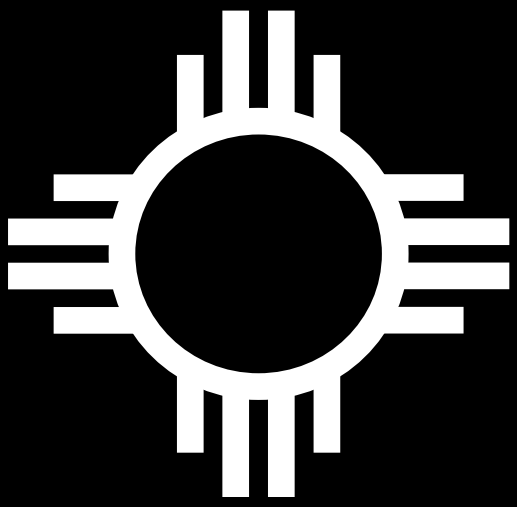
NEW MEXICO REGISTER



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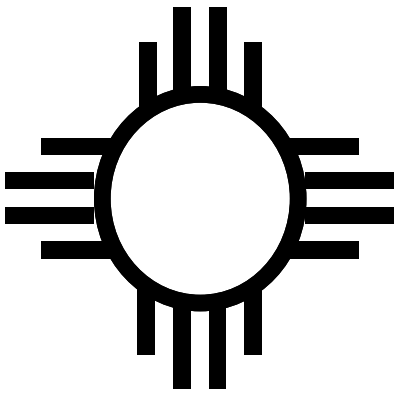

The official publication for all notices of rulemaking and filings of adopted, proposed and emergency rules in New Mexico

The Commission of Public Records
Administrative Law Division
Santa Fe, New Mexico
2005

New Mexico Register

Volume XVI, Number 18
September 30, 2005

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Adopted Rules

Effective Date and Validity of Rule Filings

Rules published in this issue of the New Mexico Register are effective on the publication date of this issue unless otherwise specified. "No rule shall be valid or enforceable until it is filed with the records center and published in the New Mexico register as provided by the State Rules Act. Unless a later date is otherwise provided by law, the effective date of a rule shall be the date of publication in the New Mexico register." Section 14-4-5 NMSA 1978.

A=*Amended*, E=*Emergency*, N=*New*, R=*Repealed*, Rn=*Renumbered*

Other Material Related to Administrative Law

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The ***New Mexico Register*** is available free at **http://www.nmcpr.state.nm.us/nmregister**

Notices of Rulemaking and Proposed Rules

ALBUQUERQUE-BERNALILLO COUNTY AIR QUALITY CONTROL BOARD

ALBUQUERQUE-BERNALILLO COUNTY AIR QUALITY CONTROL BOARD NOTICE OF HEARING AND REGULAR MEETING

On November 9, 2005, at 5:15 PM, the Albuquerque-Bernalillo County Air Quality Control Board (Board) will re-open the combined public hearing held on August 10, 2005. The hearing will be held in the Vincent E. Griego Chambers located in the basement level of the Albuquerque-Bernalillo County Government Center, 400 Marquette Avenue NW, Albuquerque, NM. The hearing will address:

* Proposal to adopt the *Implementation Plan for Municipal Solid Waste Landfills for Albuquerque and Bernalillo County*. This implementation plan is designed to control emissions of non-methane organic compounds (NMOC) from municipal solid waste landfills in Bernalillo County. This plan fulfills requirements for "designated pollutants" under Section 111(d) of the Clean Air Act. The adoption of this plan also fulfills part of the requirements set forth by EPA in order to accept delegation of 40 CFR 60 Subparts WWW, *Standards of Performance for Municipal Solid Waste Landfills* and Cc, *Emission Guidelines and Compliance Times for Municipal Solid Waste Landfills*. Delegation of authority will enable the Air Quality Division to oversee landfill gas emissions at landfills located in Bernalillo County. The U. S. Environmental Protection Agency (EPA) currently administers and enforces Subparts WWW and Cc in Bernalillo County.

* Proposal to adopt a new regulation 20.11.71 NMAC, Municipal Solid Waste Landfills. This regulation will establish requirements for municipal solid waste landfills in order to control emissions of NMOC. This regulation will incorporate by reference the federal standards for landfill gas emissions found at 40 CFR 60 Subpart WWW *Standards of Performance for Municipal Solid Waste Landfills* and 40 CFR 60 Subpart Cc *Emission Guidelines and Compliance Times for Municipal Solid Waste Landfills*, and will become locally enforceable. Changes have been made to the "Definitions" section, 20.11.71.7 NMAC since the first public review draft was released on June 21, 2005.

* Proposal to amend 20.11.63 NMAC, New Source Performance Standards for Stationary Sources. This amendment will remove the current exclusions from delegation of 40 CFR 60 Subpart WWW *Standards of Performance for Municipal Solid Waste Landfills* and 40 CFR 60 Subpart Cc *Emission Guidelines and Compliance Times for Municipal Solid Waste Landfills*. If the proposed deletion of these exclusions is adopted, the City Of Albuquerque Air Quality Division will administer and enforce Subparts WWW and Cc.

Following the combined hearing, the Board will hold its regular monthly meeting during which the Board is expected to consider adopting the *Implementation Plan for Municipal Solid Waste Landfills for Albuquerque and Bernalillo County*, the new regulation 20.11.71 NMAC, Municipal Solid Waste Landfills, and the proposed amendments to 20.11.63 NMAC, New Source Performance Standards for Stationary Sources.

The Air Quality Control Board is the federally-delegated air quality authority for Albuquerque and Bernalillo County. Local delegation authorizes the Board to administer and enforce the Clean Air Act and the New Mexico Air Quality Control Act, and to require local air pollution sources to comply with air quality standards and regulations.

Hearings and meetings of the Board are open to the public and all interested persons are encouraged to participate. All persons who wish to testify regarding the subject of the hearing may do so at the hearing and will be given a reasonable opportunity to submit relevant evidence, data, views, and arguments, orally or in writing, to introduce exhibits and to examine witnesses in accordance with the Joint Air Quality Control Board Ordinances, Section 9-5-1-6 ROA 1994 and Bernalillo County Ordinance 94-5, Section 6.

Anyone intending to present technical testimony is asked to submit a written notice of intent before 5:00 pm on Wednesday November 2, 2005 to: Attn: November Hearing Record, Mr. Neal Butt, Albuquerque Environmental Health Department, P.O. Box 1293, Albuquerque, NM 87103, or in person in Room 3023, 400 Marquette Avenue NW. The notice of intent shall identify the name, address, and affiliation of the person.

In addition, written comments to be incorporated into the public record should be received at the above P.O. Box, or Environmental Health Department office, before 5:00 pm on November 2, 2005. The comments shall include the name, address and affiliation of the individual or organization submitting the statement. Written comments may also be submitted electronically to nbutt@cabq.gov and shall include the required name, address and affiliation information. Interested persons may obtain a copy of the proposed regulation at the Environmental Health Department Office, or by contacting Mr. Neal Butt electronically at nbutt@cabq.gov or by phone (505) 768-2660.

NOTICE FOR PERSON WITH DISABILITIES: If you have a disability and/or require special assistance please call (505) 768-2600 [Voice] and special assistance will be made available to you to review any public meeting documents, including agendas and minutes. TTY users call the New Mexico Relay at 1-800-659-8331 and special assistance will be made available to you to review any public meeting documents, including agendas and minutes

NEW MEXICO BOARD OF CHIROPRACTIC EXAMINERS

Public Rule Hearing and Regular Board Meeting

Notice is hereby given that the New Mexico Board of Chiropractic Examiners will convene a public rule hearing at 9:00 a.m. on Friday, October 14, 2005, followed by a regular business meeting during which action will be taken on the proposed rules. During the regular meeting, the Board may enter into Executive Session to discuss licensing matters. The hearing and meeting will be held at the Radisson Hotel & Conference Center, 2500 Carlisle Blvd. NE, Albuquerque, NM.

The purpose of the rule hearing is to consider adoption of proposed amendments to the following Board Rules and Regulations in 16.4 NMAC: Part 1 General Provisions; Part 3 Requirements for Licensure by Examination; Part 4 Licensure by Endorsement; Part 9 License Renewal Procedures; Part 10 Continuing Education; Part 12 Classification of a Chiropractic Licensure; Part 13 Reinstatement of Chiropractic Licensure; Part 17 Supervision of Interns; Part 18 Practice Procedures; and a proposed new rule on Disciplinary Proceedings.

Persons desiring to present their views on the proposed rules may write to request draft copies from the Board office at the Toney Anaya Building located at the

West Capitol Complex, 2550 Cerrillos Road in Santa Fe, New Mexico 87504, or call (505) 476-4613 after September 23, 2005. In order for the Board members to review the comments in their meeting packets prior to the meeting, persons wishing to make comment regarding the proposed rules must present them to the Board office in writing no later then September 30, 2005. Persons wishing to present their comments at the hearing will need (9) copies of any comments or proposed changes for distribution to the Board and staff.

If you have questions, or if you are an individual with a disability who wishes to attend the hearing or meeting, but you need a reader, amplifier, qualified sign language interpreter, or any other form of auxiliary aid or service to participate, please call the Board office at (505) 476-4613 at least two weeks prior to the meeting or as soon as possible.

NEW MEXICO DEPARTMENT OF FINANCE AND ADMINISTRATION
BOARD OF FINANCE

NEW MEXICO
DEPARTMENT OF FINANCE AND ADMINISTRATION

STATE BOARD OF FINANCE

NOTICE OF BOARD OF FINANCE RULE

The state Board of Finance is in the process of revising one of its rules: Distribution of Private Activity Bond Allocations. Copies of the existing rule and proposed changes are available in room 181, Bataan Memorial Building, Santa Fe, NM 87501 and on the Board of Finance website, http://nmsbof.state.nm.us. The Board will consider adopting the proposed rule at its November 8, 2005 meeting, which takes place at 9:30 in the Governor's Cabinet Room, State Capitol Building. Please mail or deliver written comments on the proposed changes to Olivia Padilla-Jackson, 181 Bataan Memorial Building, Santa Fe, NM 87501 by October 31, 2005.

NEW MEXICO DEPARTMENT OF HEALTH
DIVISION OF HEALTH IMPROVEMENT

NOTICE OF PUBLIC HEARING

The New Mexico Department of Health will hold a public hearing on 7.1.9 NMAC "Caregivers Criminal History Screening Requirements". The hearing will be held at 1:30 p.m. on Tuesday, November 1, 2005 in the Runnels Building Auditorium located at 1190 St. Francis Drive, Santa Fe, NM 87502.

The public hearing will be conducted to establish the requirements for complying with the Caregivers Criminal History Screening Act.

A draft of the proposed regulation can be obtained from:

Thomasine Martin, Administrative Assistant
Division of Health Improvement
1190 St. Francis Drive
Santa Fe, NM 87502
(505) 827-2677

Please submit any written comments regarding the proposed regulation to the attention of:

Brian Royer
Division of Health Improvement
1190 St. Francis Drive
P.O. Box 26110
Santa Fe, NM 87502-6110

If you are an individual with a disability who is in need of special assistance or accommodations to attend or participate in the hearing, please contact Thomasine Martin, Administrative Assistant, Division of Health Improvement at (505) 827-2677. The Department requests at least ten (10) days advance notice to provide requested special accommodations.

NEW MEXICO DEPARTMENT OF HEALTH
DIVISION OF HEALTH IMPROVEMENT

NOTICE OF PUBLIC HEARING

The New Mexico Department of Health will hold a public hearing on 7.1.12 NMAC "Employee Abuse Registry". The hearing will be held at 9:00 a.m. on Tuesday, November 1, 2005 in the Runnels Building Auditorium located at 1190 St. Francis Drive, Santa Fe, NM 87502.

The public hearing will be conducted to establish the Employee Abuse Registry Act.

A draft of the proposed regulation can be obtained from:

Thomasine Martin, Administrative Assistant
Division of Health Improvement
1190 St. Francis Drive
Santa Fe, NM 87502
(505) 827-2677

Please submit any written comments regarding the proposed regulation to the attention of:

Steve Dossey, Deputy Director
Division of Health Improvement
1190 St. Francis Drive
P.O. Box 26110
Santa Fe, NM 87502-6110

If you are an individual with a disability who is in need of special assistance or accommodations to attend or participate in the hearing, please contact Thomasine Martin, Administrative Assistant, Division of Health Improvement at (505) 827-2677. The Department requests at least ten (10) days advance notice to provide requested special accommodations.

NEW MEXICO DEPARTMENT OF HEALTH
DIVISION OF HEALTH IMPROVEMENT

NOTICE OF HEARING

The New Mexico Department of Health will hold a public hearing on 7.14.3 NMAC "Incident Management Reporting and Training Requirements for Providers". The hearing will be held at 3:00 p.m. on Tuesday, November 1, 2005 in the Runnels Building Auditorium located at 1190 St. Francis Drive, Santa Fe, NM 87502.

The public hearing will be conducted to establish standards for licensed health care facilities and community based service providers to institute and maintain an incident management system and employee training program for the reporting of abuse, neglect and misappropriation of property and other reportable incidents.

A draft of the proposed regulation can be obtained from:

Thomasine Martin, Administrative Assistant
Division of Health Improvement
1190 St. Francis Drive
Santa Fe, NM 87502
(505) 827-2677

Please submit any written comments regarding the proposed regulation to the attention of:

Brian Royer
Division of Health Improvement
1190 St. Francis Drive
P.O. Box 26110
Santa Fe, NM 87502-6110

If you are an individual with a disability who is in need of special assistance or accommodations to attend or participate in the hearing, please contact Thomasine Martin, Administrative Assistant, Division of Health Improvement at (505) 827-2677. The Department requests at least ten (10) days advance notice to provide requested special accommodations.

NEW MEXICO HUMAN SERVICES DEPARTMENT
INCOME SUPPORT DIVISION

NOTICE OF PUBLIC HEARING

The Human Services Department will hold a public hearing for changes to the Food Stamp Program income limits for participation, standards and deductions available to otherwise eligible households, and to the maximum food stamp allotments (Thrifty Food Plan). The Department will also make changes to the NMW Cash Assistance, Education Works, Support Services and General Assistance programs income limits for participation, which are adjusted each year in compliance with the New Mexico Works Act, and are made effective for benefit month October. The hearing will be held at 9:00 am on Tuesday, November 1, 2005. The hearing will be held at the Income Support Division conference room, 2009 S. Pacheco St., Santa Fe, NM. The conference room is located in Room 120 on the lower level.

Each year the Department is required to make changes to the Food Stamp Program income limits for participation, standards and deductions available to otherwise eligible households, and to the maximum food stamp allotments (Thrifty Food Plan). The United States Department of Agriculture, Food and Nutrition Services determine these amounts. The Department received notification of the adjusted amounts on August 9, 2005 and will make the adjustments effective for benefit month October 2005.

The Department will also make changes to the NMW Cash Assistance, Education Works, Support Services and General Assistance programs income limits for participation, which are adjusted each year in compliance with the New Mexico Works Act, and are made effective for benefit month October.

Pursuant to the Human Services Department Act at NMSA 1978, at 9-8-6(F), because the Department has received less than sixty days notice of federal legislation, the Department will implement an interim rule to make effective the federal mandates for the Food Stamp Program, and will also implement the mandated changes to the NMW Cash Assistance, Support Services, General Assistance and Education Works Programs.

If you are a person with a disability and you require this information in an alternative format or require a special accommodation to participate in the public hearing, please contact the Department toll free at 1-800-432-6217, TDD 1-800-609-4TDD (4833), or through the New Mexico Relay System toll free at 1-800-659-8331. The Department requests at least a 10-day advance notice to provide requested alternative formats and special accommodations.

Individuals wishing to testify or requesting a copy of the proposed regulation should contact the Income Support Division, P.O. Box 2348, Pollon Plaza, Santa Fe, NM 87505-2348, or by calling toll free 1-800-432-6217.

Individuals who do not wish to attend the hearing may submit written or recorded comments. Written or recorded comments must be received by 5:00 PM on the date of the hearing. Please send comments to:

Pamela S. Hyde, J.D., Secretary
Human Services Department
P.O. Box 2348
Pollon Plaza
Santa Fe, NM 87504-2348

You may send comments electronically to: Ted.Roth@state.nm.us

NEW MEXICO HUMAN SERVICES DEPARTMENT
INCOME SUPPORT DIVISION

NOTICE OF PUBLIC HEARING

The Human Services Department will hold a public hearing to consider making the Education Works Program its own part and to align the Education Works rules with the Education Works Act. The hearing will be held at 10:00 am on Tuesday, November 1, 2005. The hearing will be held at the Income Support Division conference room, 2009 S. Pacheco St., Santa Fe, NM. The conference room is located in Room 120 on the lower level.

The Department proposes to amend the section at 8.102.610.12 NMAC and to make the Education Works Program its own part at 8.102.611 NMAC. The Department proposes to take this action in order to align the Education Works rules with the Education Works Act to clarify the grade point average requirement. In addition, the 47th Legislature through House Bill 1007 amended the Education Works Act and mandated the following changes to the Education Works rules: one additional academic term following the twenty-four month participation limit if doing so will result in the recipient earning a degree or two additional academic terms following the twenty-four month participation limit at the discretion of the director if doing so will result in the recipient earning a degree.

If you are a person with a disability and you require this information in an alternative format or require a special accommodation to participate in the public hearing, please contact the Department toll free at 1-800-432-6217, TDD 1-800-609-4TDD (4833), or through the New Mexico Relay System toll free at 1-800-659-8331. The Department requests at least a 10-day advance notice to provide requested alternative formats and special accommodations.

Individuals wishing to testify or requesting a copy of the proposed regulation should contact the Income Support Division, P.O. Box 2348, Pollon Plaza, Santa Fe, NM 87505-2348, or by calling toll free 1-800-432-6217.

Individuals who do not wish to attend the hearing may submit written or recorded comments. Written or recorded comments must be received by 5:00 PM on the date of the hearing. Please send comments to:

Pamela S. Hyde, J.D., Secretary
Human Services Department
P.O. Box 2348 Pollon Plaza
Santa Fe, NM 87504-2348

You may send comments electronically to: Ted.Roth@state.nm.us

NEW MEXICO MEDICAL BOARD

NEW MEXICO MEDICAL BOARD

Notice

The New Mexico Medical Board will convene a Public Rule hearing on Monday, October 31, 2005 at 4:30 p.m. in the Conference Room, 2055 S. Pacheco, Building 400, Santa Fe, New Mexico, before a hearing officer. A decision will be made on the proposed rules at a Regular board meeting on Thursday, November 10, 2005.

The purpose of the Rule Hearing is to consider amending 16.10.13 NMAC (Use of Devices & Procedures by Unlicensed Personnel) and to add 16.10.17 NMAC (Management of Medical Records).

The amendment will provide further clarification of the requirements for procedures performed by medical assistants under the supervision of a physician and the new rule will establish requirements for the management of medical records.

Copies of the proposed rules will be available on September 30th on request from the Board office at the address listed above, by phone (505) 476-7220, or on the Internet at www.nmmb@state.nm.us.

Persons desiring to present their views on the proposed amendments may appear in person at said time and place or may submit written comments no later than 5:00 p.m., October 24, 2005, to the board office, 2055 S. Pacheco, Building 400, Santa Fe, NM, 87505.

If you are an individual with a disability who is in need of a reader, amplifier, qualified sign language interpreter, or any other form of auxiliary aid or service in order to attend or participate in the hearing, please contact Lynnelle Tipton, Administrative Assistant at 2055 S. Pacheco, Building 400, Santa Fe, NM at least one week prior to the meeting. Public documents, including the agenda and minutes, can be provided in various accessible formats.

NEW MEXICO DEPARTMENT OF PUBLIC SAFETY

New Mexico Department of Public Safety

Notice of Proposed Rule Making

The Secretary of the New Mexico Department of Public Safety proposes to amend 10.8.2 NMAC, Concealed Handgun Carry Act, NMSA 1978, Section 29-19. There will be a public hearing regarding the proposed rule on November 1, 2005, 9:00 a.m. at the Department of Public Safety, Law Enforcement Academy, Auditorium located at 4491 Cerrillos Road, Santa Fe, New Mexico 87504-1628.

Copies of the proposed rules may be obtained by contacting Sharron Henderson, Department of Public Safety, Special Investigations Division, 4491 Cerrillos Road, Santa Fe, New Mexico 87504-1628, at (505)-827-9097. Written comments regarding the proposed rule making should be submitted to Sharron Henderson at the address shown above. Written comments must be submitted no later than 5:00 p.m. on November 1, 2005. If you are an individual with a disability who is in need of a reader, amplifier, qualified sign language interpreter, or any other form of auxiliary aid or service to attend or participate in the hearing, please contact Sharron Henderson at (505)-827-9097.

NEW MEXICO TAXATION AND REVENUE DEPARTMENT

NEW MEXICO TAXATION AND REVENUE DEPARTMENT

NOTICE OF HEARING AND PROPOSED RULES

The Department proposes to amend the following regulations:

Gross Receipts and Compensating Tax Act
3.2.201.11 NMAC Section 7-9-43 NMSA 1978
(Construction contractors)
3.2.206.12 Section 7-9-48 NMSA 1978
(Nonconstruction Services Not Resold By Construction Contractors)
3.2.207.8 NMAC Section 7-9-49 NMSA 1978
(General Qualifications - Examples)
3.2.210.7 NMAC Section 7-9-52 NMSA 1978
(Hauling and Spreading Defined)
3.2.210.10 NMAC Section 7-9-52 NMSA 1978
(Transportation Services)
3.2.210.19 NMAC Section 7-9-52 NMSA 1978
(Blueprints- Photostats)
3.2.210.22 NMAC Section 7-9-52 NMSA 1978
(Lease of Construction Equipment)
3.2.211.9 NMAC Section 7-9-53 NMSA 1978
(Amount Attributable to Improvements and the Cost of Land)

Tax Administration Act
3.1.11.19 NMAC Section 7-1-71.2 NMSA 1978
(Penalty for Failure to correctly Report Deduction Amount)

The Department also proposes to repeal 3.2.210.11 NMAC ***("Force Account Work")*** to Section 7-9-52 NMSA 1978.

