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

13.10.35.1 ISSUING AGENCY: Office of Superintendent of Insurance ("OSI").
[13.10.35.1 NMAC - N, 01/01/2022]

13.10.35.2 SCOPE: This rule applies to every carrier who offers or sells any individual or group dental or vision insurance plan ("plan") separately from a health benefits plan, whether on or off the exchange. This rule does not apply to any pediatric dental or vision plan, or to any prepaid dental plan. Subject to the foregoing, this rule applies to a group dental or vision plan offered or sold to a New Mexico resident under a master policy delivered outside of this state.
[13.10.35.2 NMAC - N, 01/01/2022; A, 01/01/2024]

13.10.35.3 STATUTORY AUTHORITY: Sections 59A-2-9, 59A-23F-7, and 59A-23G-1 et seq. NMSA 1978.
[13.10.35.3 NMAC - N, 01/01/2022; A, 01/01/2024]

13.10.35.4 DURATION: Permanent.
[13.10.35.4 NMAC - N, 01/01/2022]

13.10.35.5 EFFECTIVE DATE: January 1, 2022, unless a later date is cited at the end of a section. If the superintendent previously approved a subject plan, that plan shall comply with this rule no later than January 1, 2022, if issued on or after that date.
[13.10.35.5 NMAC - N, 01/01/2022]

13.10.35.6 OBJECTIVE: Establish minimum regulatory standards and sales practices relating to 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.
[13.10.35.6 NMAC - N, 01/01/2022]

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

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

B. "Earned premiums" for a reporting year means the premium received up to the loss ratio measurement date that provided coverage during that reporting year.

C. "Incurred claims" for a reporting year means the claims for which services were provided in the reporting year. This includes such claims that were paid in the reporting year plus unpaid claims reserves for such reporting year.

D. "Loss ratio" means the incurred claims divided by earned premiums, calculated pursuant to Subsection D of 13.10.35.9 NMAC.

E. "Loss ratio measurement date" means the date as of which the incurred claims and earned premiums for each reporting year are determined for the reporting required in Subsection M of 13.10.35.9 NMAC of this rule.

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

G. "Reporting year" means a calendar year during which group or individual dental coverage is provided by a policy, contract or certificate covering dental services.

H. "Schedule of benefits" means any form that is part of an insurance policy filed with and approved by the superintendent that contains any of the following information: coverage levels, cost-sharing features, covered services, benefit maximums and exclusions.

I. "Unpaid claim reserves" for a reporting year means reserves and liabilities established as of the applicable loss ratio reporting year but were paid after the reporting year.
[13.10.35.7 NMAC - N, 01/01/2022; A, 01/01/2024]

13.10.35.8 GENERAL PROHIBITED POLICY PROVISIONS:

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

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

C. Exclusions. A plan that includes any exclusions shall comply with these requirements:

(1) each plan application shall include a prominent notice that the plan includes a preexisting exclusion, and display either the full text of the exclusion or directions as to how to obtain a copy of that text.

(2) the carrier shall not enforce a preexisting condition exclusion if an enrollee renews coverage under a plan offered by the same carrier.

(3) a plan application shall not request family member health information unless the family member is also seeking coverage under the plan; and

(4) a plan may exclude benefits for the replacement of a tooth that the covered person lost prior to the covered person's plan effective date unless the covered person had coverage from a prior carrier.

D. Evidence of coverage. Upon request, a carrier shall provide a current or former enrollee evidence of that person's current or former coverage under 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.

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 dental or vision service provider from discussing a treatment option with a covered person.

[13.10.35.8 NMAC - N, 01/01/2022, A, 01/01/2024]

13.10.35.9 GENERAL STANDARDS FOR POLICIES AND BENEFITS:

A. For individual plans. The following general standards apply to individual plans.

(1) An individual plan shall have a minimum term of 12 months.

(2) 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.

(3) An individual plan shall protect consumer rights as follows:

(a) The terms "noncancellable" or "noncancellable and guaranteed renewable" may only be used in an individual dental or vision 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.

(b) 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.

(c) A plan shall not terminate the coverage of a covered person except for "good cause," as follows:

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

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

(iii) fraud or misrepresentation affecting coverage;

(iv) policyholder request for cancellation;

(v) policy term ends; or

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

(4) 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.

B. For individual and group plans. The following general standards apply to both individual and group plans.

(1) 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 dental or vision 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, or sexual orientation of covered persons under the contract. Age may only be a factor in termination of coverage as outlined in Paragraph (4) of Subsection A and Paragraph (8) of Subsection B of this section;

(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 by phone or on the OSI's website; 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.

