum regulatory standards and sales practices relating to limited scope dental and vision plans. 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 the subject plans.
[13.10.35.5 NMAC - N, 05/01/2021]

13.10.35.6 EFFECTIVE DATE: May 1, 2021
[13.10.35.6 NMAC - N, 05/01/2021]

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

A. "Preferred provider" means a dental or vision care provider, or group of providers, who contracts with a vision or dental insurance carrier to provide vision or dental services to a covered person.

B. "Domestic co-insured" means a spouse or domestic partner insured under the same plan or certificate.
[13.10.35.7 NMAC - N, 05/01/2021]

13.10.35.8 GENERAL PROHIBITED POLICY PROVISIONS.

A. Probationary and waiting periods. Except as otherwise expressly stated in Section 10 and 11 of this rule, a plan shall not include a probationary or waiting period during which no coverage is provided for a covered benefit under the plan. A probationary period does not include an eligibility waiting period during which no premium is paid.

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

C. Preexisting conditions. A plan shall provide coverage for a preexisting conditions unless:

(1) the policyholder is made aware of the covered benefits and exclusions of the plan prior to enrollment or if the application or enrollment form requires disclosure of prior illness, disease or physical conditions, or of prior medical care and treatment. Any exclusions or waiting periods for coverage of pre-existing conditions shall be waived if the policyholder is renewing coverage under the same plan. A disclosure form shall not request family member health information unless the family member is also seeking coverage under the plan; and

(2) the preexisting condition requires the replacement of a tooth that the covered person has lost prior to the covered person's plan effective date; however, if the covered person has had continuous coverage from a previous carrier, this exclusion is waived.

D. Evidence of coverage. Upon request, a carrier shall provide evidence of current or former coverage with a plan.

E. Marketing of blanket or group coverages. A carrier shall not sell any blanket coverage to a group 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.

F. Arbitration provisions. A plan shall not require a covered person to submit a dispute to mediation or arbitration.

G. Plan governance. 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.

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

I. Conversion privileges. A carrier shall not offer a conversion plan that is not approved by the superintendent.

J. Gag rule. A plan shall not include, and a carrier shall not otherwise impose, a gag rule or practice that prohibits a vision or dental care provider from discussing a treatment option with a covered person.

[13.10.35.8 NMAC - N, 05/01/2021]

13.10.35.9 GENERAL STANDARDS FOR POLICIES AND BENEFITS.

A. Coverage period. An individual plan subject to this rule shall have a minimum term of 12 months.

B. 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 a covered person with the issuance of a new policy and completed agreement.

C. Consumer rights. An individual plan shall protect consumer rights as follows:

(1) The terms "noncancellable" or "noncancellable and guaranteed renewable" may only be used in an individual vision or dental 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, whichever is later, 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, whichever is later, 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) A plan shall not terminate the coverage of a covered person except for "good cause," which means:

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

(b) material failure to abide by the rules, policies or procedures of the plan;

(c) fraud or misrepresentation affecting coverage;

(d) policyholder request for cancellation;

(e) policy term ends; and

(f) a reason for termination or failure to renew that the superintendent determines is not objectionable.

(4) A carrier may not terminate a plan unless it provides written notice of termination to a covered person one month prior to the coverage renewal date. A notice of termination shall:

(a) be in writing and dated;

(b) state the reason(s) for termination, with specific references to the clauses of the vision or dental plan giving rise to the termination;

(c) state that a covered person's plan cannot be terminated because of health status, need for services, race, gender, age or sexual orientation of covered persons under the contract;

(d) 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, gender, 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

(e) state that in the event of termination by either the covered person or the plan, except in the case of fraud or deception, the plan shall, within 30 calendar days, return to the covered person or subscriber the pro rata portion of the money paid to the plan that corresponds to any unexpired period for which payment had been received together with amounts due on claims, if any, less any amounts due to the plan, provided, however, that the superintendent may approve other reasonable reimbursement practices.

(5) A plan shall include a notice prominently printed on or attached to the first page of the plan stating that the covered person shall have the right to return the plan within 30 days of its delivery, and to have the premium and any required membership fees refunded, if after examination of the plan the covered person is not satisfied for any reason, provided no claim has been paid.