The proposals were placed on file in the Office of the Secretary on September 15, 2005. Pursuant to Section 9-11-6.2 NMSA 1978 of the Taxation and Revenue Department Act, the final of the proposals, if filed, will be filed as required by law on or about November 30, 2005.

A public hearing will be held on the proposals on Wednesday, November 9, 2005, at 9:30 a.m. in the Secretary's Conference Room No. 3002/3137 of the Taxation and Revenue Department, Joseph M. Montoya Building, 1100 St. Francis Drive, Santa Fe, New Mexico. Auxiliary aids and accessible copies of the proposals are available upon request; contact (505) 827-0928. Comments on the proposals are invited. Comments may be made in person at the hearing or in writing. Written comments on the proposals should be submitted to the Taxation and Revenue Department, Director of Tax Policy, Post Office Box 630, Santa Fe, New Mexico 87504-0630 on or before November 9, 2005.

3.2.201.11 **CONSTRUCTION CONTRACTORS:**

A. Any person applying to execute nontaxable transaction certificates (nttcs) related to construction as defined in Section 7-9-3 NMSA 1978 must indicate the applicant's New Mexico contractor's license number or furnish proof that no contractor's license is required by the construction industries division. Failure to comply with Section 3.2.201.11 NMAC will result in denial of the requested certificates.

B. A person performing construction services who makes any false or misleading representations in any material respect in an application for nttcs may become subject to the penalties imposed by Section 7-1-73 NMSA 1978 as well as other penalties, civil or criminal, prescribed in the Tax Administration Act. False or misleading representations include, but are not confined to:

(1) indicating a contractor's license number on the application which is not issued to the applicant or which cannot lawfully be used by the applicant;

(2) applying for nttcs which someone other than the applicant will execute; or

(3) furnishing false or misleading documentation that a contractor's license is not required of the applicant by the construction industries division.

C. Any person who has previously applied for and been issued nttcs related to construction as defined in Section 7-9-3 NMSA 1978, under circumstances wherein the person would not have been entitled to obtain such certificates pursuant to Section 3.2.201.11 NMAC, will be assessed gross receipts or compensating tax, as appropriate, based on the representations actually made in the application for nttcs.

D. Any person engaged in the business of construction, as defined by Section 7-9-3.4 NMSA 1978, is presumed to be engaged solely in the business of construction and not to be engaged in reselling services other than construction services in the ordinary course of business. Except as provided in Subsection E of this section, this person will not be issued nontaxable

transaction certificates (NTTCs) other than those appropriate for the deductions under Sections 7-9-51 and 7-9-52 NMSA 1978.

E. A person who can demonstrate to the department's satisfaction that the person is engaged in the business of construction and in the business of selling property other than construction materials or performing or selling one or more services, such as engineering or architectural design, that are not construction services may qualify for and be issued NTTCs in addition to those appropriate for the deductions under Sections 7-9-51 and 7-9-52 NMSA 1978. The additional types of NTTC may be executed by the person only when the person is acquiring tangible personal property other than construction material or a service other than a construction service in a manner meeting the conditions for execution of the additional type of NTTC. In determining whether the person engaged in the construction business is engaged in a business in addition to the construction business, the department will consider these factors:

(1) whether the person possesses, when possession is required, a current license to sell or lease the nonconstruction property or to perform or sell the nonconstruction service;

(2) whether the person has entered into a contract requiring the sale or lease of the nonconstruction property or the performance or sale of the nonconstruction service;

(3) whether the person holds himself out to be in the business; and

(4) other factors deemed appropriate by the secretary.

[7/26/76, 6/18/79, 4/7/82, 5/4/84, 4/2/86, 11/26/90, 9/20/93, 11/15/96, 4/30/99; 3.2.201.11 NMAC - Rn, 3 NMAC 2.43.1.11 & A, 5/31/01; A, XXX]

3.2.206.12 **NONCONSTRUCTION SERVICES NOT RESOLD BY CONSTRUCTION CONTRACTORS:** Any person engaged solely in the business of construction, as defined by Section 7-9-3.4 NMSA 1978, is not engaged in reselling services other than construction services in the ordinary course of business and [~~cannot~~] may not issue a nontaxable transaction certificate to purchase services for resale in connection with the construction business under the provisions of Section 7-9-48 NMSA 1978.

[3/11/88, 11/26/90, 11/15/96; 3.2.206.12 NMAC - Rn, 3 NMAC 2.48.12 & A; 5/31/01; A, XXX]

3.2.207.8 **GENERAL QUALIFICATIONS - EXAMPLES:**

A. To qualify to issue a nontaxable transaction certificate (nttc) under the provisions of Section 7-9-49 NMSA 1978, the business issuing the nttc must derive a substantial portion of its income from the sale or lease of the same type of property which is being purchased under the nttc. The property purchased under the nttc must subsequently be sold or leased in the ordinary course of business. If the seller accepts an nttc in good faith and if either of these requirements is not met the value of the tangible property purchased under such nttc will be subject to the compensating tax.

B. Example 1: X derives a substantial portion of its receipts from leasing or selling air compressors. When X buys air compressors from M, the manufacturer, X gives M an nttc. M's receipts from the sales are deductible.

C. Example 2: X, an office machine company, buys a typewriter from the manufacturer, M. X has given M an nttc. X leases the typewriter for six months after which X uses it in its office. M may deduct the receipts from the sale of the typewriter from its gross receipts. X must pay gross receipts tax on its receipts from leasing the typewriter. As a result of converting the typewriter to its own use, X must pay compensating tax on the market value of the typewriter at the time of its conversion to use under Section 7-9-7 NMSA 1978.

D. Example 3: A substantial portion of L's business is from leasing or selling lawnmowers. L has given an nttc to D, the dealer from whom L buys its lawnmowers. L buys five lawnmowers from D to lease to its customers. L sells one of the lawnmowers to Y and leases the others to X. D may deduct receipts from the sale of all five of the lawnmowers to L. L must pay the gross receipts tax on the receipts from leasing to X and the sale to Y.

E. Example 4: C, a flying service, sells new and used airplanes, rents airplanes, provides in-state charter service, and provides flying instruction. C purchases five airplanes from X, a New Mexico airplane manufacturer, for use in its charter service. "Chartering" is here defined as hiring a plane and a pilot to fly the customer, not freight. Receipts from in-state charter flights are not subject to gross receipts tax. A charter is not a lease. The receipts from leasing airplanes and flight instructions are subject to the gross receipts tax. X's receipts from the sale of planes to C are subject to the gross receipts tax. If C bought the planes under nttc it issued X, C would be liable for compensating tax on the value of the charter planes. Later, when C sells these planes, the receipts from the sales of the used planes also are taxable. Sale of used planes is in the normal course of C's business. If C converts a plane it purchased for leasing to charter flights, even if the conversion is for a single flight, compensating tax becomes due on the market value of the plane at the time of conversion.

[~~F. Example 5: B holds bulldozers out for lease to construction companies. B purchases its bulldozers under an nttc. C, a construction company, hires B's bulldozers, with operators, to use for two weeks on a roadbed under the direction of C's construction supervisor. This is not a construction service by B (as used in Section 7-9-52 NMSA 1978) because this is not a service performed by B as an independent construction contractor, since C exercises control over the means of accomplishing the result. B is not leasing as that term is used in Section 7-9-49 NMSA 1978. The use of the tangible personal property by B is in a manner other than holding it for lease or sale. At the time of that conversion from the use for leasing, compensating tax is due from B on the market value of the bulldozers furnished with operators to C.~~]

[12/5/69, 3/9/72, 11/20/72, 3/20/74, 7/26/76, 6/18/79, 4/7/82, 5/4/84, 4/2/86, 11/26/90, 11/15/96; 3.2.207.8 NMAC - Rn, 3 NMAC 2.49.8 & A, 5/31/01; A, XXX]

3.2.210.7 **DEFINITIONS: HAULING AND SPREADING DEFINED:** For purposes of Subsection C of Section 3.2.210.10 NMAC, hauling and spreading means the transporting of material from a location on or in proximity to a construction site and applying the material to the point of usage required as a step in completing the construction project.

[11/15/96; 3.2.210.7 NMAC - Rn, 3 NMAC 2.52.7, 5/31/01; A, XXX]

3.2.210.10 **TRANSPORTATION SERVICES**

A. **HAULING:** Receipts from hauling materials and supplies to and from a building site for a person engaged in the construction business are not deductible from the hauler's gross receipts pursuant to Section 7-9-52 NMSA 1978 because hauling materials and supplies to and from a construction site is not a construction service pursuant to Subsection A of Section 7-9-3.4 NMSA 1978.

B. **HAULING PREFABRICATED BUILDINGS:** A builder of prefabricated buildings may not issue a type 7 nontaxable transaction certificate to a company hired to move completed buildings from the builder's lot to the permanent site. Haulers are not engaged in construction as defined under Section 7-9-3 NMSA 1978. A deduction may be available under Section 7-9-48 NMSA 1978 if all the criteria of that section are met.

C. **HAULING AND SPREADING MATERIALS WITHIN**

CONSTRUCTION PROJECT: Receipts of a person from hauling and spreading dirt, sand, gravel and rock, treated or untreated, for the purpose of furnishing materials to a construction project when such materials have been obtained from a source which is on or in the proximity of that construction project are receipts from performing a construction service. Such receipts may be deducted from the seller's gross receipts if the buyer delivers a nontaxable transaction certificate to the seller. [12/5/69, 3/9/72, 11/20/72, 3/20/74, 7/26/76, 3/16/79, 6/18/79, 11/8/79, 4/7/82, 5/4/84, 4/2/86, 11/26/90, 11/15/96; 3.2.210.10 NMAC - Rn, 3 NMAC 2.52.10 & A, 5/31/01; A, XXX]

3.2.210.19 **BLUEPRINTS - PHOTOSTATS:** Receipts from the sale of blueprints or photostats to a person engaged in the construction business are subject to the gross receipts tax. These receipts may not be deducted pursuant to Section 7-9-52 NMSA 1978 because they are not construction services [~~performed directly upon a construction project~~].

[3/20/74, 7/26/76, 6/18/79, 4/7/82, 5/4/84, 4/2/86, 11/26/90, 11/15/96; 3.2.210.19 NMAC - Rn, 3 NMAC 2.52.19 & A, 5/31/01; A, XXX]

3.2.210.22 **LEASE OF CONSTRUCTION EQUIPMENT:**

A. Receipts from leasing construction equipment, with or without operators, to a person engaged in the construction business may not be deducted from the lessor's gross receipts pursuant to Section 7-9-52 NMSA 1978. Leasing of construction equipment is not a construction service as defined in [~~Section 7-9-3 NMSA 1978~~] Subsection A of Section 7-9-3.4 NMSA 1978.

B. In contrast, when a person who is regularly engaged in the selling of construction services, such as a subcontractor, uses the subcontractor's own construction equipment to perform construction services for a person engaged in the construction business, the subcontractor may deduct the receipts for the services and equipment under Section 7-9-52 NMSA 1978 if:

(1) the subcontractor is an independent contractor and not an employee of the person engaged in the construction business; and

(2) the subcontractor exercises control over the use of the property in performing the services; the controlling factor is whether the equipment owner has control over the performance of the construction service which involves using the equipment or is simply operating the equipment at the direction of some other person engaged in the construction business.

C. Example 1: A is regularly engaged in the lease and rental of construction equipment. A enters into an agreement to lease a crane with an operator to a contractor engaged in the construction business to be used on a construction project. The contractor will direct all of the activity of the crane and operator on the construction site. A's receipts from the lease of the crane with an operator are not receipts from performing construction services. A cannot deduct such receipts.

D. Example 2: X is a heating and air conditioning subcontractor on a construction project. X owns a crane which X regularly uses to lift equipment onto the roof of buildings on which X works. X's receipts for construction services includes payment for using the crane. X may deduct those receipts under Section 7-9-52 NMSA 1978. If, however, X agrees to lease the crane with an operator to the prime contractor for work unrelated to the subcontract, which work is performed at the direction of the prime contractor, X would not be able to deduct the receipts for the leasing of the crane.

[11/8/79, 4/7/82, 5/4/84, 4/2/86, 11/26/90, 11/15/96; 3.2.210.22 NMAC - Rn, 3 NMAC 2.52.22 & A, 5/31/01; A, XXX]

3.2.211.9 **AMOUNT ATTRIBUTABLE TO IMPROVEMENTS AND THE COST OF LAND:**

A. The proportion of the receipts from the sale of real property which is attributable to improvements constructed on the real property is determined by:

(1) subtracting from the sales price the cost of the land to the seller; or

(2) if there is substantial evidence that the value of the land is not the cost of the land to the seller, by subtracting from the sales price the value of the land as determined by an independent appraisal acceptable to the department, but in no case may the appraised value of the land exceed the difference between the sale price of the real property and the total cost of the improvements constructed on the real property.

B. The cost of the land to the seller is determined by the original cost of the land to the seller plus any amounts attributable to the land being sold, paid by the seller for offsite improvements such as paving.

[~~C. Example 1: Q, a developer, purchased a quarter section (160 acres) of land for $16,000. Q then subdivides this parcel into 160 lots and installs streets, utility lines and sidewalks at a cost of $64,000. Q deeds all these offsite improvements to the city and begins to build houses. Q sells a house to H for $30,000. Q can deduct the cost of the land, $100 per lot in initial cost plus $400 per lot in offsite improvements, or $500, from the sale price of the house to determine the gross receipts. The value of the land deeded to the city may be added pro rata to the cost of the lots. In this case, Q would have gross receipts of $29,500. However, since the offsite improvements are deeded to the city and not resold, Q cannot purchase materials or construction services (Sections 7-9-51 and 7-9-52 NMSA 1978) for these offsite improvements under a nontaxable transaction certificate (ntte). If Q makes such a purchase and delivers an ntte, Q will be liable for the compensating tax.~~]

[~~D. Example 2~~] C. Example 1: X, a construction company, purchases a lot in 1969 for $1,000. X builds a house on this lot in 1971. X then sells this real property to Y for $20,000. On the basis of an F.H.A. appraisal the value of the land is $5,000; however, the total cost of the improvements constructed on the lot is $18,000. X would be liable for gross receipts tax on $18,000. The F.H.A. appraisal, assuming acceptance by the department, is substantial evidence of an increase in the value of the land, but the appraisal value of the land cannot exceed the difference between the sale price of the real property and the total cost of the improvements constructed on the real property.

[~~E. Example 3~~] D. Example 2: X, a construction company, purchases a lot. In order to prepare the lot as a building site, X levels and excavates a portion of the real property. The receipts of X from the sale of real property which are attributable to improvements such as leveling and excavating the lot in preparation of a building site may not be deducted from gross receipts pursuant to Section 7-9-53 NMSA 1978.

[~~F. Example 4~~] E. Example 3: X, a construction company, purchases a lot, makes certain improvements, and then sells the lot in the ordinary course of business. The receipts of X from improvements on real property owned and sold by it in the ordinary course of business do not include amounts retained by financial institutions which loaned the purchase price directly to the purchaser as prepaid finance charges or discounts, if these amounts are not received by the real estate vendor. It is immaterial whether or not such amounts are included in the quoted real estate price. The receipts of X do include all amounts actually paid over to it which are attributable to improvements constructed on real property sold by X in the ordinary course of business. The receipts of such a business also include any amounts deducted by title insurance companies to cover title insurance, legal fees, escrow fees, real estate brokerage commissions, real estate taxes, principal and interest on construction loans, liens and the like.

[12/5/69, 3/9/72, 11/20/72, 3/20/74,

7/26/76, 6/18/79, 4/7/82, 5/4/84, 4/2/86, 11/26/90, 11/15/96; 3.2.211.9 NMAC - Rn, 3 NMAC 2.53.9 & A, 5/31/01; A, XXX]

3.1.11.19 **PENALTY FOR FAILURE TO CORRECTLY REPORT DEDUCTION AMOUNT:**

A. A taxpayer who takes the benefit of the deduction provided by either Section 7-9-92 or 7-9-93 NMSA 1978 and fails to correctly report an amount deductible under those sections is subject to the penalty provided by Section 7-1-71.2. NMSA 1972.

B. A taxpayer fails to correctly report the amount of a deduction provided by Section 7-9-92 or 7-9-93 NMSA 1978 when the taxpayer:

(1) excludes from both reported gross receipts and reported deductions an amount deductible under those sections and not otherwise exempt;

(2) example 1: a "big box" store has sales of $200,000. $10,000 is from sales of food in exchange for food stamps and $20,000 is from other sales of food; the taxpayer reports gross receipts of $170,000 and zero deductions and pays the appropriate tax on the $170,000; although the $10,000 in food stamp sales is exempt under Section 7-9-18.1 NMSA 1978, the other $20,000 in food sales is not; those sales are deductible under Section 7-9-92 NMSA 1978 and must be reported as gross receipts and then deducted properly; the penalty under Section 7-1-71.2 NMSA 1978 applies to the under-reported $20,000;

(3) does not report an amount deductible under those sections separately from other deductions in accordance with instructions of the secretary

(4) example 2: an osteopath has $25,000 in receipts; the osteopath sold under contract $5,000 worth of services to a hospital for re-sale to a patient and has accepted a type 5 nontaxable transaction certificate in connection with those services; the $5,000 is deductible under Section 7-9-48 NMSA 1978; the remaining $20,000 in services are also deductible, but under Section 7-9-93 NMSA 1978; the osteopath reports, contrary to the instructions of the secretary, on a single line $25,000 in gross receipts and $25,000 in deductions; the penalty under Section 7-1-71.2 NMSA 1978 applies to this $20,000 under-reporting of the deductions subject to Section 7-9-93 NMSA 1978;

(5) reports an amount as a deduction under those sections when the amount should be reported as an exemption or deduction under another section of the Gross Receipts and Compensating Tax Act;

(a) example 3: a grocer sells qualifying food items to a food stamp recipient in exchange for food stamps; the grocer deducts the value of the food stamps received under Section 7-9-92 NMSA 1978; the sale of food items purchased with food stamps is exempt under Section 7-9-18.1 NMSA 1978; the taxpayer has over-reported deductions under Section 7-9-92 NMSA 1978 and the penalty under Section 7-1-71.2 NMSA 1978 applies to the amount of the over-reporting;

(b) example 4: a physician receives payment from a medicare administrator for health care services provided to a medicare enrollee; the physician deducts the payment from gross receipts under Section 7-9-93 NMSA 1978; medicare payments to physicians are deductible under Section 7-9-77.1 NMSA 1978; the physician has over-reported the deduction under Section 7-9-93 NMSA 1978 and the penalty under Section 7-1-71.2 NMSA 1978 applies to the over-reporting;

(6) reports as a deduction under those sections an amount in excess of that permitted by those sections.

C. The penalty provided by Section 7-1-71.2 NMSA 1978 is in addition to other penalties provided by the Tax Administration Act.

D. Because not claiming a deduction is not a failure to correctly report the amount of a deduction, the penalty will not apply if the taxpayer is entitled to, but does not claim, a deduction under Section 7-9-92 or 7-9-93 NMSA 1978.

E. If a return subject to the penalty provided by Section 7-1-71.2 NMSA 1978 is amended one or more times on or before the due date of the return, and the food and/or medical deductions provided under 7-9-92 and/or 7-9-93 NMSA 1978 are reported correctly on the last timely amended return, no local option penalty shall be assessed.

F. Example: Grocery store B has total gross receipts of $160,000. B files a timely CRS-1 return reporting regular gross receipts of $60,000 and deductions allowed under other sections of the Gross Receipts and Compensating Tax Act of $10,000 on line one and gross receipts and food deductions pursuant to Section 7-9-92 NMSA 1978, of $100,000 using the special code "F" on line two. Before the due date of the return, B discovers that food stamp sales of $40,000 were included on line 2 as a food deduction and files an amended report changing line two to reflect the correct gross receipts and food deductions of $60,000. B is assessed no penalty.

G. If a return subject to the penalty provided by Section 7-1-71.2 NMSA 1978 is amended more than once, and all subsequently filed amended returns for that reporting period are received after the due date of the return, the maximum local option penalty shall be the penalty that would result from comparing the food and/or medical deductions reported pursuant to Sections 7-9-92 and/or 7-9-93 NMSA 1978 on the timely filed return to the food and/or medical deductions reported on the most recent amended return for that reporting period.

(1) Example: Grocery store G has total gross receipts of $100,000. G submits a timely CRS-1 return showing $100,000 in gross receipts and $40,000 in deductions on line one. Line two is left blank.

(2) After the due date of the return, G amends the return to report $70,000 in gross receipts and $10,000 in deductions on line one, and $30,000 in gross receipts and deductions on line two. An "F" in column B of line two identifies line two as food sales deductible under 7-9-92 NMSA 1978.

(3) G submits a second amended report in which line two is adjusted to report $20,000 in deductible food sales. G will be assessed the local option penalty on the difference between the food deduction on the most recent amended return ($20,000) and the first timely filed return ($0). Since no food deduction was reported on the first filed-timely return, the penalty is calculated on the difference of $20,000 multiplied by twice the applicable local option gross receipts tax rate.

H. If a return subject to the penalty provided by Section 7-1-71.2 NMSA 1978 is amended both before and after the due date of the return, the maximum local option penalty for that reporting period shall be the penalty that would result from a comparing the last timely filed amended return for that reporting period postmarked on or before the due date of the return and the most recent amended return for that reporting period.

I. Example: C is a medical practitioner. C files a timely CRS-1 return showing $100,000 in total gross receipts and $60,000 in deductions on line 1. Line 2 is blank. Before the due date of the return, C files an amended return showing $100,000 in gross receipts and no deductions on line 1. Sixty thousand dollars in gross receipts deductible under 7-9-93, identified by an "M" in column B, are reported on line 2. After the due date of the return, C amends a second time. On the second amended return, C reports $70,000 in gross receipts and $30,000 in deductions on line 1 and $30,000 in gross receipts deductible under 7-9-93 on line 2. C's penalty for misreporting will be calculated on the $30,000 difference between the "M" deduction reported on the most recent amended report received before the due date of the return ($60,000) and the "M" deduction reported on the last amended report received after the due date of the return

($30,000) multiplied by twice the applicable local option gross receipts tax rate.