(2) 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.

(3) 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.

(4) 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 be 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 15 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.

(5) 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.

(6) A carrier shall not use any untrue statement or inducement not specified in a policy to solicit a prospective plan enrollee.

(a) 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.

(b) Inducements shall meet the requirements of Subsections G and H of Section 59A-16-17 NMSA 1978.

(7) If coverage of dependents is provided, a carrier shall not terminate coverage of an unmarried dependent by reason of the dependent's age before the dependent's 26th birthday, regardless of whether the dependent is enrolled in an educational institution.

(8) 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.

C. For group coverage. A group plan that offers dental or vision coverage shall comply with all sections of this rule.

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

E. Prior approval of rates required. A carrier shall not use rates or modified rates for dental and vision plans unless and until such rates are filed with and approved by the superintendent.

F. Minimum loss ratios for group and individual dental plans. Benefits dental plans shall be subject to a sixty-five percent minimum loss ratio requirement.

G. Minimum loss ratios for group and individual vision plans. Benefits under vision plans shall be subject to a fifty-five percent minimum loss ratio requirement.

H. Rate filing requirements. Each carrier providing dental or vision insurance must provide an actuarial analysis in an actuarial memorandum, certified by a qualified actuary, for each individual or group plan sold in New Mexico. Experience data may be aggregated for those policies or certificates that are rated together due to noncredible experience. A rate filing for a plan which provides both dental and vision benefits under the same policy must provide information in the actuarial memorandum and other supporting documentation to separately identify and support the premiums attributed to the dental and vision coverages. The superintendent shall post on its website requirements for filing actuarial memorandums and rates for rate filing requests. These requirements may differ for:

(1) dental and vision plans;

(2) individual, small group, and large group dental and vision plans;

(3) dental and vision plans sold on and off the health benefits exchange.

I. Calculating the loss ratio for individual and group dental and vision plans. The loss ratio is calculated as the ratio of the numerator to the denominator, as defined in Paragraphs (1) and (2) below. The loss ratio shall be calculated separately for dental and vision coverages, even if both dental and vision benefits are included in a single policy or contract.

(1) Numerator. The numerator is equal to the incurred claims for the loss ratio reporting year.

(2) Denominator. The denominator is the earned premiums for the loss ratio reporting year.

J. Rate revisions. The following requirements shall apply to rate revision requests: With respect to filing rate revisions for a previously approved form, or a group of previously approved forms combined for experience, benefits may be deemed reasonable in relation to premiums provided the revised rates meet the minimum loss ratio requirements of Subsections F or G of this rule, as applicable, and most current standards applicable to rate filings as prescribed by the superintendent, pursuant to Subsection I above based on actual experience and expected experience in the rating period,

K. Rates for new plans. The following requirements shall apply to rates for dental and vision plans not previously offered for sale in New Mexico: with respect to filing rates for a new plan, benefits may be deemed reasonable in relation to premiums provided the proposed rates meet the minimum loss ratio requirements of this rule, as applicable, and most current standards applicable to rate filings as prescribed by the superintendent, based on expected experience in the first three years.

L. Disapproval of forms and rates. The superintendent shall issue a disapproval:

(1) if the benefits provided therein are unreasonable in relation to the premium charged. For purposes of this rule, a dental or vision plan that meets the minimum loss ratio requirements will be considered to have benefits that are reasonable in relation to the premium charged;

(2) If there is misrepresentation of the benefits, advantages, conditions or terms of any plan or if the plan is characterized as more favorable to the covered person than the actual terms of the plan, such as naming coverage for services or conditions for which the primary forms of treatment are listed as exclusions;

(3) If there are false or misleading statements;

(4) If the name or title of a form is misrepresenting the true nature thereof; or

(5) If the plan contains provisions that are contrary to law, discriminatory, deceptive, unfair, impractical, unnecessary or unreasonable.

M. Disclosure and reporting compliance with minimum loss ratio requirements. By July 31st following each reporting year, carriers providing dental or vision benefit coverage must submit to the superintendent an actuarial memorandum prepared by a qualified actuary, which discloses the actual loss ratio for each plan, form or certificate subject to this rule. The annual filing shall, at a minimum, include rates, rating schedules, and supporting documentation, including ratios of incurred claims to earned premiums for each calendar year since issue. Information shall be in the form prescribed by the superintendent and shall demonstrate that each plan complies with the minimum loss ratio standards. Carriers that provide dental or vision insurance coverage that acquire a line or block of business from another carrier during a reporting year are responsible for submitting the required information and reports for the assumed business, including for that part of the reporting year that preceded the acquisition.