(6) 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 provided as an approved plan form used by the carrier for that purpose.

D. Domestic co-insureds. If an individual plan covers domestic co-insureds, the age of the younger insured shall be used as the basis for meeting the age and durational requirements of the definitions of "noncancellable" or "guaranteed renewable." However, this requirement shall not prevent termination of coverage of the older insured upon attainment of the stated age so long as the policy may be continued in force as to the younger spouse to the age or for the durational period specified in the policy.

E. Dependent child. A plan may terminate the coverage of a dependent due to limiting age for a dependent per the plan's contracted age limits. However, a plan must offer coverage to dependents, regardless of age, who are physically or mentally disabled prior to reaching the limiting age and are incapable of self-sustaining employment. Coverage for a child who is physically or mentally disabled prior to reaching the limiting age and 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.

F. Group coverage discontinuance and replacement. A group plan shall comply with Sections 8, 9, Subsection D of Section 10, 11 and 12 of 13.10.5 NMAC.

G. Proof of loss. If a carrier requires submission of a claim form as a condition of payment, the carrier, upon receipt of notice of a claim, shall furnish to the covered person a form to the delivered in the manner offered by the carrier that is preferred by the covered person. If the carrier does not furnish a claim form within fifteen days after notice of a claim, the claimant shall be deemed to have complied with the requirement to provide proof of loss if the notice of claim contains written proof describing the claim, including the character and extent of the loss of which the claim is made. Adequate proof of loss must be in the possession of the insurance company at the time funds are disbursed in payment of claims.

H. Grace Periods. A grace period of at least 10 days for a monthly premium plan and at least 31 days for any plan billed less frequently shall be granted for the payment of each premium falling due after the first premium. During this grace period, the plan shall continue in force.

I. Inducements. Inducements shall be defined and prohibited in the following manner:

(1) No plan shall use monetary or other valuable consideration, engage in misleading or deceptive practices, or make untrue, misleading, or deceptive representations to applicants in order to induce enrollment.

(2) A statement shall be deemed untrue if it does not conform to fact in any respect and would be considered significant to a person contemplating enrollment with a plan.

(3) Inducements do not include incentives specified or provided for in the plan contract given to covered persons and to promote the delivery of preventive care or other health improvement activities.

[13.10.35.9 NMAC - N, 05/01/2021]

13.10.35.10 DENTAL PLANS:

A. Applicability. This section applies only to dental plans.

B. Definitions. For purposes of this section:

(1) "Dental plan" is a policy, contract, agreement or arrangement under which an entity undertakes to reimburse claims for the cost of dental services or dental supplies.

(2) "Dental service" means a professional service rendered by a person duly licensed under the laws of this state to practice dentistry or dental therapy, or dental hygienists or dental hygienists certified in collaborative practice and any service constituting the practice of dentistry under state law.

(2) "Primary dentist" means a dentist who is not a specialist.

(3) "Specialist" means a dentist whose training and expertise are in a specific area of dentistry. Recognized clinical specialists in dentistry include, but are not limited to, endodontists, oral and maxillofacial surgeons, oral pathologists, periodontists, and prosthodontists.

C. Required minimum benefits. A dental plan shall, at a minimum, provide each covered person benefits for the following dental services and dental supplies. Qualified dental plan coverage must provide benefits at the same level as those provided under the regulation at 8.310.2 NMAC unless the benefits described below are more favorable.

(1) Emergency services. "Emergency services" means dentally necessary procedures to evaluate and stabilize dental conditions of recent onset and severity accompanied by excessive bleeding, severe pain, or acute infections that would cause a prudent layperson to believe that immediate care is needed. Care shall include operative procedures necessary to prevent pulpal death and the imminent loss of teeth, and the treatment of injuries to the teeth or supporting structures.

(a) Routine restorative procedures and root canal therapy are not emergency procedures.

(b) A dental plan shall not require prior authorization for emergency care services.

(c) A dental plan shall not impose a waiting period for emergency dental care services.