J. If an extension pursuant to Section 7-1-13 NMSA 1978 has been granted, for purposes of calculating the local option penalty under Section 7-9-71.1 NMSA 1978, the due date of the return is the last date of the extension period. No extension shall prevent the accrual of interest as otherwise provided by law.

[3.1.11.19 NMAC - N, 1/31/05; A, XXX]

3.2.210.11 ~~[**"FORCE ACCOUNT WORK":**~~

~~A. Receipts from selling construction services which are termed in the construction business "force account work" may be deducted from gross receipts if the sale is made to a person engaged in the construction business who delivers a nontaxable transaction certificate to the seller and who uses that construction service on a construction project, the sale of which is subject to the gross receipts tax.~~

~~B. Receipts from the rental of the equipment alone or with operators, even though termed "force account work", are not receipts from selling construction services and may not be deducted from gross receipts.~~] [RESERVED]

[3/9/72, 3/20/74, 7/26/76, 6/18/79, 4/7/82, 5/4/84, 4/2/86, 11/26/90, 11/15/96; 3.2.210.11 NMAC - Rn, 3 NMAC 2.52.11, 5/31/01; Repealed, XXX]

End of Notices and Proposed Rules Section

Adopted Rules

NEW MEXICO ENERGY, MINERALS AND NATURAL RESOURCES DEPARTMENT

OIL CONSERVATION DIVISION

Energy, Minerals and Natural Resources Department, Oil Conservation Division is repealing 19.15.14 NMAC, Procedure (filed 8-14-2003) and replacing it with 19.15.14 NMAC, Procedure, effective on 9/30/2005.

NEW MEXICO ENERGY, MINERALS AND NATURAL RESOURCES DEPARTMENT

OIL CONSERVATION DIVISION

TITLE 19 NATURAL RESOURCES AND WILDLIFE
CHAPTER 15 OIL AND GAS
PART 14 PROCEDURE

19.15.14.1 ISSUING AGENCY: Energy, Minerals and Natural Resources Department, Oil Conservation Division, 1220 S. St. Francis Drive, Santa Fe, New Mexico 87505, (505) 476-3440.
[19.15.14.1 NMAC - Rp, 19.15.14.1 NMAC, 09/30/05]

19.15.14.2 SCOPE: All rulemaking hearings before the oil conservation commission or adjudicatory hearings before the oil conservation commission (commission) or oil conservation division (division).
[19.15.14.2 NMAC - Rp, 19.15.14.2 NMAC, 09/30/05]

19.15.14.3 STATUTORY AUTHORITY: NMSA 1978, Sections 70-2-1 through 70-2-38 set forth the Oil and Gas Act, which grants the division jurisdiction and authority over all matters relating to the conservation of oil and gas, the prevention of waste of oil and gas and of potash as a result of oil and gas operations, the protection of correlative rights and the disposition of wastes resulting from oil and gas operations, and grants the commission concurrent jurisdiction and authority with the division to the extent necessary for the commission to perform its duties.
[19.15.14.3 NMAC - Rp, 19.15.14.3 NMAC, 09/30/05]

19.15.14.4 DURATION: Permanent.
[19.15.14.4 NMAC - Rp, 19.15.14.4 NMAC, 09/30/05]

19.15.14.5 EFFECTIVE DATE: September 30, 2005, unless a later date is cited at the end of a section.
[19.15.14.5 NMAC - Rp, 19.15.14.5 NMAC, 09/30/05]

19.15.14.6 OBJECTIVE: This part's objective is to set forth general provisions and definitions pertaining to the division's and the commission's authority pursuant to the Oil and Gas Act, NMSA 1978, Sections 70-2-1 through 70-2-38, by encouraging participation in the division's and commission's hearings, making possible effective presentation of the evidence and the parties' and the general public's points of view, allowing all participants a reasonable opportunity to submit data, views and arguments and to assure that division and commission hearings are conducted in a fair and equitable manner.
[19.15.14.6 NMAC - Rp, 19.15.14.6 NMAC, 09/30/05]

19.15.14.7 - 1200 [RESERVED]

19.15.14.1201 RULEMAKING INITIATION:

A. The commission may commence a rulemaking proceeding by issuing an order initiating rulemaking. The division, any operator or producer or any other person may initiate a rulemaking proceeding by filing an application to adopt, amend or repeal a rule with the commission clerk. The application shall be in writing and applicants shall specifically identify the rule the applicant seeks for the commission to adopt, amend or repeal. The application or order initiating rulemaking shall include the following:

(1) a brief summary of the proposed rule change's intended effect;

(2) a proposed draft of the new rule or amendment;

(3) the applicant's name;

(4) the applicant's address, or the address of its attorney, including an e-mail address and fax number if available;

(5) a proposed legal notice for publication; and

(6) any other matter a commission order requires.

B. An applicant shall file six sets of the application for rulemaking with the commission clerk. The applicant shall file the application by delivering the application to the commission clerk in person, by mail or by facsimile, as long as the applicant mails or delivers six sets of the application to the commission clerk on the next business day.

C. Upon receiving an application for rule change the commission clerk shall file the application, and shall deliver a copy to all commissioners within 10 business days of the application's receipt. Unless the commission chairman or another commissioner indicates, within 10 business days following the commission clerk's delivery of the rule change application, that a hearing is not necessary or appropriate, the chairman shall schedule a hearing on the rule change application. If a commissioner indicates to the chairman, or if the chairman concludes, that a hearing is not necessary or appropriate because the application is repetitive or frivolous or for any other lawful reason, the commission shall determine within 60 days of the application's filing whether to hear the application, and if the commission decides to hear the application, the chairman shall schedule a hearing on the rule change application.

D. 19.15.14.1201 NMAC shall not apply to special pool rules, which the commission or the division may adopt, amend or rescind in adjudicatory proceedings subject to 19.15.14.1207 and 1210 NMAC's notice provisions.
[19.15.14.1201 NMAC - Rp, 19.15.14.1201 NMAC, 09/30/05]

19.15.14.1202 RULEMAKING NOTICE:

A. The division shall publish notice of any proposed rulemaking set for the hearing in the name of the "State of New Mexico", signed by the division director and bearing the commission's seal. The notice shall state the hearing's date, time and place and the date by which those commenting shall submit their written comments to the commission clerk. The notice shall be published as follows:

(1) one time in a newspaper of general circulation in the counties that the proposed rule change affects, or if the proposed rule change will have statewide effect, in a newspaper of general circulation in the state, no less than 20 days prior to the scheduled hearing date;

(2) on the applicable docket for the commission hearing at which the commission will hear the matter, which the commission clerk shall send by regular or electronic mail not less than 20 days prior to the hearing to all who have requested such notice;

(3) one time in the New Mexico register, with the publication date not less than 10 business days prior to the scheduled hearing date; and

(4) by posting on the division's website not less than 20 days prior to the scheduled hearing date.

B. In cases of emergency, the division director may shorten these time limits by written order.

[19.15.14.1202 NMAC - Rp, 19.15.14.1201 &1205 NMAC, 09/30/05]

19.15.14.1203 COMMENTS ON RULEMAKING: Any person may submit written, electronic or facsimile comments on a proposed rule change, and those comments shall be made part of the hearing record. Individuals or entities shall provide written comments on the proposed rule change to the commission clerk not later than five business days before the scheduled hearing date, unless the division director or the commission extends the time for filing comments. The division director or the commission may extend the time for filing written, electronic or facsimile comments by making an announcement at the hearing, or by posting notice on the division's website. Any person may review written, electronic or facsimile comments on a proposed rule change at the division's Santa Fe office. The division shall post copies of written, electronic or facsimile comments that individuals or entities have filed with the commission clerk on the division's website as soon as practicable after they are filed.

[19.15.14.1203 NMAC - N, 09/30/05]

19.15.14.1204 RULEMAKING HEARING PARTICIPATION:

A. Non-technical testimony.

(1) Any person may testify or make an un-sworn statement at the rulemaking hearing. A person does not need to file prior notification with the commission clerk to present non-technical testimony at the hearing,

(2) Any person may also offer exhibits in connection with his testimony, so long as the exhibits are relevant to the proposed rule change and do not unduly repeat the testimony. A person offering exhibits shall file any exhibits prior to the scheduled hearing date or submit them at the hearing. A person offering exhibits shall provide six sets of each exhibit for the commission, copies for each of those individuals or entities that have filed an intent to present technical testimony or cross-examine witnesses at the hearing and five additional copies for others who may attend the hearing.

(3) Members of the general public who wish to present non-technical testimony should indicate their intent on a sign-in sheet at the hearing.

B. Technical testimony.

(1) Any person, including the division, who intends to present technical testimony or cross-examine witnesses at the hearing shall, no later than five business days before the scheduled hearing date, file six sets of a pre-hearing statement with the commission clerk. Corporations, partnerships, governmental agencies, political subdivisions, unincorporated associations and other collective entities may appear only through an attorney or through a duly authorized officer or member.

(2) The pre-hearing statement shall include the person or entity's name and its attorney's name; the names of all witnesses the person or entity will call to testify at the hearing; a concise statement of each witnesses' testimony; all technical witnesses' qualifications including a description of the witnesses' education and experience; and the approximate time the person or entity will need to present its testimony. The person or entity shall attach to the pre-hearing statement any exhibits it plans to offer as evidence at the hearing. A corporation or other entity not represented by an attorney shall identify in its pre-hearing statement the person who will conduct its presentation and shall attach a sworn and notarized statement from the corporation's or entity's governing body or chief executive officer attesting that it authorizes that person to represent the corporation or entity.

(3) The commission may exclude any expert witnesses or technical exhibits not identified in or attached to the pre-hearing statement unless the testimony or exhibit is offered solely for rebuttal or the person or entity offering the testimony or exhibits demonstrates good cause for omitting the witness or exhibit from its pre-hearing statement.

(4) The division shall post copies of pre-hearing statements filed with the commission clerk on the division's website as soon as practicable after they are filed. Any person may review pre-hearing statements filed with the commission clerk at the division's Santa Fe office.

C. Modifications to proposed rule changes.

(1) Any person, other than the applicant or a commissioner, recommending modifications to a proposed rule change shall, no later than 10 business days prior to the scheduled hearing date, file a notice of recommended modifications with the commission clerk.

(2) The notice shall include:

(a) the text of the recommended modifications to the proposed rule change;

(b) an explanation of the recommended modification's impact; and

(c) reasons for adopting the modification.

[19.15.14.1204 NMAC - Rp, 19.15.14.1208 & 1212 NMAC, 09/30/05]

19.15.14.1205 RULEMAKING HEARINGS:

A. Conduct of hearings.

(1) The rules of civil procedure and the rules of evidence shall not apply.

(2) The commission shall conduct the hearing so as to provide a reasonable opportunity for all persons to be heard without making the hearing unreasonably lengthy or cumbersome and without unnecessary repetition. The hearing shall proceed as follows:

(a) the hearing shall begin with a statement from the commission chairman identifying the hearing's nature and subject matter and explaining the procedures to be followed;

(b) the commission may allow any person to make a brief opening statement;

(c) unless otherwise ordered, the applicant, or in the case of commission initiated rulemaking, commission or division staff, shall present its case first;

(d) the commission chairman shall establish an order for other participants' testimony based upon notices of intent to present technical testimony, sign-in sheets, the availability of witnesses who cannot be present for the entire hearing and any other appropriate factor;

(e) the commission may allow any person to make a brief closing statement;

(f) if the hearing continues for more than one day, the commission shall provide an opportunity each day for public comment;

(g) at the close of the hearing, the commission shall determine whether to keep the record open for written submittals including arguments and proposed statements of reasons supporting the proposed commission decision. In considering whether the record will remain open, the commission shall consider the reasons why the material was not presented during the hearing, the significance of material to be submitted and the necessity for a prompt decision; if the commission keeps the record open, the commission chairman shall announce at the hearing's conclusion the subjects on which the commission will allow submittals and the deadline for filing the submittals; and

(h) if the hearing is not completed on the day that it commences, the commission may, by announcement, continue the hearing as necessary without further notice.

B. Testimony and cross-examination.

(1) The commission shall take all testimony under oath or affirmation, which may be accomplished en masse or individually. However, any person may make an unsworn position statement.

(2) The commission shall admit any relevant evidence, unless the commission determines that the evidence is incompetent or unduly repetitious.

(3) Any person who testifies at the hearing is subject to cross-examination by any person who has filed a pre-hearing statement on the subject matter of his direct testimony. Any person who presents technical testimony may also be cross-examined on matters related to his background and qualifications. The commission may limit cross-examination to avoid harassment, intimidation, needless expenditure of time or undue repetition.

C. Exhibits.

(1) Any person offering an exhibit shall provide six sets of the exhibit for the commission, copies for each of those individuals or entities that have filed an intent to present technical testimony or cross-examine witnesses at the hearing and five additional copies for others who may attend the hearing.

(2) All exhibits offered at the hearing shall be marked with a designation identifying the person offering the exhibit and shall be numbered sequentially.

D. Transcript of proceeding.

(1) A verbatim record shall be made of the hearing.

(2) Any person may obtain a copy of the hearing transcript. The person requesting the copy shall pay for the cost of the copy of the hearing transcript.

E. Deliberation and decision.

(1) If a quorum of the commission attended the hearing, and if the hearing agenda indicates that a decision might be made at the hearing's conclusion, the commission may immediately deliberate and make a decision in open session on the proposed rule change based on a motion that includes reasons for the decision.

(2) If, during the course of deliberations, the commission determines that additional testimony or documentary evidence is necessary for a proper decision on the proposed rule change, the commission may reopen the hearing for additional evidence after notice pursuant to 19.15.14.1202 NMAC.

(3) The commission shall issue a written order adopting or refusing to adopt the proposed rule change, or adopting the proposed rule change in part, and shall include in the order the reasons for the action taken.

(4) Upon the commission's issuance of the order, the commission clerk shall post the order on the division's website and mail or e-mail a copy of the order to each person who presented non-technical testimony at the hearing or who filed a pre-hearing statement, or the person's attorney.

F. Filing. The division shall file with the state records center and archives and publish any rule the commission adopts, amends or repeals consistent with the State Rules Act.

[19.15.14.1205 NMAC - Rp, 19.15.14.1212 NMAC, 09/30/05]

19.15.14.1206 INITIATING AN ADJUDICATORY HEARING:

A. The division, attorney general, any operator or producer or any other person with standing may file an application with the division for an adjudicatory hearing. The division director, upon receiving a division examiner's recommendation, may dismiss an application for an adjudicatory proceeding upon a showing that the applicant does not have standing. The person applying for the hearing or an attorney representing that person shall sign the application requesting an adjudicatory hearing. The application shall include:

(1) the applicant's name;

(2) the applicant's address, or the address of the applicant's attorney, including an e-mail address and fax number if available;

(3) the name or general description of the common source or sources of supply or the area the order sought affects;

(4) briefly, the general nature of the order sought;

(5) a proposed legal notice for publication; and

(6) any other matter these rules or a division order require.

B. Applicants for adjudicatory hearings shall file written applications with the division clerk at least 30 days before the application's scheduled hearing date.

[19.15.14.1206 NMAC - Rp, 19.15.14.1203 NMAC, 09/30/05]

19.15.14.1207 ADJUDICATORY HEARING NOTICE:

A. The division shall publish notice of any adjudicatory hearing in the name of the "State of New Mexico", signed by the division director and bearing the commission's seal, stating:

(1) the adjudicatory hearing's time and place;

(2) whether the case is set for hearing before the commission or a division examiner;

(3) the applicant's name and address, or address of the applicant's attorney, including an e-mail address and fax number if available;

(4) a case name and number;

(5) a brief description of the hearing's purpose;

(6) a reasonable identification of the adjudication's subject matter that alerts persons who may be affected if the division grants the application;

(7) if the application seeks to adopt, revoke or amend special pool rules; establish or alter a non-standard unit; permit an unorthodox location or establish or affect any well's or proration unit's allowable, the notice shall specify each pool or common source of supply that the division or commission's granting the application may affect; and

(8) if the application seeks compulsory pooling or statutory unitization, the notice shall contain a legal description of the spacing unit or geographical area the applicant seeks to pool or unitize.

B. The division shall publish notice of each adjudicatory hearing before the commission or a division examiner at least 20 days before the hearing by:

(1) posting notice on the division's website;

(2) delivering notice by ordinary first class United States mail or electronic mail to each person who has requested in writing to be notified of such hearings; and

(3) if before the commission, publishing notice in a newspaper of general circulation in the counties the application affects, or if the application's effect will be statewide, in a newspaper of general circulation in the state.

[19.15.14.1207 NMAC - Rp, 19.15.14.1204 & 1205 NMAC, 09/30/05]

19.15.14.1208 PARTIES TO ADJUDICATORY PROCEEDINGS:

A. The parties to an adjudicatory proceeding shall include:

(1) the applicant;

(2) any person to whom statute, rule or order requires notice (not including those persons to whom 19.15.14.1207 NMAC requires distribution of hearing notices, who are not otherwise entitled to notice of the particular application), who has entered an appearance in the case; and

(3) any person who properly intervenes in the case.

B. A person entitled to notice may enter an appearance at any time by filing a written notice of appearance with the division or the commission clerk, as applicable, or, subject to the provisions in Subsection C of 19.15.4.1208 NMAC below, by oral appearance on the record at the hearing.

C. A party who has not entered an appearance at least one business day prior to the pre-hearing statement filing date provided in Paragraph (1) of Subsection B of 19.15.14.1211 NMAC shall not be allowed to present technical evidence at the hearing unless the commission chairman or the division examiner, for good cause, otherwise directs.

D. A party shall be entitled to a continuance of any hearing if it did not receive notice of the hearing at least three

business days prior to the date for filing a timely appearance as these rules provide.
[19.15.14.1208 NMAC - Rp, 19.15.14.1203 NMAC, 09/30/05]

19.15.14.1209 ADJUDICATORY PROCEEDING INTERVENTION:

A. Any person with standing with respect to the case's subject matter may intervene by filing a written notice of intervention with the division or commission clerk, as applicable, at least one business day before the date for filing a pre-hearing statement. Notice of intervention shall include:

(1) the intervenor's name;

(2) the intervenor's address, or the address of the intervenor's attorney, including an e-mail address and fax number if available;

(3) the nature of intervenor's interest in the application; and

(4) the extent to which the intervenor opposes issuance of the order applicant seeks.

B. The division examiner or commission chairman may, at their discretion, allow late intervenors to participate if the intervenor files a written notice on or after the date provided in Subsection A of 19.15.14.1206 NMAC, or by oral appearance on the record at the hearing.

C. The division examiner or the commission chairman may strike a notice of intervention on a party's motion if the intervenor fails to show that the intervenor has standing, unless the intervenor shows that intervenor's participation will contribute substantially to the prevention of waste, protection of correlative rights or protection of public health or the environment.
[19.15.14.1209 NMAC - N, 09/30/05]

19.15.14.1210 NOTICE REQUIREMENTS FOR SPECIFIC ADJUDICATIONS:

A. Applicants for the following adjudicatory hearings before the division or commission shall give notice, in addition to that 19.15.14.1207 NMAC requires, as set forth below:

(1) Compulsory pooling and statutory unitization.

(a) The applicant shall give notice to any owner of an interest in the mineral estate of any portion of the lands the applicant proposes to be pooled or unitized whose interest is evidenced by a written conveyance document either of record or known to the applicant at the time the applicant filed the application and whose interest has not been voluntarily committed to the area proposed to be pooled or unitized (other than a royalty interest subject to a pooling or unitization clause).

(b) When the applicant has given notice as required in Subparagraph (a) of Paragraph (1) of Subjection A of 19.15.14.1207 NMAC, of a compulsory pooling application, the proposed unit is not larger in size than provided in 19.15.3.104 NMAC or applicable special pool orders, and those owners the applicant has located do not oppose the application, the applicant may file under the following alternative procedure. The application shall include the following:

(i) a statement that the applicant expects no opposition including the reasons why;

(ii) a map outlining the spacing unit to be pooled, showing the ownership of each separate tract in the proposed unit and the proposed well's location;

(iii) the names and last known addresses of the interest owners to be pooled and the nature and percent of their interests and an attestation that the applicant has conducted a diligent search of all public records in the county where the well is located and of phone directories, including computer searches;

(iv) the names of the formations and pools to be pooled;

(v) a statement as to whether the pooled unit is for gas or oil production or both;

(vi) written evidence of attempts the applicant made to gain voluntary agreement including but not limited to copies of relevant correspondence;

(vii) proposed overhead charges (combined fixed rates) to be applied during drilling and production operations along with the basis for such charges;

(viii) the location and proposed depth of the well to be drilled on the pooled units; and

(ix) a copy of the authorization for expenditure (AFE) the applicant, if appointed operator, will submit to the well's interest owners.

(c) Applicants shall provide with all submittals sworn and notarized statements by those persons who prepared submittals, attesting that the information is correct and complete to the best of their knowledge and belief.

(d) The division shall set all unopposed pooling applications for hearing. If the division finds the application complete, the information submitted with the application will constitute the record in the case, and the division shall issue an order based on the record.

(e) At any interested person's request or upon the division's own initiative, the division shall set any pooling application for full hearing with oral testimony by the applicant.

(2) Unorthodox well locations.

(a) "Affected persons" are the following persons owning interests in the adjoining spacing units:

(i) the division-designated operator;

(ii) in the absence of an operator, any lessee whose interest is evidenced by a written conveyance document either of record or known to the applicant as of the date he files the application; and

(iii) in the absence of an operator or lessee, any mineral interest owner whose interest is evidenced by a written conveyance document either of record or known to the applicant as of the date he filed the application.

(b) In the event the proposed unorthodox well's operator is also the operator of an existing, adjoining spacing unit, and ownership is not common between the adjoining spacing unit and the spacing unit containing the proposed unorthodox well, then "affected persons" include all working interest owners in that spacing unit.

(c) If the proposed location is unorthodox by being located closer to the spacing unit's outer boundary than 19.15.3.104 NMAC or applicable special pool rules permit, the applicant shall notify the affected persons in the adjoining spacing units towards which the unorthodox location encroaches.