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

(2) Aggregation. Experience data may be aggregated for those policies or certificates that are rated together due to noncredible experience.

(3) Measurement period. Compliance with the minimum loss ratio shall be measured over the last three calendar years of experience and for each calendar year of experience utilized in the rate determination process, but never less than the last three calendar years, after the initial transition period (2024 to 2026). The initial measurement period shall be calendar year 2024; the second measurement year shall be calendar years 2024 and 2025; the third measurement period shall be calendar years 2024, 2025 and 2026. Each year thereafter, the subsequent calendar year shall be added to the rolling three-year period and the oldest calendar year shall be removed. For example, the fourth measurement period shall be calendar years 2025, 2026, and 2027.

(4) Frequency. Loss ratios shall be calculated annually by carriers that issue vision or dental plans specified in this rule, beginning with the 2024 reporting year.

(5) Timeline. The evidence of compliance with the minimum loss ratio requirements shall be filed with the superintendent by July 31 of the year following the reporting year. For noncredible blocks of business, 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 plan, and the reason for the request.

(6) Methodology. For existing plans, actual loss ratios shall be calculated using company historical claim data including an estimate for claims incurred but not reported, as appropriate.

(a) The superintendent shall assure that reserves are reasonable and based on sound actuarial principles with respect to the aggregate dollar amount of reserves for claims that are incurred but not yet paid, and for claims that are incurred but not yet reported.

(b) The claims will be reported 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.

(c) A plan shall be deemed to comply with the purposes of this section if the expected losses in relation to expected premiums over the entire period for which the plan is rated comply with the requirements of this section and either of the following applies:

(i) For policies or certificates that have been in force for three years or more, for the last three years, the ratio of incurred losses to earned premiums is greater than or equal to the minimum loss ratios established by this rule.

(ii) For policies or certificates that have been in force for fewer than three years, the expected third-year loss ratio can be demonstrated to be greater than or equal to the minimum loss ratio.

(7) Credibility. The certifying actuary shall include a statement related to the credibility of the data and the methodology used to determine such credibility in accordance with the applicable actuarial standards of practice.

(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.

(9) Corrective action plan. The superintendent may require a corrective action plan to return excess premiums or increase benefits if the minimum loss ratio requirements are not met.

(a) A carrier shall not return excess premiums per the above guidelines, until the carrier files a corrective action plan and obtains approval of such plan by the superintendent.

(b) If, in the opinion of the superintendent, a plan's failure to meet the minimum loss ratio requirements is due to unusual reserve fluctuations, economic conditions, or other nonrecurring conditions, the superintendent may elect not to issue a corrective action plan. Any such exemption shall be in writing.

[13.10.35.9 NMAC - N, 01/01/2022; A, 01/01/2024]

13.10.35.10 DENTAL PLANS:

A. Applicability. This section applies only to subject 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 and 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.

C. Required minimum benefits. A dental plan shall, at a minimum, provide each covered person benefits for the following dental services and dental supplies.

(1) Diagnostic services. A dental plan shall cover the following diagnostic services with no waiting period:

(a) one clinical oral examination twice per plan year;

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

(2) 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 least once a year unless greater frequency is deemed medically necessary; and

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

(3) 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 at least one fluoride treatment per calendar year furnished in a health care setting for children up to 14 years old or older as medically necessary.

(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.

(4) Cavities. A dental plan shall cover necessary fillings for cavities. A dental plan may not apply a waiting period for cavity fillings.

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

[13.10.35.10 NMAC - N, 01/01/2022; A, 01/01/2024]

13.10.35.11 VISION PLANS:

A. Applicability. This section only applies to subject 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) contact lenses; and

(d) 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 or ophthalmologist.

C. Required minimum benefits. A vision plan shall provide each covered person benefits for the following vision services and vision materials.

(1) Examinations. At least once every consecutive two-year period for adults and once every 12-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.

(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 and up to the stated benefit limit of the plan. 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.

(b) A vision plan shall provide an elective contact lens allowance up to the stated benefit limit of the plan.

(c) This benefit may be limited to once each 12-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:

(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, 01/01/2022; A, 01/01/2024]

13.10.35.12 COORDINATION AND COMBINATION OF BENEFITS:

A. A dental or vision plan shall only coordinate or combine benefits as permitted under state or federal law and as specified in the plan.