(2) Diagnostic services. A dental plan shall cover the following diagnostic services with a waiting period of no longer than six consecutive months:

(a) one clinical oral examination every six consecutive months;

(b) when performed as a part of an emergency service to relieve pain and suffering.

(3) Radiology services. A dental plan shall cover the following radiology services with a waiting period of no longer than six consecutive months:

(a) Bitewing x-rays at when medically necessary; or

(b) Panoramic films or an intraoral-complete series, if covered at least once every five consecutive years if necessary.

(4) Preventive services. A dental plan shall cover the following services with no waiting period, subject to the following limitations:

(a) Prophylaxis. A dental plan shall cover at least two prophylaxis services every plan year.

(b) Fluoride treatment. A dental plan shall cover fluoride treatments furnished in a dental office setting for children up to 14 years old.

(c) Molar sealants. A dental plan shall cover one treatment of molar sealant per tooth every five consecutive years as medically necessary. A dental plan may

exclude coverage where an occlusal restoration has been completed on the tooth. A dental plan may apply a waiting period of six consecutive months for medically necessary sealants.

(5) Pediatric benefits. Pediatric benefits shall cover dentally necessary fillings for cavities.

(6) Craniomandibular and temporomandibular joint disorders. A dental plan shall cover the diagnosis and treatment of craniomandibular and temporomandibular joint disorders.

D. Maximum out-of-pocket. To be certified for sale on New Mexico's health insurance exchange, a dental plan shall comply with federally mandated maximum out-of-pocket limits.

[13.10.35.10 NMAC - N, 05/01/2021]

13.10.35.11 VISION PLANS:

A. Applicability. This section only applies to vision plans.

B. Definitions. For purposes of this section:

(1) "covered materials" means materials that are reimbursable by a vision plan to a vision care provider subject to any deductible, copayment, coinsurance, or other plan limitation;

(2) "covered services" means services that are reimbursable by a vision plan vision plan to a vision care provider subject to any deductible, copayment, coinsurance, or other plan limitation;

(3) "materials" means ophthalmic devices, including;

(a) lenses;

(b) frames;

(c) ophthalmic frames;

(d) lens-mounting apparatus; and

(e) spectacle or contact lens treatments and coatings;

(4) "noncovered materials" means materials that are not covered by a vision plan;

(5) "noncovered services" means services that are not covered by a vision plan.

(6) "vision services" means services provided by a vision care provider;

(7) "vision plan" is a policy, contract, agreement or arrangement under which an entity undertakes to reimburse claims for the cost of vision services or vision materials; and

(8) "vision care provider" means an individual licensed under state law as an optometrist, osteopathic or medical physician, or a physician that has completed a residency in ophthalmology.

C. Required minimum benefits. A vision plan shall provide each covered person benefits for the following vision services and vision materials. For qualified vision plans, pediatric vision coverage must provide benefits at the same level as those provided under the regulation at 8.324.5.12 NMAC unless the benefits described below are more favorable.

(1) Examinations. At least once every consecutive two year period for adults and once every twelve month consecutive period for children under the age of 19, a comprehensive vision examination. The comprehensive vision examination shall include a complete analysis of the eyes and related structures, as appropriate, to determine the presence of vision problems or other abnormalities as follows:

(a) Review of a covered person's main reason for the visit, past history, medications, general health, ocular symptoms, and family history.

(b) Evaluation of the health status of the visual system, including:

(i) external and internal examination, including direct and indirect ophthalmoscopy;

(ii) assessment of neurological integrity, including that of pupillary reflexes and extraocular muscles;

(iii) biomicroscopy of the anterior segment of the eye, including observation of the cornea, lens, iris, conjunctiva, lids and lashes;

(iv) screening of gross visual fields; and

(v) pressure testing through tonometry.

(c) Evaluation of refractive status, including:

(i) evaluation for visual acuity;

(ii) evaluation of subjective, refractive, and accommodative function; and

(iii) objective testing of a patient's prescription through retinoscopy.

(d) Binocular function test.

(e) Diagnosis and treatment plan, if needed.

(2) Lenses. If the vision examination indicates that corrective lenses are necessary, each covered person is entitled to necessary frames and lenses, including coverage for single vision, bifocal, trifocal, and lenticular as medically necessary. This benefit may be limited to once each two-year consecutive period, unless medical necessity requires increased frequency, and may be subject to a maximum one month waiting period.