(d) If the proposed location is unorthodox by being located in a different quarter-quarter section or quarter section than special pool orders provide, the applicant shall notify all affected persons.

(3) Non-standard proration unit. The applicant shall notify all owners of interest in the mineral estate to be excluded from the proration unit in the quarter-quarter section (for 40-acre pools or formations), the one-half quarter section (for 80-acre pools or formations), the quarter section (for 160-acre pools for formations), the half section (for 320-acre pools or formations) or section (for 640-acre pools or formations) in which the non-standard unit is located and to such other persons as the division requires.

(4) Special pool orders regulating or affecting a specific pool.

(a) Except for non-standard proration unit applications, if the application involves changing the amount of acreage to be dedicated to a well, the applicant shall notify:

(i) all division-designated operators in the pool; and

(ii) all owners of interests in the mineral estate in existing spacing units with producing wells.

(b) If the application involves other matters, the applicant shall notify:

(i) all division-designated operators in the pool; and

(ii) all division-designated operators of wells within the same formation as the pool and within one mile of

the pool's outer boundary that have not been assigned to another pool.

(5) Special orders regarding any division-designated potash area. The applicant shall notify all potash lessees, oil and gas operators, oil and gas lessees and unleased mineral interest owners within the designated potash area.

(6) Downhole commingling. The applicant shall notify all owners of interests in the mineral estate in the spacing unit if ownership is not common for all commingled zones within the spacing unit.

(7) Surface disposal of produced water or other fluids. The applicant shall notify any surface owner within one-half mile of the site.

(8) Surface commingling. The applicant shall give notice as 19.15.5.303 NMAC prescribes.

(9) Adjudications not listed above. The applicant shall give notice as the division requires.

B. Type and content of notice. The applicant shall send any notice 19.15.14.1207 NMAC requires by certified mail, return receipt requested, to the last known address of the person to whom notice is to be given at least 20 days prior to the application's scheduled hearing date and shall include a copy of the application; the hearing's date, time and place and the means by which protests may be made. When an applicant has been unable to locate all persons entitled to notice after exercising reasonable diligence, the applicant shall provide notice by publication, and submit proof of publication at the hearing. Such proof shall consist of a copy of a legal advertisement that was published at least 10 business days before the hearing in a newspaper of general circulation in the county or counties in which the property is located, or if the application's effect is statewide, in a newspaper of general circulation in this state, together with the newspaper's affidavit of publication.

C. At the hearing, the applicant shall make a record, either by testimony of affidavit, that the applicant or its authorized representative has signed, that:

(1) the applicant has complied with notice provisions of 19.15.14.1207 NMAC;

(2) the applicant has conducted a good-faith diligent effort to find the correct addresses of all persons entitled to notice; and

(3) the applicant has given notice at that correct address as 19.15.14.1207 NMAC requires. In addition, the record shall contain the name and address of each person to whom notice was sent and, where proof of receipt is available, a copy of the proof.

D. Evidence of failure to provide notice as 19.15.14.1207 NMAC requires may, upon proper showing, be considered cause for reopening the case.

E. In the case of an administrative application where the required notice was sent and a timely filed protest was made, the division shall notify the applicant and the protesting party in writing that the case has been set for hearing and the hearing's date, time and place. No further notice is required.

[19.15.14.1210 NMAC - Rp, 19.15.14.1207 NMAC, 09/30/05]

19.15.14.1211 PLEADINGS, COPIES, PRE-HEARING STATEMENTS, EXHIBITS AND MOTIONS FOR CONTINUANCE:

A. Pleadings. Applicants shall file two sets of pleadings and correspondence in cases pending before a division examiner with the division clerk and six sets of pleadings and correspondence in cases pending before the commission with the commission clerk. For cases pending before the commission, the commission clerk shall disseminate copies of pleadings and correspondence to the commission members. The party filing the pleading or correspondence shall at the same time serve a copy of the pleading or correspondence upon each party who has entered an appearance in the case on or prior to the business day immediately preceding the date when the party files the pleading or correspondence with the division or the commission clerk, as applicable. Parties shall accomplish service by hand delivery or transmission by facsimile or electronic mail to any party who has entered an appearance or, if the party is represented, the party's attorney of record. Service upon a party who has not filed a pleading containing a facsimile number or e-mail address may be made by ordinary first class mail. Parties shall be deemed to have made an appearance when they have either sent a letter regarding the case to the division or commission clerk or made an in person appearance at any hearing before the commission or before a division examiner. A written appearance, however, shall not be complete until the appearing party has provided notice to other parties of record. Any initial pleading or written entry of appearance a party other than the applicant files shall include the party's address or the address of the party's attorney and an e-mail and facsimile number if available.

B. Pre-hearing statements.

(1) Any party to an adjudicatory proceeding who intends to present evidence at the hearing shall file a pre-hearing statement, and serve copies on other parties or, for parties that are represented, their attorneys in the manner Subsection A of 19.15.14.1211 NMAC provides, at least four business days in advance of a scheduled hearing before the division or the commission, but in no event later than 5:00 pm mountain time, on the Thursday preceding the scheduled hearing date. The statement shall include:

(a) the names of the party and the party's attorney;

(b) a concise statement of the case;

(c) the names of witnesses the party will call to testify at the hearing, and in the case of expert witnesses, their fields of expertise;

(d) the approximate time the party will need to present its case; and

(e) identification of any procedural matters that are to be resolved prior to the hearing.

(2) Any party other than the applicant shall include in its pre-hearing statement a statement of the extent to which the party supports or opposes the issuance of the order the applicant seeks and the reasons for such support or opposition. In cases to be heard by the commission, each party shall include copies of all exhibits that it proposes to offer in evidence at the hearing with the pre-hearing statement. The commission may exclude witnesses the party did not identify in the pre-hearing statement, or exhibits the party did not file and serve with the pre-hearing statement, unless the party offers such evidence solely for rebuttal or makes a satisfactory showing of good cause for failure to disclose the witness or exhibit.

(3) A pre-hearing statement filed by a corporation or other entity not represented by an attorney shall identify the person who will conduct the party's presentation at the hearing and include a sworn and notarized statement attesting that the corporation's or entity's governing body or chief executive officer authorizes the person to present the corporation or entity in the matter.

(4) For cases pending before the commission, the commission clerk shall disseminate copies of pre-hearing statements and exhibits to the commission members.

C. Motions for continuance. Parties shall file and serve motions for continuance no later than 48 hours prior to time the hearing is set to begin, unless the reasons for requesting a continuance arise after the deadline, in which case the party shall file the motion as expeditiously as possible after becoming aware of the need for a continuance.

[19.15.14.1211 NMAC - Rp, 19.15.14.1208 NMAC, 09/30/05]

19.15.14.1212 CONDUCT OF ADJUDICATORY HEARINGS:

A. Testimony. Hearings before the commission or a division examiner shall be conducted without rigid formality. The division or commission shall take or have someone take a transcript of testimony and preserve the transcript as a part of the division's permanent records. Any person testifying shall do so under oath. The division examiner or commission shall designate whether or not an interested party's un-sworn comments and observations are relevant and, if relevant, include the comments and observations in the record.

B. Pre-filed testimony. The division director may order the parties to file prepared written testimony in advance of the hearing for cases pending before the commission. The witness shall be present at the hearing and shall adopt, under oath, the prepared written testimony, subject to cross-examination and motions to strike unless the witness' presence at hearing is waived upon notice to other parties and without their objection. The parties shall number pages of the prepared written testimony, which shall contain line numbers on the left-hand side.

C. Appearances pro se or through an attorney. Parties may appear and participate in hearings either pro se (on their own behalf) or through an attorney. Corporations, partnerships, governmental entities, political subdivisions, unincorporated associations and other collective entities may appear only through an attorney or through a duly authorized officer or member. Participation in adjudicatory hearings shall be limited to parties, as defined in 19.15.14.1208 NMAC, except that a representative of a federal, state or tribal governmental agency or political subdivision may make a statement on the agency's or political subdivision's behalf. The commission or division examiner shall have the discretion to allow any other person present at the hearing to make a relevant statement, but not to present evidence or cross-examine witnesses. Any person making a statement at an adjudicatory hearing shall be subject to cross-examination by the parties or their attorneys.

[19.15.14.1212 NMAC - Rp, 19.15.14.1210 NMAC, 09/30/05]

19.15.14.1213 CONTINUANCE OF AN ADJUDICATORY HEARING: Any adjudicatory hearing before the commission or a division examiner held after due notice may be continued by the person presiding at such hearing to a specified time and place without the necessity of notice of the same being served or published.

[19.15.14.1213 NMAC - Rp, 19.15.14.1209 NMAC, 09/30/05]

19.15.14.1214 POWER TO REQUIRE ATTENDANCE OF WITNESSES AND PRODUCTION OF EVIDENCE; PRE-HEARING PROCEDURE FOR ADJUDICATORY HEARINGS:

A. Subpoenas. The commission or its members and the division director or the division director's authorized representative have statutory power to subpoena witnesses and to require the production of books, papers, records, other tangible things or electronic data in any proceeding before the commission or division. The division director or the division director's authorized representative shall issue a subpoena for attendance at a hearing upon a party's written request. The division director or the division director's authorized representative shall, upon a party's request, issue a subpoena for production of books, papers, records, other tangible things or electronic data in advance of the hearing. The division director or the division examiner assigned to hear the case have discretion to consider pre-hearing motions, such as motions for protection or quashing of subpoenas, prior to the hearing pursuant to Subsection C of 19.15.14.1214 NMAC or to reserve such matters for consideration at a hearing on the merits. The commission and division director or the division director's authorized representative shall issue subpoenas for witness depositions in advance of the hearing only in extraordinary circumstances for good cause shown.

B. Pre-hearing conferences. The division examiner or the division director may hold a pre-hearing conference prior to the hearing on the merits in cases pending before the division or the commission, respectively, either upon a party's request or upon the division director or a division examiner giving notice. The pre-hearing conference's purpose shall be to narrow issues, eliminate or resolve other preliminary matters and encourage settlement. The division director or examiner may issue a pre-hearing order following the pre-hearing conference. The division director or division examiner shall either provide or ensure that written or oral notice of a pre-hearing conference is given to the applicant and to all other parties who, at the time such conference is scheduled, have filed appearances in the case.

C. Hearings on motions. The division director or any division examiner may rule on motions that are necessary or appropriate for disposition prior to a hearing on the merits. If the case is pending before the commission, the division director shall rule on any such motion; provided that the division director may refer any such motion for hearing by a division examiner specifically designated for the purpose, who, if the case is a de novo application, shall not have participated in the case prior to the filing of the application for de novo hearing. Prior to ruling on any motion, the division director or division examiner shall give written or oral notice to each party who has filed an appearance in the case and who may have an interest in the motion's disposition (except a party who has indicated that it does not oppose the motion), and shall allow interested parties an opportunity, reasonable under the circumstances, to respond to the motion. The division director or division examiner may conduct a hearing on any motion, following written or oral notice to all interested parties, either at a pre-hearing conference or otherwise. If the commission or division receives oral testimony at any hearing, the commission or division examiner shall ensure that a record is made of the testimony as at other hearings.

[19.15.14.1214 NMAC - Rp, 19.15.14.1211 NMAC, 09/30/05]

19.15.14.1215 RULES OF EVIDENCE AND EXHIBITS FOR ADJUDICATORY HEARINGS:

A. Presentation of evidence. Subject to other provisions of 19.15.1214 NMAC, the commission or division examiner shall afford full opportunity to all parties at an adjudicatory hearing before the commission or division examiner to present evidence and to cross-examine witnesses. The rules of evidence applicable in a trial before a court without a jury shall not control, but division examiners and the commission may use such rules as guidance in conducting adjudicatory hearings. The commission or division examiner may admit any relevant evidence, unless it is immaterial, repetitious or otherwise unreliable. The commission or division examiner may take administrative notice of the authenticity of documents copied from the division's files.

B. Parties introducing exhibits at hearings before the commission or a division examiner shall provide a complete set of exhibits for the court reporter, each commissioner or division examiner and other parties of record.

C. A party requesting incorporation of records from a previous hearing at a commission hearing shall include copies of the record for all commissioners.

[19.15.14.1215 NMAC - Rp, 19.15.14.1212 NMAC, 09/30/05]

19.15.14.1216 DIVISION EXAMINER'S QUALIFICATIONS, APPOINTMENT AND REFERRAL OF CASES: The division director shall appoint as division examiners division staff who are licensed attorneys, or who have experience in hydrogeology, hydrology, geology, petroleum engineering, environmental engineering or a related field and a college degree in

geology, engineering, hydrology or related field. Nothing in this section shall prevent any commission member from serving as a division examiner. The division director may refer any matter or proceeding to a division examiner for hearing in accordance with these rules.
[19.15.14.1216 NMAC - Rp, 19.15.14.1213 & 1214 NMAC, 09/30/05]

19.15.14.1217 DIVISION EXAMINER'S POWER AND AUTHORITY: The division examiner to whom the division director refers any matter under these rules shall have full authority to hold hearings on such matter in accordance with these rules, subject only to such limitations as the division director may order in a particular case. The division examiner shall have the power to perform all acts and take all measures necessary and proper for the efficient and orderly conduct of such hearing, including administering oaths to witnesses, receiving testimony and exhibits offered in evidence and ruling upon such objections as may be interposed. The division examiner shall cause a complete record of the proceedings to be made and transcribed and shall certify same to the division director as hereinafter provided.
[19.15.14.1217 NMAC - Rp, 19.15.14.1215 NMAC, 09/30/05]

19.15.14.1218 ADJUDICATORY HEARINGS THAT SHALL BE HELD BEFORE THE COMMISSION: Notwithstanding any other provisions of these rules, the hearing on any matter shall be held before the commission if:

A. it is a hearing pursuant to NMSA 1978, Section 70-2-13; or

B. the division director directs the commission to hear the matter.
[19.15.14.1218 NMAC - Rp, 19.15.14.1216 NMAC, 09/30/05]

19.15.14.1219 REPORT AND RECOMMENDATIONS FROM DIVISION EXAMINER'S HEARING: Upon conclusion of any hearing before a division examiner, the division examiner shall promptly consider the proceedings in such hearing, and based upon the hearing's record prepare a written report with recommendations for the division's disposition of the matter or proceeding. The division examiner shall draft a proposed order and submit it to the division director with the certified record of the hearing.
[19.15.14.1219 NMAC - Rp, 19.15.14.1218 NMAC, 09/30/05]

19.15.14.1220 DISPOSITION OF CASES HEARD BY DIVISION EXAMINER: After receipt of the division examiner's report, the division director shall enter the division's order, which the division director may have modified from the division examiner's proposed order, disposing of the matter.
[19.15.14.1220 NMAC - Rp, 19.15.14.1219 NMAC, 09/30/05]

19.15.14.1221 HEARING BEFORE COMMISSION AND STAYS OF DIVISION ORDERS:

A. De novo applications. When the division enters an order pursuant to a hearing that a division examiner held, a party of record whom the order adversely affects has the right to have the matter heard de novo before the commission, provided that within 30 days from the date the division issues the order the party files a written application for de novo hearing with the commission clerk. If any party files an application for a de novo hearing, the commission chairman shall set the matter or proceeding for hearing before the commission.

B. Stays of division or commission orders. Any party requesting a stay of a division or commission order shall file a motion with the commission clerk and serve copies of the motion upon all other parties who appeared in the case, as Subsection A of 19.15.14.1208 NMAC provides. The party shall attach a proposed stay order to the motion. The division director may grant a stay pursuant to a motion for stay or upon his own initiative, after according all parties who have appeared in the case notice and an opportunity to respond, if the stay is necessary to prevent waste, protect correlative rights, protect public health or the environment or prevent gross negative consequences to any affected party. Any division director's order staying a commission order shall be effective only until the commission acts on the motion for stay.
[19.15.14.1221 NMAC - Rp, 19.15.14.1220 NMAC, 09/30/05]

19.15.14.1222 COPIES OF COMMISSION AND DIVISION ORDERS: Within 10 business days after the division or commission issues an order in an adjudicatory case, including any order granting or refusing rehearing or order following rehearing, the division or commission clerk shall mail a copy of such order to each party or its attorney of record. For purposes of 19.15.14.1222 NMAC only, the parties to a case are the applicant and each person who has entered an appearance in the case, in person or by attorney, either by filing a protest, pleading or notice of appearance with the commission clerk or by entering an appearance on the record at a hearing.
[19.15.14.1222 NMAC - Rp, 19.15.14.1221 NMAC, 09/30/05]

19.15.14.1223 REHEARINGS: Within 20 days after entry of any commission order any party of record whom the order adversely affects may file with the commission clerk an application for rehearing on any matter the order determined, setting forth the respect in which the party believes the order is erroneous. The commission shall grant or refuse any such application in whole or in part within 10 business days after the party files it, and the commission's failure to act on the application within such period shall be deemed a refusal and a final disposition of such application. In the event the commission grants the rehearing, the commission may enter a new order after rehearing as the circumstances may require.
[19.15.14.1223 NMAC - Rp, 19.15.14.1222 NMAC, 09/30/05]

19.15.14.1224 EX PARTE COMMUNICATIONS:

A. In an adjudicatory proceeding, except for filed pleadings, at no time after a party files an application for hearing shall any party, interested participant or his representative advocate any position with respect to the issues the application involves to any commissioner or the division examiner appointed to hear the case unless all other parties of record to the proceedings have an opportunity to be present.

B. The prohibition in Subsection A of 19.15.14.1224 NMAC, above, does not apply to those applications that the applicant believes are unopposed. However, in the event that a party files an objection in a case previously believed to be unopposed, the prohibition in Subsection A of 19.15.14.1224 NMAC, above, is immediately applicable.

C. This provision does not prohibit communications between the division's attorney or other division staff and the division director that are essential to management of a case.
[19.15.14.1224 NMAC - Rp, 19.15.14.1223 NMAC, 09/30/05]

19.15.14.1225 EMERGENCY ORDERS AND RULES:

A. Notwithstanding any other provision of 19.15.14 NMAC, in the event the division or commission finds an emergency exists that requires adoption of a rule or issuance of an order without a hearing, such emergency rule or order shall have the same validity as if the division or commission has held a hearing before the division or commission after due notice. Such emergency rule or order shall remain in force no longer than 15 days from its effective date.

B. Notwithstanding any other provision of 19.15.14 NMAC, if the division or commission finds an emergency exists, the division or commission may conduct a hearing on any application within less than 30 days after party files an application, and the division director may set the notice period at his discretion.

[19.15.14.1225 NMAC - Rp, 19.15.14.1202 NMAC, 09/30/05]

19.15.14.1226 COMPUTATION OF TIME: In computing a period of time this part prescribes, the day from which the period of time begins to run shall not be included. The last calendar day of the time period shall be included in the computation unless it is a Saturday, Sunday or a day on which state agencies observe a legal holiday. In such case, the period of time runs to the close of business on the next regular workday. If the period is less than 11 days, a Saturday, Sunday or legal holiday is excluded from the computation.

[19.15.14.1226 NMAC - N, 09/30/05]

NEW MEXICO ENERGY, MINERALS AND NATURAL RESOURCES DEPARTMENT

OIL CONSERVATION DIVISION

This is an amendment of 19.15.1 NMAC, Section 7. The amendment to Section 7 adds definitions for commission clerk and division clerk. This amendment is to be effective 09/30/05.

19.15.1.7 DEFINITIONS:

A. Definitions beginning with the letter "A".

(1) Abate or abatement shall mean the investigation, containment, removal or other mitigation of water pollution.

(2) Abatement plan shall mean a description of any operational, monitoring, contingency and closure requirements and conditions for the prevention, investigation and abatement of water pollution.

(3) Adjoining spacing units are those existing or prospective spacing units in the same pool(s) that are touching at a point or line the spacing unit that is the subject of the application.

(4) Adjusted allowable shall mean the allowable production a well or proration unit receives after all adjustments are made.

(5) Allocated pool is one in which the total oil or natural gas production is restricted and allocated to various wells therein in accordance with proration schedules.

(6) Allowable production shall mean that number of barrels of oil or standard cubic feet of natural gas authorized by the division to be produced from an allocated pool.

(7) Aquifer shall mean a geological formation, group of formations, or a part of a formation that is capable of yielding a significant amount of water to a well or spring.

B. Definitions beginning with the letter "B".

(1) Back allowable shall mean the authorization for production of any shortage or underproduction resulting from pipeline proration.

(2) Background shall mean, for purposes of ground-water abatement plans only, the amount of ground-water contaminants naturally occurring from undisturbed geologic sources or water contaminants occurring from a source other than the responsible person's facility. This definition shall not prevent the director from requiring abatement of commingled plumes of pollution, shall not prevent responsible persons from seeking contribution or other legal or equitable relief from other persons, and shall not preclude the director from exercising enforcement authority under any applicable statute, regulation or common law.

(3) Barrel shall mean 42 United States gallons measured at 60 degrees fahrenheit and atmospheric pressure at the sea level.

(4) Barrel of oil shall mean 42 United States gallons of oil, after deductions for the full amount of basic sediment, water and other impurities present, ascertained by centrifugal or other recognized and customary test.

(5) Below-grade tank shall mean a vessel, excluding sumps and pressurized pipeline drip traps, where any portion of the sidewalls of the tank is below the surface of the ground and not visible.

(6) Berm shall mean an embankment or ridge constructed for the purpose of preventing the movement of liquids, sludge, solids, or other materials.

(7) Bottom hole or subsurface pressure shall mean the gauge pressure in pounds per square inch under conditions existing at or near the producing horizon.

(8) Bradenhead gas well shall mean any well producing gas through wellhead connections from a gas reservoir which has been successfully cased off from an underlying oil or gas reservoir.

C. Definitions beginning with the letter "C".

(1) Carbon dioxide gas shall mean noncombustible gas composed chiefly of carbon dioxide occurring naturally in underground rocks.

(2) Casinghead gas shall mean any gas or vapor or both gas and vapor indigenous to and produced from a pool classified as an oil pool by the division. This also includes gas-cap gas produced from such an oil pool.

(3) Commission shall mean the oil conservation commission.