B. A carrier and plan that offers both dental and vision benefits is subject to both the dental and vision provisions of this rule.

[13.10.35.12 NMAC - N, 01/01/2022]

13.10.35.13 COVERAGE DOCUMENTATION:

A. Coverage forms and benefits disclosures.

(1) A carrier shall issue a policy, certificate of coverage or summary of benefits to each covered person on or before the effective date of coverage or of a change in coverage. Covered groups may distribute a certificate of coverage or summary of benefits on behalf of the carrier.

(2) The policy, certificate of coverage or schedule of benefits 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) cost-sharing features must be written from the perspective of the insured;

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

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

(f) a reinstatement provision which states that when premium is not paid within the applicable grace period, a subsequent acceptance of premium by the insurer or their agent without requiring an application for reinstatement, shall reinstate the policy. However, if the insurance company requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application, lacking such approval, upon the 30th day following the date of such conditional receipt unless the insurance company has previously notified the insured in writing of its disapproval of such application;

(g) a clear and understandable description of the conditions for renewal;

(h) procedures for filing claims;

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

(j) the period during which the plan is effective; and

(k) on the front page, the identity of the carrier.

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

(4) PPO and indemnity plans cannot be combined and must be submitted in separate product filings.

B. Notice required. If the company sends a separate schedule of benefits to the insured, the following language shall be provided in the separately issued schedule 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.

C. Contact information. The policy, certificate and schedule of benefits, if issued separately, shall state the plan's contact information and the website and phone number for OSI.

D. Insurance cards. Basic consumer information, including the phone number and website of the insurer's consumer assistance bureau, shall be included on all newly-issued physical or digital insurance cards. Carriers may issue digital cards, but shall provide a physical card upon the request of the consumer.
[13.10.35.13 NMAC - N, 01/01/2022; A, 01/01/2024]

13.10.35.14 NETWORK ADEQUACY: Each dental or vision plan that in any way conditions coverage on the provision of services by a preferred provider shall maintain an adequate network of such providers:

A. Attestation. A carrier shall submit to the superintendent annually an attestation of compliance with all of the criteria of this section by October 1, 2022 and every year thereafter.

(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 ninety 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 ninety 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 dental or vision carrier 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 carrier 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 dental or vision carrier 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 dental or vision 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 as if the care was provided in-network.

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

[13.10.35.14 NMAC - N, 01/01/2022]

13.10.35.15 UTILIZATION MANAGEMENT DETERMINATIONS:

A. Denial of services. A benefit denial that is based on a determination that a dental or vision service is not medically necessary, and that is the result of a formal prior authorization review process, shall be supported by a contemporaneous opinion of a provider licensed to provide the requested service. Any such determination shall be made in accordance with medical necessity standards and appropriate clinical guidelines.

B. Pretreatment Estimates. A carrier may issue a non-binding pretreatment estimate for the coverage and reimbursement of proposed dental or vision services. A pretreatment estimate does not determine medical necessity and does not serve as a prior authorization.

(1) A pretreatment estimate shall include a statement that clearly indicates to the covered person that the estimate is not a guarantee of coverage.

(2) A pretreatment estimate shall clearly identify the services that require an approved prior authorization for coverage and shall include a statement that the covered person may be liable for the full cost of the service if an approved prior authorization is not obtained.

C. Timeliness of determinations. A carrier shall make all prior authorization determinations as required by the exigencies of the situation and in accordance with sound medical principles, and in no more than five business days. If after five business days the carrier does not expect to be able to complete the determination due to unforeseen circumstances or missing information, the carrier shall inform the covered person or their provider of the circumstances or the information missing and the need to extend the determination timeframe.

D. Post-authorization denials. A carrier shall not deny any claim subsequently submitted for procedures specifically included in an approved prior authorization unless the date of service is within 18 months and at least one of the circumstances below applies for each denied procedure:

(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 payer is responsible for the payment;

(6) another payer 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 carrier 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.

E. Notice of denial. If a carrier denies a request for prior 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.

[13.10.35.15 NMAC - N, 01/01/2022]

13.10.35.16 CONSUMER COMPLAINTS: A carrier shall 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.

[13.10.35.16 NMAC - N, 01/01/2022]

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.
[13.10.35.17 NMAC - N, 01/01/2022]

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.
[13.10.35.18 NMAC - N, 01/01/2022]

History of 13.10.35 NMAC: [RESERVED]