(3) Contact lenses shall be covered as follows:

(a) Medically necessary contact lenses shall be covered in full, up to a benefit maximum, subject to prior authorization from the vision plan if dispensed or provided by an in-network provider or vendor.

(b) Elective contact lenses may be chosen instead of corrective spectacles and lenses for a maximum benefit allowance of at least $100 per plan year, which includes fittings and lenses.

(c) This benefit may be limited to once each twelve-month consecutive period, and may be subject to a maximum one month waiting period.

D. Noncovered services and materials. A vision plan may exclude coverage for the following services and materials include:

(1) any that are not medically necessary;

(2) any that were not obtained in compliance with the requirements of the vision plan;

(3) any medical or surgical treatment of the eyes;

(4) vision therapy; and

(5) two pairs of glasses in lieu of bifocals.

[13.10.35.11 NMAC - N, 05/01/2021]

13.10.35.12 COORDINATION OF BENEFITS: A dental or vision plan shall not prohibit coordination or duplication of benefits.

[13.10.35.12 NMAC - N, 05/01/2021]

13.10.35.13 COVERAGE DOCUMENTATION:

A. Coverage forms and benefits disclosures.

(1) A dental or vision plan shall issue a certificate of coverage or summary of benefits to each covered person within 60 days of the effective date of coverage or of a change in coverage. Covered groups may distribute the certificate of coverage or benefits summary on behalf of the plan.

(2) The certificate of coverage or benefits summary shall include a clear and complete statement of:

(a) the covered services, supplies and materials;

(b) any limitations or exclusions including any charge, deductible or copayment feature;

(c) where and in what manner information is available as to how services may be obtained; and

(d) a clear and understandable description of the method for resolving a covered person's complaint.

(e) conditions for renewal and reinstatement**;**

(f) procedures for filing claims;

(g) a statement of the amounts payable to the plan by a covered person and the times at which the amounts shall be paid;

(h) the period during which the plan is effective;

(i) the identity of the carrier on the front page.

(3) Any subsequent change in coverage or premium shall be explained in a separate document delivered to the covered person.

B. Notice required. The following language shall be provided in a summary of benefits:

READ YOUR PLAN CAREFULLY – THIS BENEFITS SUMMARY PROVIDES A VERY BRIEF DESCRIPTION OF THE IMPORTANT FEATURES OF YOUR PLAN. THIS IS NOT THE INSURANCE CONTRACT. YOUR FULL RIGHTS AND BENEFITS ARE EXPRESSED IN THE ACTUAL PLAN DOCUMENTS THAT ARE AVAILABLE TO YOU UPON YOUR REQUEST TO US.

C. Contact information. The benefits summary shall state the plan's contact information and the website and phone number of the Office of Superintendent of Insurance. [13.10.35.14 NMAC - N, 05/01/2021]

13.10.35.14 NETWORK ADEQUACY: Each vision or dental plan shall maintain an adequate network of licensed providers.

A. Attestation. Those vision and dental plans currently doing business in New Mexico shall submit to the superintendent an attestation of compliance with all of the criteria of this section by October 1, 2021. The attestation shall state:

(1) That, in population areas of 50,000 or more residents, two dental or vision care providers are available in any county within no more than 20 miles or 20 minutes' average driving time for 90 percent of the enrolled population, or, in population areas of less than 50,000, whether two dental or vision care providers are available in any county or service area within no

more than 60 miles or 60 minutes' average driving time for 90 percent of the enrolled population. For remote rural areas, the superintendent shall consider on a case by case basis whether the dental or vision plan has made sufficient providers available given the number of residents in the county or service area and given the community's standard of care.

(2) That the dental or vision plan provides reasonable and reliable access for its covered persons to qualified health care professionals in those specialties that are covered by the dental or vision plan.

(3) Any major deficiencies in the dental or vision plan's provider network and a description of current activities to remedy network deficiencies.

B. Provider lists. A vision or dental plan must maintain a list on its website of all providers contracted with the plan.