(4) Commission clerk means the oil conservation division employee the division director designates to provide staff support to the commission, and accept filings in rulemaking or adjudicatory cases before the commission.

[~~**(4)**~~]**(5)** Common purchaser for natural gas shall mean any person now or hereafter engaged in purchasing from one or more producers gas produced from gas wells within each common source of supply from which it purchases.

[~~**(5)**~~]**(6)** Common purchaser for oil shall mean every person now engaged or hereafter engaging in the business of purchasing oil to be transported through pipelines.

[~~(6)~~](7) Common source of supply. See pool.

[~~**(7)**~~]**(8)** Condensate shall mean the liquid recovered at the surface that results from condensation due to reduced pressure or temperature of petroleum hydrocarbons existing in a gaseous phase in the reservoir.

[~~(8)~~](9) Contiguous shall mean acreage joined by more than one common point, that is, the common boundary must be at least one side of a governmental quarter-quarter section.

[~~(9)~~](10) Conventional completion shall mean a well completion in which the production string of casing has an outside diameter in excess of 2.875 inches.

[~~(10)~~](11) Correlative rights shall mean the opportunity afforded, as far as it is practicable to do so, to the owner of each property in a pool to produce without waste his just and equitable share of the oil or gas, or both, in the pool, being an amount, so far as can be practically determined, and so far as can be practicably obtained without waste, substantially in the proportion that the quantity of recoverable oil or gas, or both, under such property bears to the total recoverable oil or gas, or both, in the pool, and for such purpose to use his just and equitable share of the reservoir energy.

[~~(11)~~](12) Cubic feet of gas or standard cubic foot of gas, for the purpose of these rules, shall mean that volume of gas contained in one cubic foot of space and computed at a base pressure of 10 ounces per square inch above the average barometric pressure of 14.4 pounds per square inch (15.025 psia), at a standard base temperature of 60 degrees fahrenheit.

D. Definitions beginning with the letter "D".

(1) Deep pool shall mean a com-

mon source of supply which is situated 5000 feet or more below the surface.

(2) Depth bracket allowable shall mean the basic oil allowable assigned to a pool and based on its depth, unit size, or special pool rules, which, when multiplied by the market demand percentage factor in effect, will determine the top unit allowable for the pool.

(3) Director shall mean the director of the oil conservation division of the New Mexico energy, minerals and natural resources department.

(4) Division shall mean the oil conservation division of the New Mexico energy, minerals and natural resources department.

(5) Division clerk means the oil conservation division employee the division director designates to accept filings in adjudicatory cases before the division.

E. Definitions beginning with the letter "E".

(1) Exempted aquifer shall mean an aquifer that does not currently serve as a source of drinking water, and which cannot now and will not in the foreseeable future serve as a source of drinking water because: is hydrocarbon producing;

(a) it is hydrocarbon producing;

(b) it is situated at a depth or location which makes the recovery of water for drinking water purposes economically or technologically impractical; or,

(c) it is so contaminated that it would be economically or technologically impractical to render that water fit for human consumption.

(2) Existing spacing unit is a spacing unit containing a producing well.

F. Definitions beginning with the letter "F".

(1) Facility shall mean any structure, installation, operation, storage tank, transmission line, access road, motor vehicle, rolling stock, or activity of any kind, whether stationary or mobile.

(2) Field means the general area which is underlaid or appears to be underlaid by at least one pool; and field also includes the underground reservoir or reservoirs containing such crude petroleum oil or natural gas, or both. The words field and pool mean the same thing when only one underground reservoir is involved; however, field unlike pool may relate to two or more pools.

(3) Fresh water (to be protected) includes the water in lakes and playas, the surface waters of all streams regardless of the quality of the water within any given reach, and all underground waters containing 10,000 milligrams per liter (mg/1) or less of total dissolved solids (TDS) except for which, after notice and hearing, it is found there is no present or reasonably foreseeable beneficial use which would be impaired by contamination of such waters. The water in lakes and playas shall be protected from contamination even though it may contain more than 10,000 mg/1 of TDS unless it can be shown that hydrologically connected fresh ground water will not be adversely affected.

G. Definitions beginning with the letter "G".

(1) Gas lift shall mean any method of lifting liquid to the surface by injecting gas into a well from which oil production is obtained.

(2) Gas-oil ratio shall mean the ratio of the casinghead gas produced in standard cubic feet to the number of barrels of oil concurrently produced during any stated period.

(3) Gas-oil ratio adjustment shall mean the reduction in allowable of a high gas oil ratio unit to conform with the production permitted by the limiting gas-oil ratio for the particular pool during a particular proration period.

(4) Gas transportation facility shall mean a pipeline in operation serving gas wells for the transportation of natural gas, or some other device or equipment in like operation whereby natural gas produced from gas wells connected therewith can be transported or used for consumption.

(5) Gas well shall mean a well producing gas or natural gas from a gas pool, or a well with a gas-oil ratio in excess of 100,000 cubic feet of gas per barrel of oil producing from an oil pool.

(6) Ground water shall mean interstitial water which occurs in saturated earth material and which is capable of entering a well in sufficient amounts to be utilized as a water supply.

(7) Groundwater sensitive area shall mean an area specifically so designated by the division after evaluation of technical evidence where groundwater exists that would likely exceed water quality control commission standards if contaminants were introduced into the environment.

H. Definitions beginning with the letter "H".

(1) Hazard to public health exists when water which is used or is reasonably expected to be used in the future as a human drinking water supply exceeds at the time and place of such use, one or more of the numerical standards of Subsection A of 20.6.2.3103 NMAC, or the naturally occurring concentrations, whichever is higher, or if any toxic pollutant as defined at Subsection VV of 20.6.2.7 NMAC affecting human health is present in the water. In determining whether a release would cause a hazard to public health to exist, the director shall investigate and consider the purification and dilution reasonably expected to occur from the time and place of release to the time and place of withdrawal for use as human drinking water.

(2) High gas-oil ratio proration unit shall mean a unit with at least one producing oil well with a gas-oil ratio in excess of the limiting gas-oil ratio for the pool in which the unit is located.

I. Definitions beginning with the letter "I".

(1) Illegal gas shall mean natural gas produced from a gas well in excess of the allowable determined by the division.

(2) Illegal oil shall mean crude petroleum oil produced in excess of the allowable as fixed by the division.

(3) Illegal product shall mean any product of illegal gas or illegal oil.

(4) Inactive well shall be a well which is not being utilized for beneficial purposes such as production, injection or monitoring and which is not being drilled, completed, repaired or worked over.

(5) Injection or input well shall mean any well used for the injection of air, gas, water, or other fluids into any underground stratum.

J. Reserved.

K. Reserved.

L. Definitions beginning with the letter "L".

(1) Limiting gas-oil ratio shall mean the gas-oil ratio assigned by the division to a particular oil pool to limit the volumes of casinghead gas which may be produced from the various oil producing units within that particular pool.

(2) Load oil is any oil or liquid hydrocarbon which has been used in remedial operation in any oil or gas well.

(3) Log or well log shall mean a systematic detailed and correct record of formations encountered in the drilling of a well.

M. Definitions beginning with the letter "M".

(1) Marginal unit shall mean a proration unit which is incapable of producing top unit allowable for the pool in which it is located.

(2) Market demand percentage factor shall mean that percentage factor of 100 percent or less as determined by the division at an oil allowable hearing, which, when multiplied by the depth bracket allowable applicable to each pool, will determine the top unit allowable for that pool.

(3) Mineral estate is the most complete ownership of oil and gas recognized in law and includes all the mineral interests and all the royalty interests.

(4) Mineral interest owners are owners of an interest in the executive rights, which are the rights to explore and develop, including oil and gas lessees (i.e., "working interest owners") and mineral interest own-

ers who have not signed an oil and gas lease.

(5) Minimum allowable shall mean the minimum amount of production from an oil or gas well which may be advisable from time to time to the end that production will repay reasonable lifting cost and thus prevent premature abandonment and resulting waste.

(6) Multiple completion (combination) shall mean a multiple completion in which two or more common sources of supply are produced through a combination of two or more conventional diameter casing strings cemented in a common well-bore, or a combination of small diameter and conventional diameter casing strings cemented in a common well-bore, the conventional diameter strings of which might or might not be a multiple completion (conventional).

(7) Multiple completion (conventional) shall mean a completion in which two or more common sources of supply are produced through one or more strings of tubing installed within a single casing string, with the production from each common source of supply completely segregated by means of packers.

(8) Multiple completion (tubingless) shall mean completion in which two or more common sources of supply are produced through an equal number of casing strings cemented in a common well-bore, each such string of casing having an outside diameter of 2.875 inches or less, with the production from each common source of supply completely segregated by use of cement.

N. Definitions beginning with the letter "N".

(1) Natural gas or gas shall mean any combustible vapor composed chiefly of hydrocarbons occurring naturally in a pool classified by the division as a gas pool.

(2) Non-aqueous phase liquid shall mean an interstitial body of liquid oil, petroleum product, petrochemical, or organic solvent, including an emulsion containing such material.

(3) Non-marginal unit shall mean a proration unit which is capable of producing top unit allowable for the pool in which it is located, and to which has been assigned a top unit allowable.

O. Definitions beginning with the letter "O".

(1) Official gas-oil ratio test shall mean the periodic gas-oil ratio test made by order of the division by such method and means and in such manner as prescribed by the division.

(2) Oil, crude oil, or crude petroleum oil shall mean any petroleum hydrocarbon produced from a well in the liquid phase and which existed in a liquid phase in the reservoir.

(3) Oil field wastes shall mean those wastes produced in conjunction with the exploration, production, refining, processing and transportation of crude oil and/or natural gas and commonly collected at field storage, processing, disposal, or service facilities, and waste collected at gas processing plants, refineries and other processing or transportation facilities.

(4) Oil well shall mean any well capable of producing oil and which is not a gas well as defined herein.

(5) Operator shall mean any person who, duly authorized, is in charge of the development of a lease or the operation of a producing property, or who is in charge of the operation or management of a facility.

(6) Overage or overproduction shall mean the amount of oil or the amount of natural gas produced during a proration period in excess of the amount authorized on the proration schedule.

(7) Owner means the person who has the right to drill into and to produce from any pool, and to appropriate the production either for himself or for himself and another.

P. Definitions beginning with the letter "P".

(1) Penalized unit shall mean a proration unit to which, because of an excessive gas-oil ratio, an allowable has been assigned which is less than top unit allowable for the pool in which it is located and also less than the ability of the well(s) on the unit to produce.

(2) Person shall mean an individual or any other entity including partnerships, corporation, associations, responsible business or association agents or officers, the state or a political subdivision of the state or any agency, department or instrumentality of the United States and any of its officers, agents or employees.

(3) Pit shall mean any surface or sub-surface impoundment, man-made or natural depression, or diked area on the surface. Excluded from this definition are berms constructed around tanks or other facilities solely for the purpose of safety and secondary containment.

(4) Playa lake shall mean a level or nearly level area that occupies the lowest part of a completely closed basin and that is covered with water at irregular intervals, forming a temporary lake.

(5) Pool means any underground reservoir containing a common accumulation of crude petroleum oil or natural gas or both. Each zone of a general structure, which zone is completely separated from any other zone in the structure, is covered by the word "pool" as used herein. "Pool" is synonymous with "common source of supply" and with "common reservoir."

(6) Potential shall mean the properly determined capacity of a well to produce oil, or gas, or both, under conditions prescribed by the division.

(7) Pressure maintenance shall mean the injection of gas or other fluid into a reservoir, either to maintain the existing pressure in such reservoir or to retard the natural decline in the reservoir pressure.

(8) Produced water shall mean those waters produced in conjunction with the production of crude oil and/or natural gas and commonly collected at field storage, processing, or disposal facilities including but not limited to: lease tanks, commingled tank batteries, burn pits, LACT units, and community or lease salt water disposal systems and which may be collected at gas processing plants, pipeline drips and other processing or transportation facilities.

(9) Producer shall mean the owner of a well or wells capable of producing oil or natural gas or both in paying quantities.

(10) Product means any commodity or thing made or manufactured from crude petroleum oil or natural gas, and all derivatives of crude petroleum oil or natural gas, including refined crude oil, crude tops, topped crude, processed crude petroleum, residue from crude petroleum, cracking stock, uncracked fuel oil, treated crude oil, fuel oil, residuum, gas oil, naphtha, distillate, gasoline, kerosene, benzene, wash oil, lubricating oil, and blends or mixtures of crude petroleum oil or natural gas or any derivative thereof.

(11) Proration day shall consist of 24 consecutive hours which shall begin at 7 a.m. and end at 7 a.m. on the following day. The language in this paragraph is different than that which was filed 02-28-97 (effective

(12) Proration month shall mean the calendar month which shall begin at 7 a.m. on the first day of such month and end at 7 a.m. on the first day of the next succeeding month.

(13) Proration period shall mean for oil the proration month and for gas the twelve-month period which shall begin at 7 a.m. on January 1 of each year and end at 7 a.m. on January 1 of the succeeding year or other period designated by general or special order of the division.

(14) Proration schedule shall mean the order of the division authorizing the production, purchase, and transportation of oil, casinghead gas, and natural gas from the various units of oil or of natural gas in allocated pools.

(15) Proration unit is the area in a pool that can be effectively and efficiently drained by one well as determined by the division or commission (See NMSA 1978 Section 70-2-17.B) as well as the area assigned to an individual well for the purposes of allocating allowable production

pursuant to a prorationing order for the pool. A proration unit will be the same size and shape as a spacing unit. All proration units are spacing units but not all spacing units are proration units.

(16) Prospective spacing unit is a hypothetical spacing unit that does not yet have a producing well.

Q. Reserved.

R. Definitions beginning with the letter "R".

(1) Recomplete shall mean the subsequent completion of a well in a different pool from the pool in which it was originally completed.

(2) Regulated naturally occurring radioactive material (regulated NORM) shall mean naturally occurring radioactive material (NORM) contained in any oil-field soils, equipment, sludges or any other materials related to oil-field operations or processes exceeding the radiation levels specified in 20.3.14.1403 NMAC.

(3) Release shall mean all breaks, leaks, spills, releases, fires or blowouts involving crude oil, produced water, condensate, drilling fluids, completion fluids or other chemical or contaminant or mixture thereof, including oil field wastes and natural gases to the environment.

(4) Remediation plan shall mean a written description of a program to address unauthorized releases. The plan may include appropriate information, including assessment data, health risk demonstrations, and corrective action(s). The plan may also include an alternative proposing no action beyond the submittal of a spill report.

(5) Responsible person shall mean the owner or operator who must complete division approved corrective action for pollution from releases.

(6) Royalty interest owners are owners of an interest in the non-executive rights including lessors, royalty interest owners and overriding royalty interest owners. Royalty interests are non-cost bearing.

S. Definitions beginning with the letter "S".

(1) Secondary recovery shall mean a method of recovering quantities of oil or gas from a reservoir which quantities would not be recoverable by ordinary primary depletion methods.

(2) Shallow pool shall mean a pool which has a depth range from 0 to 5000 feet.

(3) Shortage or underproduction shall mean the amount of oil or the amount of natural gas during a proration period by which a given proration unit failed to produce an amount equal to that authorized in the proration schedule.

(4) Shut-in shall be the status of a production well or an injection well which is temporarily closed down, whether by closing a valve or disconnection or other physical means.

(5) Shut-in pressure shall mean the gauge pressure noted at the wellhead when the well is completely shut in, not to be confused with bottom hole pressure.

(6) Significant modification of an abatement plan shall mean a change in the abatement technology used excluding design and operational parameters, or relocation of 25% or more of the compliance sampling stations, for any single medium, as designated pursuant to Subsection E, Paragraph (4), Subparagraph (b), Subsubparagraph (iv) of Section 19.15.5.19 NMAC.

(7) Spacing unit is the area allocated to a well under a well spacing order or rule. Under the Oil & Gas Act, NMSA 1978, Section 70-2-12.B(10), the commission has the power to fix spacing units without first creating proration units. See *Rutter & Wilbanks Corp. v. Oil Conservation Comm'n*, 87 NM 286 (1975). This is the area designated on division form C-102.

(8) Subsurface water shall mean ground water and water in the vadose zone that may become ground water or surface water in the reasonably foreseeable future or may be utilized by vegetation.

T. Definitions beginning with the letter "T".

(1) Tank bottoms shall mean that accumulation of hydrocarbon material and other substances which settles naturally below crude oil in tanks and receptacles that are used in handling and storing of crude oil, and which accumulation contains in excess of two (2%) percent of basic sediment and water; provided, however, that with respect to lease production and for lease storage tanks, a tank bottom shall be limited to that volume of the tank in which it is contained that lies below the bottom of the pipeline outlet thereto.

(2) Temporary abandonment shall be the status of a well which is inactive and has been approved for temporary abandonment in accordance with the provisions of these rules.

(3) Top unit allowable for gas shall mean the maximum number of cubic feet of natural gas, for the proration period, allocated to a gas producing unit in an allocated gas pool.

(4) Top unit allowable for oil shall mean the maximum number of barrels for oil daily for each calendar month allocated on a proration unit basis in a pool to non-marginal units. The top unit allowable for a pool shall be determined by multiplying the applicable depth bracket allowable by the market demand percentage factor in effect.

(5) Treating plant shall mean any plant constructed for the purpose of wholly or partially or being used wholly or partially for reclaiming, treating, processing, or in any manner making tank bottoms or any other waste oil marketable.

(6) Tubingless completion shall mean a well completion in which the production string of casing has an outside diameter of 2.875 inches or less.

U. Definitions beginning with the letter "U".

(1) Underground source of drinking water shall mean an aquifer which supplies water for human consumption or which contains ground water having a total dissolved solids concentration of 10,000 mg/1 or less and which is not an exempted aquifer.

(2) Unit of proration for gas shall consist of such multiples of 40 acres as may be prescribed by special pool rules issued by the division.

(3) Unit of proration for oil shall consist of one 40-acre tract or such multiples of 40-acre tracts as may be prescribed by special pool rules issued by the division.

(4) Unorthodox well location shall mean a location which does not conform to the spacing requirements established by the rules and regulations of the division.

V. Definitions beginning with the letter "V". Vadose zone shall mean unsaturated earth material below the land surface and above ground water, or in between bodies of ground water.

W. Definitions beginning with the letter "W".

(1) Waste, in addition to its ordinary meaning, shall include:

(a) underground waste as those words are generally understood in the oil and gas business, and in any event to embrace the inefficient, excessive, or improper use or dissipation of the reservoir energy, including gas energy and water drive, of any pool, and the locating, spacing, drilling, equipping, operating, or producing, of any well or wells in a manner to reduce or tend to reduce the total quantity of crude petroleum oil or natural gas ultimately recovered from any pool, and the use of inefficient underground storage of natural gas;

(b) surface waste as those words are generally understood in the oil and gas business, and in any event to embrace the unnecessary or excessive surface loss or destruction without beneficial use, however caused, of natural gas of any type or in any form, or crude petroleum oil, or any product thereof, but including the loss or destruction, without beneficial use, resulting from evaporation, seepage, leakage, or fire, especially such loss or destruction incident to or resulting from the manner of spacing, equipping, operating or producing a well or

wells, or incident to or resulting from the use of inefficient storage or from the production of crude petroleum oil or natural gas, in excess of the reasonable market demand;

(c) the production of crude petroleum oil in this state in excess of the reasonable market demand for such crude petroleum oil; such excess production causes or results in waste which is prohibited by the Oil and Gas Act; the words "reasonable market demand" as used herein with respect to crude petroleum oil, shall be construed to mean the demand for such crude petroleum oil, for reasonable current requirements for current consumption and use within or outside of the state, together with the demand of such amounts as are reasonably necessary for building up or maintaining reasonable storage reserves of crude petroleum oil or the products thereof, or both such crude petroleum oil and products;

(d) the non-ratable purchase or taking of crude petroleum oil in this state; such non-ratable taking and purchasing causes or results in waste, as defined in Subparagraphs (a), (b), and (c) of this definition and causes waste by violating Section 70-2-16 of the Oil and Gas Act;

(e) the production in this state of natural gas from any gas well or wells, or from any gas pool, in excess of the reasonable market demand from such source for natural gas of the type produced or in excess of the capacity of gas transportation facilities for such type of natural gas; the words "reasonable market demand," as used herein with respect to natural gas, shall be construed to mean the demand for natural gas for reasonable current requirements, for current consumption and for use within or outside the state, together with the demand for such amounts as are necessary for building up or maintaining reasonable storage reserves of natural gas or products thereof, or both such natural gas and products.

(2) Water shall mean all water including water situated wholly or partly within or bordering upon the state, whether surface or subsurface, public or private, except private waters that do not combine with other surface or subsurface water.

(3) Water contaminant shall mean any substance that could alter if released or spilled the physical, chemical, biological or radiological qualities of water. "Water contaminant" does not mean source, special nuclear or by-product material as defined by the Atomic Energy Act of 1954.

(4) Watercourse shall mean any lake bed, or gully, draw, stream bed, wash, arroyo, or natural or human-made channel through which water flows or has flowed.

(5) Water pollution shall mean introducing or permitting the introduction into water, either directly or indirectly, of one or more water contaminants in such quantity and of such duration as may with reasonable probability injure human health, animal or plant life or property, or to unreasonably interfere with the public welfare or the use of property.

(6) Well blowout shall mean a loss of control over and subsequent eruption of any drilling or workover well or the rupture of the casing, casinghead, or wellhead or any oil or gas well or injection or disposal well, whether active or inactive, accompanied by the sudden emission of fluids, gaseous or liquids, from the well.

(7) Wellhead protection area shall mean the area within 200 horizontal feet of any private, domestic fresh water well or spring used by less than five households for domestic or stock watering purposes or within1000 horizontal feet of any other fresh water well or spring. Wellhead protection areas shall not include areas around water wells drilled after an existing oil or natural gas waste storage, treatment, or disposal site was established.

(8) Wetlands shall mean those areas that are inundated or saturated by surface or groundwater at a frequency and duration sufficient to support, and under normal circumstances do support, a prevalence of vegetation typically adapted for life in saturated soil conditions in New Mexico. Constructed wetlands used for wastewater treatment purposes are not included in this definition.

(9) Working interest owners are the owners of the operating interest under an oil and gas lease who have the exclusive right to exploit the oil & gas minerals. Working interests are cost bearing.

[1-5-50…2-1-96; A, 7-15-96; Rn, 19 NMAC 15.A.7.1 through 7.84, 3-15-97; A, 7-15-99; 19.15.1.7 NMAC - Rn, 19 NMAC 15.A.7, 5-15-001; A, 3/31/04; A, 9/15/04; A, 09/30/05]

NEW MEXICO ENVIRONMENTAL IMPROVEMENT BOARD

This is an amendment to 20.2.99 NMAC, Sections 2, 7, 109, 112-118, 120-123, 125, 128-129, 135-140, and 143-154, effective 10/15/05.

20.2.99.2 SCOPE. Agencies affected by this part are: federal transportation agencies (the federal highway administration (FHWA) and the federal transit administration (FTA) of the United States department of transportation (US DOT)), and state and local agencies responsible for transportation planning and air quality management that are within the geographic jurisdiction of the environmental improvement board (see also 20.2.99.6 NMAC).

A. The provisions of this part shall apply in all non-attainment and maintenance areas for transportation-related criteria pollutants for which the area is designated non-attainment or has a maintenance plan.

B. The provisions of this part apply with respect to emissions of the following criteria pollutants: ozone, carbon monoxide, nitrogen dioxide, and particles with an aerodynamic diameter less than or equal to a nominal 10 micrometers (PM10) and particles with an aerodynamic diameter less than or equal to a nominal 2.5 micrometers (PM2.5).

C. The provisions of this part apply with respect to emissions of the following precursor pollutants in nonattainment or maintenance areas:

(1) volatile organic compounds and nitrogen oxides in ozone areas;

(2) nitrogen oxides in nitrogen dioxide areas; and

(3) volatile organic compounds and/or, nitrogen oxides, [~~and PM10~~] in PM10 areas if:

(a) the EPA region 6 administrator or the department has made a finding (including a finding as part of a SIP or a submitted implementation plan revision) that transportation-related emissions of one or both of these precursor emissions within the nonattainment area are a significant contributor to the PM10 nonattainment problem and has so notified the MPO (or the [~~NMSHTD~~] NMDOT in the absence of an MPO) and US DOT; or

(b) the applicable SIP (or implementation plan submission) establishes [~~a~~] an approved (or adequate) budget for such emissions as part of the reasonable further progress, attainment or maintenance strategy.

D. The provisions of this part apply to PM2.5 nonattainment and maintenance areas with respect to PM2.5 from re-entrained road dust if the EPA regional administrator or the department has made finding that re-entrained road dust emissions within the area are a significant contributor to the PM2.5 nonattainment problem and has so notified the MPO (or the NMDOT in the absence of an MPO) and US DOT, or if the applicable SIP (or implementation plan submission) includes re-entrained road dust in the approved (or adequate) budget as part of the reasonable further progress, attainment or maintenance strategy. Re-entrained road dust emissions are produced by travel and paved and unpaved roads (including emissions from anti-skid and deicing material(s)).

[~~D~~]**E.** The provisions of this part apply to maintenance areas for 20 years from the date US EPA approves the department's request under Section 107(d) of the

CAA for redesignation to attainment, unless the applicable implementation plan specifies that the provisions of this part shall apply for more than 20 years.
[12/14/94; 11/23/98; 20.2.99.2 NMAC - Rn, 20 NMAC 2.99.101 10/31/02; A, 10/15/05]

20.2.99.7 DEFINITIONS. Terms used but not defined in this part shall have the meaning given them by the CAA titles 23 and 49 U.S.C., US EPA regulations, US DOT regulations, and 20.2.2 NMAC (Definitions), in that order of priority.

A. "1-hour ozone NAAQS" means the 1-hour ozone national ambient air quality standard codified at 40 CFR 50.9.

B. "8-hour ozone NAAQS" means the 8-hour ozone national ambient air quality standard codified at 40 CFR 50.10.

[~~A~~]**C. "Applicable implementation plan"** is defined in Section 302(q) of the CAA and means the portion (or portions) of the implementation plan, or most recent revision thereof, which has been approved under Section 110 (of the CAA), promulgated under Section 110(c), or promulgated or approved pursuant to regulations promulgated under Section 301(d) and which implements the relevant requirements of the CAA.

[~~B~~]**D. "CAA"** means the Clean Air Act, as amended, 42 U.S.C. 7401, et seq.

[~~C~~]**E. "Cause or contribute to a new violation"** for a project means:

(1) to cause or contribute to a new violation of a standard in the area substantially affected by the project or over a region which would otherwise not be in violation of the standard during the future period in question, if the project were not implemented, or

(2) to contribute to a new violation in a manner that would increase the frequency or severity of a new violation of a standard in such area.

[~~D~~]**F. "CFR"** means the code of federal regulations.

[~~E~~]**G. "Clean data"** means air quality monitoring data determined by US EPA to meet the e national ambient air quality standard.

[~~F~~]**H. "Conformity analyses"** means regional or localized "hot-spot" computer modeling assessment or any other analyses which serve as the basis for the conformity determination.

[~~G~~]**I. "Conformity determination"** means the demonstration of consistency with motor vehicle emissions budgets for each pollutant and precursor identified in the applicable SIP. The conformity determination is the affirmative written documentation declaring conformity with the applicable SIP which is submitted to FHWA and FTA for approval with EPA consultation. An affirmative conformity determination means conformity to the plans purpose of eliminating or reducing the severity and number of violations of the NAAQS and achieving expeditious attainment of such standards; and that such activities will not:

(1) cause or contribute to any new violations of any standard in any area;

(2) increase the frequency or severity of any existing violation of any standard in any area; or

(3) delay timely attainment of any standard or any required interim emission reductions or other milestones in any area.

[~~H~~]**J. "Consultation"** means that one party confers with another identified party, provides or makes available all relevant information to that party, and, prior to taking any action, considers the views of that party and (except with respect to those actions for which only notification is required) responds to written comments in a timely, substantive written manner prior to any final decision on such action. Such views and written response shall be made part of the record of any decision or action. Specific procedures and processes are described in 20.2.99.116 through 20.2.99.124 NMAC.

[~~I~~]**K. "Control strategy implementation plan revision"** is the [~~portion of the SIP~~] implementation plan which contains specific strategies for controlling the emissions of and reducing ambient levels of pollutants in order to satisfy CAA requirements for demonstrations of reasonable further progress and attainment (including implementation plan revisions submitted to satisfy CAA Sections 172(c), 182(b)(1), 182(c)(2)(A), 182(c)(2)(B), 187(a)(7), 189(a)(1)(B), [~~and~~] 189(b)(1)(A) and 189(d); and Sections 192(a) and 192(b), for nitrogen dioxide; and any other applicable CAA provisions requiring a demonstration of reasonable further progress or attainment).

L. "Department" means the New Mexico environment department.

[~~J~~]**M. "Design concept"** means the type of facility identified by the project, e.g., freeway, expressway, arterial highway, grade separated highway, reserved right-of-way rail transit, mixed traffic rail transit, exclusive busway, etc.

[~~K~~]**N. "Design scope"** means the design aspects of a facility which will affect the proposed facility's impact on regional emissions, usually as they relate to vehicle or person carrying capacity and control, e.g., number of lanes or tracks to be constructed or added, length of project, signalization, access control including approximate number and location of interchanges, preferential treatment for high-occupancy vehicles, etc.

O. "Donut areas" are geographic areas outside a metropolitan planning area boundary, but inside the boundary of a nonattainment or maintenance area that contains any part of a metropolitan area(s). These areas are not isolated rural nonattainment and maintenance areas.

[~~L~~]**P. "FHWA"** means the federal highway administration of US DOT.

[~~M~~]**Q. " F H W A / F T A project"**, for the purpose of this part, is any highway or transit project which is proposed to receive funding assistance and approval through the federal-aid highway program or the federal mass transit program, or requires federal highway administration (FHWA) or federal transit administration (FTA) approval for some aspect of the project, such as connection to an interstate highway or deviation from applicable design standards on the interstate system.

[~~N~~]**R. "Forecast period"** with respect to a transportation plan is the period covered by the transportation plan pursuant to 23 CFR part 450.

[~~O~~]**S. "FTA"** means the federal transit administration of US DOT.

[~~P~~]**T. "Highway project"** is an undertaking to implement or modify a highway facility or highway-related program. Such an undertaking consists of all required phases necessary for implementation. For analytical purposes, it shall be defined sufficiently to:

(1) connect logical termini and be of sufficient length to address environmental matters on a broad scope;

(2) have independent utility or significance, i.e., be usable and be a reasonable expenditure even if no additional transportation improvements in the area are made; and

(3) not restrict consideration of alternatives for other reasonably foreseeable transportation improvements.

[~~Q~~]**U. "Horizon year"** is a year for which the transportation plan describes the envisioned transportation system in accordance with 20.2.99.125 NMAC.

[~~R~~]**V. "Hot-spot analysis"** is an estimation of likely future localized CO and PM10 pollutant concentrations and a comparison of those concentrations to the national ambient air quality standards. Hot-spot analysis assesses impacts on a scale smaller than the entire nonattainment or maintenance area, including, for example, congested roadway intersections and highways or transit terminals, and uses an air quality dispersion model to determine the effects of emissions on air quality.

[~~S~~]**W. "Increase the frequen-**

cy or severity" means to cause a location or region to exceed a standard more often or to cause a violation at a greater concentration than previously existed and/or would otherwise exist during the future period in question, if the project were not implemented.

X. "Isolated rural nonattainment and maintenance areas" are areas that do not contain or are not part of any metropolitan planning area as designated under the transportation planning regulations. Isolated rural areas do not have federally required metropolitan transportation plans or TIPs and do not have projects that are part of the emissions in such areas are instead included in statewide transportation improvement programs. These are not donut areas.

[~~T~~]**Y. "Lapse"** means that the conformity determination for a transportation plan or TIP has expired, and thus there is no currently conforming transportation plan and TIP.

Z. "Limited maintenance plan" is a maintenance plan that EPA has determined meets EPA's limited maintenance plan policy criteria for a given NAAQS and pollutant. To qualify for a limited maintenance plan, for example, an area must have a design value that is significantly below a given NAAQS, and it must be reasonable to expect that a NAAQS violation will not result from any level of future motor vehicle emissions growth.

[~~U~~]**AA. "Maintenance area"** means any geographic region of the United States previously designated nonattainment pursuant to the CAA Amendments of 1990 and subsequently redesignated to attainment subject to the requirement to develop a maintenance plan under Section 175A of the CAA, as amended.

[~~V~~]**AB. "Maintenance plan"** means an implementation plan under Section 175A of the CAA, as amended.

[~~W~~]**AC. "Metropolitan planning organization (MPO)"** is that organization designated as being responsible, together with the state, for conducting the continuing, cooperative, and comprehensive planning process under 23 U.S.C. 134 and 49 U.S.C. 5303. It is the forum for cooperative transportation decision-making. In the absence of an MPO, the [~~NMSHTD~~] NMDOT shall be responsible for the transportation planning processes assigned to MPOs under this part

[~~X~~]**AD. "Milestone"** has the meaning given in CAA Sections 182(g)(1) and 189(c) [~~of the CAA~~] for serious and above ozone nonattainment areas and PM10 nonattainment areas, respectively. For all other nonattainment areas, [~~A~~] a milestone consists of an emissions level and the date on which [~~it is required to be~~] that level is to be achieved as required by the applicable CAA provision for reasonable further progress towards attainment.

[~~Y~~]**AE. "Motor vehicle emissions budget"** is that portion of the total allowable emissions defined in the submitted or approved control strategy implementation plan revision or maintenance plan for a certain date for the purpose of meeting reasonable further progress milestones or demonstrating attainment or maintenance of the NAAQS, for any criteria pollutant or its precursors, allocated by the SIP to highway and transit vehicle use and emissions.

[~~Z~~]**AF. "National ambient air quality standards (NAAQS)"** are those standards established pursuant to Section 109 of the CAA.

[~~AA~~]**AG. "NEPA"** means the National Environmental Policy Act of 1969, as amended, 42 U.S.C. 4321, et seq.

[~~AB~~]**AH. "NEPA process completion"**, for the purposes of this part, with respect to FHWA or FTA, means the point at which there is a specific action to make a determination that a project is categorically excluded, to make a finding of no significant impact, or to issue a record of decision on a final environmental impact statement under NEPA.

[~~AC~~]**AI. " [~~N M S H T D~~] NMDOT"** means the New Mexico [~~State Highway and Transportation~~] department of transportation or its successor agency or authority, as represented by the department secretary or his or her designee.

[~~AD~~]**AJ. "Nonattainment area"** means any geographic region of the United States which has been designated as nonattainment under Section 107 of the CAA for any pollutant for which a national ambient air quality standard exists.

[~~AE~~]**AK. "Project"** means a highway project or transit project.

[~~AF~~]**AL. "Protective finding"** means a determination by US EPA that a submitted control strategy implementation plan revision contains adopted control measures or written commitments to adopt enforceable control measures that fully satisfy the emissions reductions requirements relevant to the statutory provision for which the implementation plan revision was submitted, such as reasonable further progress or attainment.

[~~AG~~]**AM. "Recipient of funds designated under title 23 U.S.C. or the federal transit laws"** means any agency at any level of state, county, city, or regional government that routinely receives title 23 U.S.C. or federal transit law funds to construct FHWA/FTA projects, operate FHWA/FTA projects or equipment, purchase equipment, or undertake other services or operations via contracts or agreements. This definition does not include private landowners or developers, or contractors or entities that are only paid for services or products created by their own employees.

[~~AH~~]**AN. "Regionally significant project"** means a transportation project (other than an exempt project) that is on a facility which serves regional transportation needs (such as access to and from the area outside of the region, major activity centers in the region, major planned developments such as new retail malls, sports complexes, etc., or transportation terminals, as well as most terminals themselves) and would normally be included in the modeling of a metropolitan area's transportation network, including at a minimum:

(1) all principal arterial highways; and

(2) all fixed guideway transit facilities that offer an alternative to regional highway travel.

[~~AI~~]**AO. "Safety margin"** means the amount by which the total projected emissions from all sources of a given pollutant are less than the total emissions that would satisfy the applicable requirement for reasonable further progress, attainment, or maintenance.

[~~AJ~~]**AP. "Standard"** means a national ambient air quality standard.

[~~AK~~]**AQ. "State implementation plan (SIP)"** means an applicable implementation plan and the applicable portion (or portions) of the New Mexico state implementation plan, or most recent revision thereof, which has been approved under Section 110, or promulgated under Section 110(c), or promulgated or approved pursuant to regulations promulgated under Section 301(d) of the CAA and which implements the relevant requirements of the CAA (see the definition for "applicable implementation plan").

[~~AL~~]**AR. "Title 23 U.S.C."** means title 23 of the United States Code.

[~~AM~~]**AS. "Transit"** is mass transportation by bus, rail, or other conveyance which provides general or special service to the public on a regular and continuing basis. It does not include school buses or charter or sightseeing services.

[~~AN~~]**AT. "Transit project"** is an undertaking to implement or modify a transit facility or transit-related program; purchase transit vehicles or equipment; or provide financial assistance for transit operations. It does not include actions that are solely within the jurisdiction of local transit agencies, such as changes in routes, schedules, or fares. It may consist of several phases. For analytical purposes, it shall be defined inclusively enough to:

(1) connect logical termini and be of sufficient length to address environmental matters on a broad scope;

(2) have independent utility or independent significance, i.e., be a reasonable expenditure even if no additional trans-

portation improvements in the area are made; and

(3) not restrict consideration of alternatives for other reasonably foreseeable transportation improvements.

[~~AO~~]**AU. "Transportation control measure (TCM)"** is any measure that is specifically identified and committed to in the SIP that is either one of the types listed in Section 108 of the CAA, or any other measure for the purpose of reducing emissions or concentrations of air pollutants from transportation sources by reducing vehicle use or changing traffic flow or congestion conditions. Notwithstanding the above, vehicle technology-based, fuel-based, and maintenance-based measures which control the emissions from vehicles under fixed traffic conditions are not TCMs for the purposes of this part.

[~~AP~~]**AV. "Transportation improvement program (TIP)"** means a staged, multi-year, intermodal program of transportation projects covering a metropolitan planning area which is consistent with the metropolitan transportation plan, and developed pursuant to 23 CFR part 450.

[~~AQ~~]**AW. "Transportation plan"** means the official intermodal metropolitan transportation plan that is developed through the metropolitan planning process for the metropolitan planning area, developed pursuant to 23 CFR part 450.

[~~AR~~]**AX. "Transportation project"** is a highway project or a transit project.

AY. "US EPA" means the United States environmental protection agency

[~~AS~~]**AZ. "US DOT"** means the United States department of transportation.

[~~AT~~]**BA. "Written commitment"** for the purposes of this part means a written commitment that includes a description of the action to be taken; a schedule for the completion of the action; a demonstration that funding necessary to implement the action has been authorized by the appropriating or authorizing body; and an acknowledgment that the commitment is an enforceable obligation under the applicable implementation plan.

[12/14/94; 11/23/98; 20.2.99.7 NMAC - Rn, 20 NMAC 2.99.107 10/31/02; A, 10/15/05]

20.2.99.109 APPLICABILITY

A. Action applicability.

(1) Except as provided for in Subsection C of 20.2.99.109 NMAC or Subsection A of 20.2.99.149 NMAC conformity determinations are required for:

(a) the adoption, acceptance, approval or support of transportation plans and transportation plan amendments developed pursuant to 23 CFR part 450 or 49 CFR part 613 by an MPO (or [~~the NMSHTD~~] NMDOT in the absence of an MPO) or US DOT;

(b) the adoption, acceptance, approval or support of TIPs and TIP amendments developed pursuant to 23 CFR part 450 or 49 CFR part 613 by an MPO (or [~~the NMSHTD~~] NMDOT in the absence of an MPO) or US DOT; and

(c) the approval, funding, or implementation of FHWA/FTA projects.

(2) Conformity determinations are not required under this part for individual projects which are not FHWA/FTA projects. However, 20.2.99.140 NMAC applies to such projects if they are regionally significant.

B. Geographic and pollutant applicability are set out in 20.2.99.2 NMAC (Scope).

C. Limitations.

[~~**(1)** Projects subject to this Part for which the NEPA process and a conformity determination have been completed by US DOT may proceed toward implementation without further conformity determinations if one of the following major steps has occurred within the most recent three year period:~~

~~**(a)** NEPA process completion;~~

~~**(b)** Start of final design;~~

~~**(c)** Acquisition of a significant portion of the right-of-way; or~~

~~**(d)** Approval of the plans, specifications and estimates.~~

~~**(2)** All phases of such projects which were considered in the conformity determination are also included, if those phases were for the purpose of funding, final design, right-of-way acquisition, construction, or any combination of these phases.~~

~~**(3)** A new conformity determination for the project will be required if there is a significant change in project design concept and scope, if a supplemental environmental document for air quality purposes is initiated, or if no major steps to advance the project have occurred within the most recent three year period.~~] In order to receive any FHWA/FTA approval or funding actions, including NEPA approvals, for a project phase subject to this subpart, a currently conforming transportation plan and TIP must be in place at the time of project approval as described in Subsection A of 20.2.99.133 NMAC, except as provided by Subsection B of 20.2.99.133 NMAC.

D. Grace period for new nonattainment areas. For areas or portions of areas which have been continuously designated attainment or not designated for any standard for ozone, CO, PM10, PM2.5 or NO2 since 1990 and are subsequently redesignated to nonattainment or designated nonattainment for any standard for any of these pollutants, the provisions of this subpart shall not apply with respect to that standard for 10 months following the effective data of final designation to nonattainment for each standard for such pollutant.

[12/14/94; 11/23/98; 20.2.99.109 NMAC - Rn, 20 NMAC 2.99.109 10/31/02; A, 10/15/05]

20.2.99.112 FREQUENCY OF CONFORMITY DETERMINATIONS - TRANSPORTATION PLANS.

A. Each new transportation plan shall be found to conform before the transportation plan is approved by the MPO (or [~~the NMSHTD~~] NMDOT in the absence of an MPO) and accepted by the US DOT.

B. All transportation plan revisions shall be found to conform before the transportation plan revisions are approved by the MPO (or [~~the NMSHTD~~] NMDOT in the absence of an MPO) or accepted by the US DOT, unless the revision merely adds or deletes exempt projects listed in 20.2.99.149 NMAC and has been made in accordance with the notification provisions of 20.2.99.122 NMAC. The conformity determination shall be based on the transportation plan and the revision taken as a whole.

C. The MPO and US DOT shall determine the conformity of the transportation plan (including a new regional emission analysis) no less frequently than every three (3) years. If more than three (3) years elapse after US DOT's conformity determination without the MPO and US DOT determining conformity of the transportation plan, the existing conformity determination will lapse.

[12/14/94; 11/23/98; 20.2.99.112 NMAC - Rn, 20 NMAC 2.99.112 10/31/02; A, 10/15/05]

20.2.99.113 FREQUENCY OF CONFORMITY DETERMINATIONS - TRANSPORTATION IMPROVEMENT PROGRAMS.

A. A new TIP must be found to conform before the TIP is approved by the MPO (or [~~the NMSHTD~~] NMDOT in the absence of an MPO) or accepted by the US DOT.

B. A TIP amendment requires a new conformity determination for the entire TIP before the amendment is approved by the MPO (or [~~the NMSHTD~~] NMDOT in the absence of an MPO) or accepted by the US DOT, unless the amendment merely adds or deletes exempt projects listed in 20.2.99.149 NMAC and has been made in accordance with the notification provisions of 20.2.99.122 NMAC.

C. The MPO and US DOT shall determine the conformity of the TIP (including a new regional emissions analy-

sis) no less frequently than every three years or else the existing conformity determination will lapse.