(1) The list shall be updated monthly and shall;

(a) include specialty providers;

(b) identify the providers who are not currently accepting new patients; and

(c) be available to both covered persons and plan applicants.

(2) The dental or vision plan shall audit its provider list for accuracy on an annual basis.

C. Out of state providers. A plan is permitted to enter contracts or other arrangements with out of state providers to meet the access requirements of this rule.

D. Provider grievances. A vision or dental plan shall accept, investigate and resolve provider grievances about plan operations pursuant to 13.10.16 NMAC.

E. Emergency care. If a covered person receives emergency care for a covered dental or vision service specified in this rule and cannot reach a preferred provider, as judged by the perspective of a reasonable person in the same or similar circumstances or after prior authorization, the plan shall reimburse the covered person at in-network rates.

F. Preferred provider arrangements. A vision or dental plan that delivers services through a preferred provider arrangement shall comply with the preferred provider arrangements law, Section 59A-22A-2 NMSA 1978.

[13.10.35.15 NMAC - N, 05/01/2021]

13.10.35.15 UTILIZATION MANAGEMENT DETERMINATIONS:

A. Denial of services. A benefit denial based on a determination that a vision or dental service is not medically necessary shall be supported by a contemporaneous opinion of a licensed dentist or vision provider, as appropriate. Such determinations shall be made in accordance with medical necessity standards and appropriate clinical guidelines.

B. Timeliness of determinations. A vision or dental plan shall make all utilization determinations on a timely basis as required by the exigencies of the situation and in accordance with sound medical principles, which, in any event, shall not exceed 24 hours pre-service for emergency care and ten business days for all other determinations. If after ten calendar days the vision or dental plan does not expect to be able to complete the determination due to unforeseen circumstances or missing information, the vision or dental plan shall inform the covered person or their provider of the circumstances or information missing and the need to extend the determination timeframe.

C. Post-authorization denials. A vision or dental plan shall not deny any claim subsequently submitted for procedures specifically included in a prior authorization unless at least one of the circumstances applies for each procedure denied:

(1) benefit limitations, such as annual maximums and frequency limitations not applicable at the time of prior authorization are reached due to utilization subsequent to the issuance of prior authorization;

(2) documentation for the claim provided by the person submitting the claim clearly fails to support the claim as originally authorized;

(3) if, after the issuance of the prior authorization, new procedures are provided to the patient or a change in the patient's condition occurs such that the prior authorized procedure would no longer be considered medically necessary based on the prevailing standard of care;

(4) if, after the issuance of the prior authorization, new care is rendered to the patient or a change in the patient's condition occurs such that the prior authorized procedure would at that time require disapproval pursuant to the terms and conditions for coverage under the patient's plan in effect at the time the prior authorization was issued;

(5) another payor is responsible for the payment;

(6) another payor has already paid the claim;

(7) the claim was submitted fraudulently or the prior authorization was based on whole or material part on erroneous information provided to the plan by the provider, covered person or other person not related to the carrier; or

(8) the person receiving care was not eligible for covered benefits on the date of service and the carrier did not know, and with the exercise of reasonable care could not have known of the person's eligibility status.

D. Notice of denial. If a vision or dental plan denies a request for pre-authorization, it shall deliver to the covered persons a written explanation of the basis for the denial within 24 hours of the determination for emergency care and within 10 calendar days for all other care.
[13.10.35.16 NMAC - N, 05/01/2021]

13.10.35.16 CONSUMER COMPLAINTS: A vision or dental plan state in all plan documents that a covered person who cannot resolve a complaint with the plan may contact the Office of the Superintendent of Insurance.
[13.10.35.17 NMAC - N, 05/01/2021]

13.10.35.17 PENALTIES: In addition to any applicable suspension, revocation or refusal to continue any certificate of authority or license under the Insurance Code, a penalty for any material violation of this rule may be imposed against a health care insurance carrier by the superintendent in accordance with Sections 59A-1-18 and 59A-46-25 NMSA 1978.
[13.10.35.18 NMAC - N, 05/01/2021]

13.10.35.18 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.
[13.10.35.19 NMAC - N, 05/01/2021]