[~~D. After an MPO (or the NMSHTD in the absence of an MPO) adopts a new or revised transportation plan, conformity of the TIP shall be redetermined by the MPO (or the NMSHTD in the absence of an MPO) and the US DOT within six months from the date of US DOT's conformity determination for the transportation plan, unless the new or revised plan merely adds or deletes exempt projects listed in 20.2.99.149 NMAC and has been made in accordance with the notification provisions of 20.2.99.122 NMAC. Otherwise, the existing conformity determination for the TIP will lapse.~~]

[12/14/94; 11/23/98; 20.2.99.113 NMAC - Rn, 20 NMAC 2.99.113 10/31/02; A, 10/15/05]

20.2.99.114 FREQUENCY OF CONFORMITY DETERMINATIONS - PROJECTS. FHWA/FTA projects must be found to conform before they are adopted, accepted, approved, or funded. Conformity must be redetermined for any FHWA/FTA project [~~three years have elapsed since the most recent major step to advance the project (NEPA process completion; start of final design; acquisition of a significant portion of the right-of-way; or approval of the plans, specifications and estimates) occurred.~~] if one of the following occurs:

(A) a significant change in the project's design concept and scope;

(B) three (3) years elapse since the most recent major step to advance the project including;

(1) NEPA process completion;

(2) start of final design;

(3) acquisition of a significant portion of the right-of-way; and

(4) construction (including federal approval of plans, specifications and estimates); or

(C) initiation of a supplemental environmental document for air quality purposes.

[12/14/94; 11/23/98; 20.2.99.114 NMAC - Rn, 20 NMAC 2.99.114; A, 10/15/05]

20.2.99.115 FREQUENCY OF CONFORMITY DETERMINATIONS - TRIGGERS FOR TRANSPORTATION PLAN AND TIP CONFORMITY DETERMINATIONS[~~:~~]. Conformity of existing transportation plans and TIPs shall be redetermined within eighteen (18) months of the following, or the existing conformity determination will lapse, and no new project-level conformity determinations may be made until conformity of the transportation plan and TIP has been determined by the MPO and US DOT:

[~~A. November 24, 1993;~~]

[~~B~~]**A.** the date of the department's initial submission to US EPA of each control strategy implementation plan or maintenance plan establishing a motor vehicle emissions budget;

[~~C~~]**B.** the effective date of US EPA approval of a control strategy implementation plan revision or maintenance plan which establishes or revises a motor vehicle emissions budget if that budget has not yet been used in a conformity determination prior to approval; and

[~~D. US EPA approval of an implementation plan revision that adds, deletes, or changes TCMs; and~~]

[~~E~~]**C.** the effective date of US EPA promulgation of an implementation plan which establishes or revises a motor vehicle emissions budget[~~or adds, deletes, or changes TCMs~~].

[12/14/94; 11/23/98; 20.2.99.115 NMAC - Rn, 20 NMAC 2.99.115 10/31/02; A, 10/15/05]

20.2.99.116 CONSULTATION.

A. 20.2.99.116 NMAC through 20.2.99.124 NMAC provide procedures for the interagency (federal, state, and local) consultation process, resolution of conflicts, and public consultation. Public consultation procedures will be developed in accordance with the requirements for public involvement in 23 CFR part 450. The affected agencies listed in Subsection C of 20.2.99.116 NMAC shall undertake a consultation process with each other prior to the development of: 1) conformity determinations, 2) major activities listed in 20.2.9.117 NMAC below; 3) specific major activities listed in 20.2.99.120 NMAC below; and 4) specific routine activities listed in 20.2.99.121 NMAC below. This consultation process shall follow the consultation procedures described in 20.2.99.119 NMAC below.

B. Prior to EPA's approval of this part, any MPO (or [~~the NMSHTD~~] NMDOT in the absence of an MPO) and [~~the NMSHTD~~] NMDOT, before making any conformity determinations, shall provide reasonable opportunity for consultation with the department, the local transportation agency in the county where the nonattainment or maintenance area is located, the local air quality agency in the county in which the nonattainment or maintenance area is located, New Mexico FHWA division offices, FTA region 6 offices, and EPA region 6, including consultation on the issues described in 20.2.99.117 NMAC. This opportunity for consultation shall be provided prior to the determination of conformity.

C. Affected agencies[~~:~~].

(1) Agencies which are affected by this part and which are required to participate in the consultation process are:

(a) the designated MPO for the nonattainment or maintenance area;

(b) the department;

(c) [~~The NMSHTD~~] NMDOT;

(d) the local transportation agency for the county or city in which the nonattainment or maintenance area is located;

(e) the local transit agency for the city or county in which the nonattainment or maintenance area is located;

(f) EPA Region 6;

(g) New Mexico FHWA division offices;

(h) FTA region 6;

(i) local air quality agencies; and

(j) any other organization or resource agency within the state responsible under state law for developing, submitting or implementing transportation-related provisions of an implementation plan.

(2) Agencies which may be affected by this part and which are entitled to participate in the interagency consultation process include:

(a) [~~The NMSHTD~~] NMDOT district office for the county in which the nonattainment or maintenance area is located; and

(b) the city or county government in the city or county where the nonattainment or maintenance area is located.

D. Policy level points of contact and policy level meetings.

(1) The policy level points of contact for participating organizations are as follows:

(a) MPO: executive director or designee;

(b) department: secretary or designee;

(c) [~~NMSHTD~~] NMDOT: secretary or designee;

(d) [~~NMSHTD~~] NMDOT district office: district engineer;

(e) local government: chief administrative officer or designee;

(f) EPA region 6: regional administrator or designee;

(g) FHWA NM division office: division administrator or designee;

(h) FTA region 6: regional administrator or designee;

(i) other organizations: as directed in writing.

(2) Policy level meetings shall be those meetings to which the following individuals have been given ample notice thereof:

(a) policy level points of contact for all agencies which are required to participate in the conformity process; and

(b) the policy level points of contact for all agencies and organizations which are entitled to participate and have submitted a written request to participate in the conformity process.

[12/14/94; 11/23/98 ; 20.2.99.116 NMAC - Rn, 20 NMAC 2.99.116 10/31/02; A, 10/15/05]

20.2.99.117 AGENCY ROLES IN CONSULTATION. Specific roles of the agencies participating in the interagency consultation process are listed below. Specific responsibilities of the agencies participating in the interagency consultation process are listed in 20.2.99.118 NMAC. For the purposes of this part, the lead agency for all conformity processes and procedures is that agency which is responsible for initiating the consultation process, preparing the initial and final drafts of the document or decision, and for assuring the adequacy of the interagency consultation process.

A. The department shall be the lead agency for the development of:

(1) applicable control strategy implementation plan revisions for the nonattainment or maintenance area;

(2) the list of TCMs to be submitted as part of the SIP; and

(3) any amendments or revisions thereto.

B. In the case of areas in which an MPO has been established, the designated MPO for the nonattainment or maintenance area shall be the lead agency for:

(1) the development of the unified planning work program under 23 CFR 450.314;

(2) development of the transportation plan for the nonattainment or maintenance area;

(3) development of the TIP for the nonattainment or maintenance area;

(4) any amendments or revisions thereto;

(5) any determinations of conformity under this part for which that MPO is responsible;

(6) choosing conformity tests and methodologies for isolated rural nonattainment and maintenance areas as required by Subparagraph (c) of Paragraph (2) of Subsection [~~G~~] L of 20.2.99.128 NMAC; and

(7) development of TCMs, in cooperation with the department.

C. In the case of areas in which an MPO has not been established, [~~the NMSHTD~~] NMDOT shall be the lead agency for:

(1) the development of the transportation plan for the nonattainment or maintenance area;

(2) development of the TIP (transportation improvement program) for the nonattainment or maintenance area;

(3) any amendments or revisions thereto;

(4) any determinations of conformity under this part for which an MPO would be otherwise responsible;

(5) choosing conformity tests and methodologies for isolated rural nonattainment and maintenance areas as required by Subparagraph (c) of Paragraph (2) of Subsection [~~G~~] L of 20.2.99.128 NMAC; and

(6) development of TCMs, in cooperation with the department.

[12/14/94; 11/23/98; 20.2.99.117 NMAC - Rn, 20 NMAC 2.99.117 10/31/02; A, 10/15/05]

20.2.99.118 AGENCY RESPONSIBILITIES IN CONSULTATION.

A. The department shall be responsible for developing or providing:

(1) emissions inventories;

(2) emissions budgets;

(3) air quality modeling;

(4) attainment demonstrations;

(5) control strategy implementation plan revisions;

(6) regulatory TCMs; and

(7) updated motor vehicle emissions factors.

B. The designated MPO (or, in nonattainment or maintenance areas where an MPO has not been established, [~~the NMSHTD~~] NMDOT) shall be responsible for:

(1) developing transportation plans and TIPs;

(2) developing and evaluating TCM transportation impacts;

(3) developing transportation and socioeconomic data and planning assumptions and providing such data and planning assumptions for use in air quality analysis to determine conformity of transportation plans, TIPs, and projects;

(4) monitoring regionally significant projects;

(5) developing system- or facility-based or other programmatic (non-regulatory) TCMs;

(6) providing technical input on emissions budgets; and

(7) performing transportation modeling, regional emissions analyses and documentation of timely implementation of TCMs needed for conformity assessments.

C. [~~The NMSHTD~~] NMDOT shall be responsible for:

(1) providing technical input on proposed revisions to motor vehicle emissions factors;

(2) distributing draft and final highway or transit project environmental documents to other agencies; and

(3) convening air quality technical review meetings on specific highway or transit plans, programs and projects when requested by other agencies or as needed.

D. FHWA New Mexico offices and FTA region 6 shall be responsible for:

(1) assuring timely action on final findings of conformity, after consultation with other agencies as provided in 20.2.99.116 through 20.2.99.124 NMAC; and

(2) providing guidance on conformity and the transportation planning process to agencies participating in the interagency consultation process.

E. EPA region 6 shall be responsible for providing guidance on conformity criteria and procedures to agencies participating in the interagency consultation process.

[12/14/94; 11/23/98; 20.2.99.118 NMAC - Rn, 20 NMAC 2.99.118 10/31/02; A, 10/15/05]

20.2.99.120 CONSULTATION PROCEDURES FOR SPECIFIC MAJOR ACTIVITIES. An interagency consultation process among the members of the lead and participating agencies shall be undertaken for the following specific major activities in accordance with all the procedures specified in 20.2.119 NMAC above. The lead agency for each activity shall be as specified, and the participating agencies shall be the agencies specified in Subsection C of 20.2.99.116 NMAC above.

A. Evaluation and choice of each model (or models) and associated methods and assumptions to be used in hot-spot analyses and regional emissions analyses, including vehicle miles traveled (VMT) forecasting. The lead agency shall be the MPO (or [~~the NMSHTD~~] NMDOT in the absence of an MPO).

B. Determination of which minor arterials and other transportation projects should be considered "regionally significant" for the purposes of regional emissions analysis (in addition to those functionally classified as principal arterial or higher or fixed guideway systems or extensions that offer an alternative to regional highway travel), and which projects should be considered to have a significant change in design concept and scope from the transportation plan or TIP. The lead agency shall be the MPO (or [~~the NMSHTD~~] NMDOT in the absence of an MPO).

C. Evaluation of whether projects otherwise exempted from meeting the requirements of this part (see 20.2.99.149 NMAC) should be treated as non-exempt in cases where potential adverse emissions impacts may exist for any reason. The lead agency shall be the MPO (or[~~the NMSHTD~~] NMDOT in the absence of an MPO).

D. Determination, as

required by Paragraph (1) of Subsection C of 20.2.99.132 NMAC of whether past obstacles to implementation of TCMs which are behind the schedule established in the SIP have been identified and are being overcome, and whether state and local agencies with influence over approvals or funding for TCMs are giving maximum priority to approval or funding for TCMs. Consultation shall also include consideration of whether delays in TCM implementation necessitate revisions to the SIP to remove TCMs or substitute TCMs or other emission reduction measures. The lead agency shall be the MPO (or [~~the NMSHTD~~] NMDOT in the absence of an MPO).

E. Determination, as required by 20.2.99.140 NMAC, of whether:

(1) the project is included in the regional emissions analysis supporting the currently conforming TIP's conformity determination, even if the project is not strictly "included" in the TIP for the purposes of MPO project selection or endorsement, and

(2) the project's design concept and scope have changed significantly from those which were included in the regional emissions analysis, or in a manner which would significantly impact use of the facility; the lead agency shall be the MPO (or [~~the NMSHTD~~] NMDOT in the absence of an MPO).

F. Determination of what forecast of vehicle miles traveled (VMT) to use in establishing or tracking emissions budgets, developing transportation plans, TIPS, or making conformity determinations. The lead agency shall be the MPO (or [~~the NMSHTD~~] NMDOT in the absence of an MPO).

G. Verification of what forecast of vehicle miles traveled (VMT) to use in developing SIPs. The lead agency shall be the air quality bureau of the department.

H. Consultation, within the context of a memorandum of agreement, on emissions analysis for transportation activities which cross the borders of MPOs or nonattainment areas or air basins. The lead agency shall be [~~the NMSHTD~~] NMDOT.

I. An interagency consultation process shall be undertaken for evaluating events which will trigger new conformity determinations in addition to those triggering events established in 20.2.99.111 NMAC through 20.2.99.115 NMAC. The lead agency shall be the MPO (or [~~the NMSHTD~~] NMDOT in the absence of an MPO).

J. In the event that the metropolitan planning area does not include the entire nonattainment or maintenance area, an interagency consultation process involving the designated MPO for the nonattainment or maintenance area, [~~the NMSHTD~~] NMDOT, local transportation agencies, and the department, shall be undertaken, in the context of an MOA, for cooperative planning and analysis for purposes of determining conformity of all projects outside the metropolitan area and within the nonattainment or maintenance area. The lead agency shall be [~~the NMSHTD~~] NMDOT.

K. In nonattainment or maintenance areas where more than one MPO is involved, such MPOs must develop a memorandum of agreement or memorandum of understanding reflecting their consultation.

L. In nonattainment or maintenance areas where the MPO's jurisdiction does not cover the entire nonattainment or maintenance area, the MPO and [~~NMSHTD~~] NMDOT must develop a memorandum of agreement or a memorandum of understanding reflecting their consultation.

M. Choosing conformity tests and methodologies for isolated rural nonattainment and maintenance areas, as required by Subparagraph (c) of Paragraph (2) of Subsection [~~G~~] L of 20.2.99.128 NMAC. The lead agency shall be the MPO (or [~~the NMSHTD~~] NMDOT in the absence of an MPO).

[12/14/94; 11/23/98; 20.2.99.120 NMAC - Rn, 20 NMAC 2.99.120 10/31/02; A, 10/15/05]

20.2.99.121 CONSULTATION PROCEDURES FOR SPECIFIC ROUTINE ACTIVITIES. An interagency consultation process among the lead and participating agencies shall be undertaken for the following routine activities in accordance with all the procedures specified in 20.2.99.119 NMAC. The lead agency for each activity shall be as specified, and the participating agencies shall be the agencies specified in Subsection C of 20.2.99.116 NMAC above or as specified for the specific activity. Not later than thirty (30) days prior to the preparation of the final document or decision, the lead agency shall supply all relevant information and documents, as appropriate, to the participating agencies.

A. Identification, as required by Subsection B of 20.2.99.146 NMAC, of projects located at sites in PM10 nonattainment areas which have vehicle and roadway emission and dispersion characteristics which are essentially identical to those at sites which have violations verified by monitoring, and therefore require quantitative PM10 hot-spot analysis. The lead agency shall be either the MPO or [~~the NMSHTD~~] NMDOT, in cooperation with the department.

B. Assumption of the location and design concept and scope of projects which are disclosed to the MPO, as required by Subsection D of 20.2.99.121 NMAC, but whose sponsors have not yet decided these features in sufficient detail to perform the regional emissions analysis according to the requirements of 20.2.99.141 NMAC through [~~20.2.99.145~~] 20.2.99.147 NMAC. The lead agency shall be either the MPO or [~~the NMSHTD~~] NMDOT. Participating agencies shall include recipients of funds designated under title 23 U.S.C. or the federal transit laws.

C. The design, schedule, and funding of research and data collection efforts; and regional transportation model development by the MPO (e.g., household/travel transportation surveys). The lead agency shall be either the [~~NMSHTD~~] NMDOT or the MPO, as applicable. Participating agencies shall be the MPO, the department, and the [~~NMSHTD~~] NMDOT.

D. Regionally Significant Non-FHWA/FTA Projects.

(1) Assurance that plans for construction of regionally significant projects which are not FHWA/FTA projects (including projects for which alternative locations, design concept and scope, or the no-build option are still being considered), including all those sponsored by recipients of funds designated under title 23 U.S.C. or the federal transit laws, are disclosed to the MPO on a regular basis, and to assure that any changes to those plans are immediately disclosed. The lead agency for this process shall be the agency which is implementing the project. Participating agencies shall be the MPO, the department, [~~the NMSHTD~~] NMDOT, local transportation and transit agencies for the city or county in which the nonattainment or maintenance area is located, and recipients of funds designated under title 23 U.S.C. or the federal transit laws.

(2) The sponsor of any such regionally significant project, and any agency that becomes aware of any such project through applications for approval, permitting or funding or otherwise, shall disclose such project to the designated MPO for the nonattainment or maintenance area and [~~the NMSHTD~~] NMDOT in a timely manner. Such disclosure shall be made not later than the first occasion on which any of the following actions is sought:

(a) any policy board action necessary for the project to proceed;

(b) the issuance of administrative permits for the facility or for construction of the facility;

(c) the execution of a contract to design or construct the facility;

(d) the execution of any indebtedness for the facility;

(e) any final action of a board, commission or administrator authorizing or directing employees to proceed with design,

permitting or construction of the project; or

(f) the execution of any contract to design or construct; or any approval needed for any facility that is dependent on the completion of regionally significant project.

(3) In the case of any such regionally significant project that has not been disclosed in a timely manner to the designated MPO for the nonattainment or maintenance area, [~~the NMSHTD~~] NMDOT, and other interested agencies participating in the consultation process, such regionally significant project and all other regionally significant projects of that sponsor shall be deemed to be not included in the regional emissions analysis supporting the currently conforming TIP's conformity determination and to be not consistent with the motor vehicle emissions budget in the SIP, for the purposes of 20.2.99.140 NMAC. In the case of repeated failures to disclose regionally significant projects by an agency that becomes aware of any such project through applications for approval, permitting or funding, all other regionally significant projects within the jurisdiction of such agency shall be deemed to be not included in the regional emissions analysis supporting the currently conforming TIP's conformity determination and to be not consistent with the motor vehicle emissions budget in the SIP, for the purposes of 20.2.99.140 NMAC.

(4) For the purposes of this section (20.2.99.121 NMAC) and 20.2.99.140 NMAC, the phrase "adopt or approve of a regionally significant project" means the first time any action necessary to authorizing a project occurs, such as any policy board action necessary for the project to proceed, the issuance of administrative permits for the facility or for construction of the facility, the execution of a contract to construct the facility, any final action of a board, commission or administrator authorizing or directing employees to proceed with construction of the project, or any written decision or authorization from the MPO that the project may be adopted or approved.

[12/14/94; 11/23/98; 20.2.99.121 NMAC - Rn, 20 NMAC 2.99.121 10/31/02; A, 10/15/05]

20.2.99.122 NOTIFICATION PROCEDURES FOR ROUTINE ACTIVITIES. Notification of affected agencies (including those listed in Paragraph (1) of Subsection C of 20.2.99.116 NMAC) of transportation plan or TIP revisions or amendments which merely add or delete exempt projects listed in 20.2.99.149 NMAC, shall be the affirmative responsibility of [~~the NMSHTD~~] NMDOT and/or the MPO. Such notification shall be provided not later than thirty (30) days prior to the preparation of the final draft of the document or decision. This process shall include:

A. notification of the affected agencies (including those listed in Paragraph (1) of Subsection C of 20.2.99.116 NMAC) early in the process of decision on the final document; and

B. supplying all relevant documents and information to the affected agencies (including those listed in Paragraph (1) of Subsection C of 20.2.99.116 NMAC).

[12/14/94; 11/23/98; 20.2.99.122 NMAC - Rn, 20 NMAC 2.99.122 10/31/02; A, 10/15/05]

20.2.99.123 CONFLICT RESOLUTION AND APPEALS TO THE GOVERNOR.

A. Any conflict among state agencies or between state agencies and an MPO shall be escalated to the governor if the conflict cannot be resolved by the heads of the involved agencies. Prior to such escalation, such agencies shall make every effort to resolve any differences, including personal meetings between the heads of such agencies or their policy-level representatives, to the extent possible.

B. The department has fourteen (14) calendar days to appeal a determination of conformity (or other policy decision under this part) to the governor after [~~the NMSHTD~~] NMDOT or MPO has notified the department of the resolution of all comments on such determination of conformity or policy decision. Such fourteen-day period shall commence when the MPO or [~~the NMSHTD~~] NMDOT has confirmed receipt by the secretary of the department of the resolution of the comments of the department. If the department appeals to the governor, the final conformity determination must have the concurrence of the governor. The department must provide notice of any appeal under this Subsection to the MPO and [~~the NMSHTD~~] NMDOT. If the department does not appeal to the governor within fourteen (14) days, the MPO or [~~NMSHTD~~] NMDOT may proceed with the final conformity determination.

C. In the case of any comments with regard to findings of fiscal constraint under 20.2.99.127 NMAC or the air quality effects of any determination of conformity, [~~the NMSHTD~~] NMDOT has fourteen (14) calendar days to appeal a determination of conformity (or other policy decision under this part) to the governor after the MPO has notified the department or [~~the NMSHTD~~] NMDOT of the resolution of all comments on such determination of conformity or policy decision. Such fourteen-day period shall commence when the MPO has confirmed receipt by the secretary of the department or [~~the NMSHTD~~] NMDOT of the resolution of the comments of [~~the NMSHTD~~] NMDOT. If [~~the NMSHTD~~] NMDOT appeals to the governor, the final conformity determination must have the concurrence of the governor. [~~The NMSHTD~~] NMDOT must provide notice of any appeal under this subsection to the MPO and the department. If [~~the NMSHTD~~] NMDOT does not appeal to the governor within fourteen days, the MPO may proceed with the final conformity determination.

D. The governor may delegate the role of hearing any such appeal under this Subsection and of deciding whether to concur in the conformity determination to another official or agency within the state, but not to the head or staff of the department or any local air quality agency, [~~the NMSHTD~~] NMDOT, a state transportation commission or board, any agency that has responsibility for one of these functions, or an MPO.

[12/14/94; 11/23/98; 20.2.99.123 NMAC - Rn, 20 NMAC 2.99.123 10/31/02; A, 10/15/05]

20.2.99.125 CONTENT OF TRANSPORTATION PLANS.

A. Transportation plans adopted after January 1, 1997, in serious, severe, or extreme ozone nonattainment areas and in serious carbon monoxide nonattainment areas. If the metropolitan planning area contains an urbanized area population greater than two hundred thousand (200,000), the transportation plan must specifically describe the transportation system envisioned for certain future years which shall be called horizon years.

(1) The agency or organization developing the transportation plan, after consultation in accordance with 20.2.99.116 NMAC through 20.2.99.124 NMAC, may choose any years to be horizon years, subject to the following restrictions:

(a) horizon years may be no more than ten (10) years apart.

(b) the first horizon year may be no more than ten (10) years from the base year used to validate the transportation demand planning model.

(c) if the attainment year is in the time span of the transportation plan, the attainment year shall be a horizon year.

(d) the last horizon year shall be the last year of the transportation plan's forecast period.

(2) For these horizon years:

(a) the transportation plan shall quantify and document the demographic and employment factors influencing expected transportation demand, including land use forecasts, in accordance with imple-

mentation plan provisions and 20.2.99.116 NMAC through 20.2.99.124 NMAC;

(b) the highway and transit system shall be described in terms of the regionally significant additions or modifications to the existing transportation network which the transportation plan envisions to be operational in the horizon years; additions and modifications to the highway network shall be sufficiently identified to indicate intersections with existing regionally significant facilities, and to determine their effect on route options between transportation analysis zones; each added or modified highway segment shall also be sufficiently identified in terms of its design concept and design scope to allow modeling of travel times under various traffic volumes, consistent with the modeling methods for area-wide transportation analysis in use by the MPO; transit facilities, equipment, and services envisioned for the future shall be identified in terms of design concept, design scope, and operating policies sufficiently to allow modeling of their transit ridership; the description of additions and modifications to the transportation network shall also be sufficiently specific to show that there is a reasonable relationship between expected land use and the envisioned transportation system; and

(c) other future transportation policies, requirements, services, and activities, including intermodal activities, shall be described.

B. [~~Moderate areas reclassified to serious: Ozone or CO nonattainment areas which are reclassified from moderate to serious and have an urbanized population greater than two hundred thousand (200,000) must meet the requirements of subsection A of 20.2.99.125 NMAC within two years from the date of reclassification.~~] Two-year grace period for transportation plan requirements in certain ozone and CO areas. The requirements of Subsection A of 20.2.99.125 NMAC applies to such areas or portions of such areas that have previously not been required to meet these requirements for any existing NAAQS two years from the following:

(1) the effective date of EPA's reclassification of an ozone or CO nonattainment area that has greater than 200,000 to serious or above;

(2) the official notice by the census bureau that determines the urbanized area population of a serious or above ozone or CO nonattainment area to be greater that 200,000; or

(3) the effective date of EPA's action that classifies a newly designated ozone or CO nonattainment area that has an urbanized area population greater than 200,000 as serious or above.

C. Transportation plans for other areas. transportation plans for other areas must meet the requirements of Subsection A of 20.2.99.125 NMAC at least to the extent it has been the previous practice of the MPO to prepare plans which meet those requirements. Otherwise, transportation plans must describe the transportation system envisioned for the future specifically enough to allow determination of conformity according to the criteria and procedures of 20.2.99.128 NMAC through 20.2.99.138 NMAC.

D. Savings. The requirements of this section (20.2.99.125 NMAC) supplement other requirements of applicable law or regulation governing the format or content of transportation plans.

[12/14/94; 11/23/98; 20.2.99.125 NMAC - Rn, 20 NMAC 2.99.125 10/31/02; A, 10/15/05]

20.2.99.128 CRITERIA AND PROCEDURES FOR DETERMINING CONFORMITY OF TRANSPORTATION PLANS, PROGRAMS, AND PROJECTS - GENERAL.

A. In order for each transportation plan, program, and FHWA/FTA project to be found to conform the MPO and US DOT must demonstrate that the applicable criteria and procedures in this part are satisfied and the MPO and US DOT must comply with all applicable conformity requirements of implementation plans and of court orders for the area which pertain specifically to conformity. The criteria for making conformity determinations differ based on the action under review (transportation plans, TIPs, and FHWA/FTA projects or state projects), the relevant pollutant(s), and the status of the implementation plan.

B. The following table (Table 1) indicates the criteria and procedures in 20.2.99.129 NMAC through 20.2.99.138 NMAC which apply for transportation plans, TIPs, and FHWA/FTA projects. Subsections C through [~~F~~] I of this section (20.2.99.128 NMAC) explain when the budget, interim emission [~~reduction~~], and hot spot tests are required for each pollutant and NAAQS. Subsection J of this section (20.2.99.128 NMAC) addresses conformity requirements for areas with approved or adequate limited maintenance plans. Subsection K of this section (20.2.99.128 NMAC) addresses nonattainment maintenance areas which EPA has determined have insignificant motor vehicle emissions. Subsection [~~G~~] L of this section (20.2.99.128 NMAC) addresses isolated rural nonattainment and maintenance areas. Table 1 follows. Table 1. Conformity Criteria.

(1) All actions at all times

(a) 20.2.99.129 NMAC. Latest planning assumptions

(b) 20.2.99.130 NMAC. Latest emissions model

(c) 20.2.99.131 NMAC. Consultation

(2) Transportation Plan

(a) Subsection B of 20.2.99.132 NMAC. TCMs

(b) 20.2.99.137 NMAC and/or 20.2.99.138 NMAC. Emissions budget and/or interim [~~E~~]emissions [~~reduction~~]

(3) TIP

(a) Subsection C of 20.2.99.132 NMAC. TCMs

(b) 20.2.99.137 NMAC and/or 20.2.99.138 NMAC. Emissions budget and /or interim [~~E~~]emissions [~~reduction~~]

(4) Project (From a conforming plan and TIP)

(a) 20.2.99.133 NMAC. Currently conforming plan and TIP

(b) 20.2.99.134 NMAC. Project from a conforming plan and TIP

(c) 20.2.99.135 NMAC. CO and PM10 hot spots

(d) 20.2.99.136 NMAC. PM10 and PM2.5 control measures

(5) Project (Not from a conforming plan and TIP)

(a) Subsection D of 20.2.99.132 NMAC. TCMs

(b) 20.2.99.133 NMAC. Currently conforming plan and TIP

(c) 20.2.99.135 NMAC. CO and PM10 hot spots

(d) 20.2.99.136 NMAC. PM10 and PM2.5 control measures

(e) 20.2.99.137 NMAC and/or 20.2.99.138 NMAC. Emissions budget and/or interim emissions [~~reduction~~]

C. 1-hour [~~O~~]ozone nonattainment and maintenance areas. This Subsection (Subsection C of Section 20.2.99.128 NMAC) applies when an area is nonattainment or maintenance for the 1-hour ozone NAAQS (i.e., until the effective date of any revocation of the 1-hour ozone NAAQS for an area). In addition to the criteria listed in Table 1 in Subsection B of this section (20.2.99.128 NMAC) that are required to be satisfied at all times, in such ozone nonattainment and maintenance areas conformity determinations must include a demonstration that the budget and/or interim emission [~~reduction~~] tests are satisfied as described in the following.

(1) In all 1-hour ozone nonattainment and maintenance areas the budget test must be satisfied as required by 20.2.99.137 NMAC for conformity determinations made on or after:

(a) [~~Forty five (45) days after a control strategy implementation plan revision or maintenance plan has been submitted to US EPA, unless US EPA has declared the motor vehicle emissions budget inadequate for transportation conformity purposes; or~~] the effective data EPA's finding that a motor vehicle emissions budget in a sub-

mitted control strategy implementation plan revision or maintenance plan for the 1-hour ozone NAAQS is adequate for transportation conformity purposes;

(b) [~~After US EPA has declared that the motor vehicle emissions budget in a submitted control strategy implementation plan revision or maintenance plan is adequate for transportation conformity purposes.~~] the publication data of EPA's approval of such a budget in the federal register; or

(c) the effective state of EPA's approval of such a budget in the federal register, if such approval is completed through direct final rulemaking.

(2) In ozone nonattainment areas that are required to submit a control strategy implementation plan revision for the 1-hour ozone NAAQS (usually moderate and above areas), the interim emissions [~~reduction~~] tests must be satisfied as required by 20.2.99.138 NMAC for conformity determinations made when there is no approved motor vehicle emissions budget form an applicable implementation plan for the 1-hour ozone NAAQS and no adequate motor vehicle emissions budget form a submitted control strategy implementation plan revision or maintenance plan for the 1-hour ozone NAAQS.

[~~**(a)** During the first forty-five (45) days after a control strategy implementation plan revision or maintenance plan has been submitted to US EPA, unless US EPA has declared a motor vehicle emissions budget adequate for transportation conformity purposes; or~~

~~**(b)** If US EPA has declared the motor vehicle emissions budget in a submitted control strategy implementation plan revision or maintenance plan inadequate for transportation conformity purposes, and there is no previously established motor vehicle emissions budget in the approved implementation plan or a previously submitted control strategy implementation plan revision or maintenance plan.~~]

(3) An ozone nonattainment area must satisfy the interim emissions [~~reduction~~] test for NOx, as required by 20.2.99.138 NMAC, if the implementation plan or plan submission that is applicable for the purposes of conformity determinations is a fifteen percent (15%) plan or phase I attainment demonstration that does not include a motor vehicle emissions budget for NOx. The implementation plan for the 1-hour ozone NAAQS will be considered to establish a motor vehicle emissions budget for NOx if the implementation plan or plan submission contains an explicit NOx motor vehicle emissions budget that is intended to act as a ceiling on future NOx emissions, and the NOx motor vehicle emissions budget is a net reduction from NOx emissions levels in 1990.

(4) Ozone nonattainment areas that have not submitted a maintenance plan and that are not required to submit a control strategy implementation plan revision for the 1-hour NAAQS (usually marginal and below areas) must satisfy one of the following requirements:

(a) the interim emissions [~~reduction~~] tests required by 20.2.99.138 NMAC; or

(b) the department shall submit to US EPA an implementation plan revision for the 1-hour ozone NAAQS that contains motor vehicle emissions budget(s) and a reasonable further progress or an attainment demonstration, and the budget test required by 20.2.99.137 NMAC must be satisfied using the adequate or approved [~~submitted~~] motor vehicle emissions budget(s) (as described in Paragraph (1) of Subsection C of 20.2.99.128 NMAC).

(5) Notwithstanding Paragraphs (1) and (2) of Subsection C of 20.2.99.128 NMAC, moderate and above ozone nonattainment areas with three years of clean data for the 1-hour ozone NAAQS that have not submitted a maintenance plan and that US EPA has determined are not subject to the Clean Air Act reasonable further progress and attainment demonstration requirements for the 1-hour NAAQS must satisfy one of the following requirements:

(a) the interim emissions [~~reduction~~] tests as required by 20.2.99.138 NMAC;

(b) the budget test as required by 20.2.99.137 NMAC, using the adequate or approved motor vehicle emissions budgets in the submitted or applicable control strategy implementation plan for the 1-hour ozone NAAQS (subject to the timing requirements of Paragraph (1) of Subsection C of 20.2.99.128 NMAC); or

(c) the budget test as required by 20.2.99.137 NMAC, using the motor vehicle emissions of ozone precursors in the most recent year of clean data as motor vehicle emissions budgets, if such budgets are established by the US EPA rulemaking that determines that the area has clean data for the 1-hour ozone NAAQS.

D. 8-hour ozone NAAQS nonattainment and maintenance areas without motor vehicle emissions budgets for the 1-hour ozone NAAQS for any portion of the 8-hour nonattainment area. This Subsection (Subsection D of Section 20.2.99.128 NMAC) applies to areas that were never designated nonattainment for the 1-hour ozone NAAQS but that never submitted a control strategy SIP or maintenance plan with approved or adequate motor vehicle emissions budgets. This Subsection (Subsection D of Section 20.2.99.128 NMAC) applies one (1) year after the effective date of EPA's nonattainment designation for the 8-hour ozone NAAQS for an area, according to Subsection D of 20.2.99.109 NMAC. In the addition to the criteria listed in Table 1 in Subsection B of 20.2.99.128 NMAC that are required to be satisfied at all times, in such 8-hour ozone nonattainment and maintenance areas conformity determinations much include a demonstration that the budget and/or interim emissions tests are satisfied as described in the following.

(1) In such 8-hour ozone nonattainment and maintenance areas the budget test much be satisfied as required by Section 20.2.99.137 NMAC for conformity determinations made on or after;

(a) the effective date of EPA's finding that a motor vehicle emissions budget in a submitted control strategy implementation plan revision or maintenance plan for the 8-hour ozone NAAQS is adequate for transportation conformity purposes;

(b) the publication date of EPA's approval of such a budget in the federal register; or

(c) the effective date of EPA's approval of such a budget in the federal register, if such approval is completed through direct final rulemaking.

(2) In ozone nonattainment areas that are required to submit a control strategy implementation plan revision for the 8-hour ozone NAAQS (usually moderate and above and certain Clean Air Act, part D subpart 1 areas), the interim emissions tests must by satisfied as required by Section 20.2.99.138 NMAC for conformity determinations made when there is no approved motor vehicle emissions budget from an applicable implementation plan for 8-hour ozone NAAQS and no adequate motor vehicle emissions budget from a submitted control strategy implementation plan revision or maintenance plan for the 8-hour NAAQS.

(3) Such an 8-hour ozone nonattainment area must satisfy the interim emissions test for NOx, as required by Section 20.2.99.138 NMAC, if the implementation plan or plan submission that is applicable for the purposes of conformity determination is a fifteen percent (15%) plan or other control strategy SIP that addresses reasonable further progress that does not include a motor vehicle emissions budget for NOx. The implementation plan for the 8-hour ozone NAAQS will be considered to establish a motor vehicle emissions budget for NOx if the implementation plan or plan submission contains an explicit NOx motor vehicle emissions budget that is intended to act as a ceiling on future NOx emissions, and the NOx motor vehicle emissions budget is a net reduction from NOx emissions

levels in 2002.

(4) Ozone nonattainment areas that have not submitted a maintenance plan and that are not required to submit a control strategy implementation plan revision for the 8-hour ozone NAAQS (usually marginal and certain Clean Air Act, part D, subpart 1 areas) must satisfy one of the following requirements:

(a) the interim emissions tests required by Section 20.2.99.138 NMAC; or

(b) the department shall submit to EPA an implementation plan revision for the 8-hour ozone NAAQS that contains motor vehicle emissions budget(s) and a reasonable further progress or attainment demonstration, and the budget test required by Section 20.2.99.137 NMAC must be satisfied using the adequate or approved motor vehicle emissions budget(s) (as described in Paragraph (1) of Subsection D of 20.2.99.128 NMAC).

(5) Notwithstanding Paragraphs (1) and (2) of Subsection D of 20.2.99.128 NMAC, ozone nonattainment areas with three (3) years of clean data for the 8-hour ozone NAAQS that have not submitted maintenance plan and that EPA has determined are not subject to the Clean Air Act reasonable further progress and attainment demonstration requirements for the 9-hour ozone NAAQS must satisfy one of the following requirements:

(a) the interim emissions tests as required by Section 20.2.99.138 NMAC;

(b) the budget test as required by Section 20.2.99.137 NMAC, using the adequate or approved motor vehicle emissions budgets in the submitted or applicable control strategy implementation plan for the 8-hour ozone NAAQS (subject to the timing requirements of Paragraph (1) of Subsection D of 20.2.99.128 NMAC; or

(c) the budget test as required by Section 20.2.137 NMAC, using the motor vehicle emissions of ozone precursors in the most recent year of clean data as motor vehicle emissions budgets, if such budgets are established by the EPA rulemaking that determines that the area has clean data for the 8-hour ozone NAAQS.

E. 8-hour ozone NAAQS nonattainment and maintenance areas with motor vehicle emissions budgets for the 1-hour ozone NAAQS that cover all or a portion of the 8-hour nonattainment area. This provision applies one (1) year after the effective date of EPA's nonattainment designation for the 8-hour ozone NAAQS for an area, according to Subsection D of Section 2.20.99.109 NMAC. In addition to the criteria listing in Table 1 in Subsection B of this section (2.20.2.128 NMAC) that are required to be satisfied at all times, in such 8-hour ozone nonattainment and maintenance areas conformity determinations must include a demonstration that the budget and/or interim emissions tests are satisfied as described in the following.

(1) In such 8-hour ozone nonattainment and maintenance areas the budget test must be satisfied as required by Section 20.2.99.137 NMAC for conformity determinations made on or after:

(a) the effective date of EPA's finding that a motor vehicle emissions budget in a submitted control strategy implementation plan revision or maintenance plan for the 8-hour ozone NAAQS is adequate for transportation conformity purposes;

(b) the publication date of EPA's approval of such a budget in the federal register; or

(c) the effective date of EPA's approval of such a budget in the federal register, is such approval is completed through direct final rulemaking.

(2) Prior to Paragraph (1) or Subsection E of this section (20.2.99.128 NMAC) applying, the following test(s) must be satisfied, subject to the exception in Subparagraph (e) of Paragraph (2) of Subsection E of this section (20.2.99.128 NMAC).

(a) If the 8-hour ozone nonattainment area covers the same geographic area as the 1-hour ozone nonattainment or maintenance area(s) , the budget test as required by Section 20.2.99.137 NMAC using the approved or adequate motor vehicle emissions budgets in the 1-hour ozone applicable implementation plan or implementation plan submission.

(b) If the 8-hour ozone nonattainment area covers a smaller geographic area within the 1-hour ozone nonattainment or maintenance area(s), the budget test as required by Section 20.2.99.137 NMAC for either the 8-hour nonattainment area using corresponding portion(s) of the approved or adequate motor vehicle emissions budgets in the 1-hour ozone applicable implementation plan or implementation plan submission where such portion(s) can reasonably be identified through the interagency consultation process required by Section 20.2.99.116 NMAC ; or the 1-hour nonattainment area using the approved or adequate motor vehicle emissions budgets in the 1-hour ozone applicable implementation plan or implementation plan submission. If additional emission reductions are necessary to meet the budget test for the 8-hour ozone NAAQS in such cases, these emissions reductions must come from within the 8-hour nonattainment area.

(c) If the 8-hour ozone nonattainment area covers a larger geographic area and encompasses the entire 1-hour ozone nonattainment or maintenance area(s) the budget test as required by Section 20.2.99.137 NMAC for the portion of the 8-hour ozone nonattainment area covered by the approved or adequate motor vehicle emissions budgets in the 1-hour ozone applicable implementation plan or implementation plan submission; and the interim emissions tests as required by Section 20.2.99.138 NMAC for either: the portion of the 8-hour ozone nonattainment area not covered by the approved or adequate budgets in the 1-hour ozone implementation plan, the entire 8-hour ozone nonattainment area, or the entire portion of the 8-hour ozone nonattainment area within an individual state, in the case where separate 1-hour SIP budgets are established for each state of a multi-state 1-hour nonattainment area partially covers a 1-hour ozone nonattainment or maintenance area(s).

(d) If the 8-hour ozone nonattainment area partially covers a 1-hour ozone nonattainment of maintenance area(s) the budget test as required by Section 20.2.99.137 NMAC for the portion of the 8-hour ozone nonattainment area covered by the corresponding portion of the approved or adequate motor vehicle emissions budgets in the 1-hour ozone applicable implementation plan or implementation plan submission where they can be reasonably identified through the interagency consultation process required by Section 20.2.99.116 NMAC ; and the interim emissions tests as required by Section 20.2.99.138 NMAC, when applicable, for either: the portion of the 8-hour ozone nonattainment area not covered by the approved or adequate budgets in the 1-hour ozone implementation plan, the entire 8-hour ozone nonattainment area, or the entire portion of the 8-hour ozone nonattainment area within an individual state, in the case where separate 1-hour SIP budgets are established for each state in a multi-state 1-hour nonattainment or maintenance area.

(e) Notwithstanding Subparagraphs (a), (b), (c), and (d) of Paragraph (2) of Subsection E of this section (20.2.99.128 NMAC), the interim emissions tests as required by Section 20.2.99.138 NMAC, where the budget test using the approved or adequate motor vehicle emissions budget in the 1-hour ozone applicable implementation plan(s) or implementation plan submission(s) for the relevant area or portion thereof is not the appropriate test and the interim emissions tests are more appropriate to ensure that the transportation plan, TIP, or project not from a conforming plan and TIP will not create new violations, worsen existing violations, or delay timely attainment of the 8-hour ozone standard, as determined through the interagency consultation process required by Section 20.2.99.116 NMAC.

(3) Such an 8-hour ozone nonattainment area must satisfy the interim emissions test for NOx, as required by Section 20.2.99.138 NMAC, if the only implemen-

tation plan or plan submission that is applicable for the purposes of conformity determinations is a fifteen percent (15%) plan or other control strategy SIP that addresses reasonable further progress that does not include a motor vehicle emissions budget for NOx. The implementation plan for the 8-hour ozone NAAQS will be considered to establish a motor vehicle emissions budget for NOx if the implementation plan or plan submission contains an explicit NOx motor vehicle emissions budget that is intended to act as a ceiling on future NOx emissions, and the NOx motor vehicle emissions budget is a net reduction from NOx emissions levels in 2002. Prior to an adequate or approved NOx motor vehicle emissions budget in the implementation plan submission for the 8-hour ozone NAAQS, the implementation plan for the 1-hour ozone NAAQS will be considered to establish a motor vehicle emissions budget for NOx if the implementation plan contains on explicit NOx motor vehicle emissions budget that is intended to act as a ceiling on future NOx emissions, and the NOx motor vehicle emission budget is a net reduction from NOx emissions levels in 1990.

(4) Notwithstanding Paragraphs (1) and (2) of Subsection E of this section (20.2.99.128 NMAC), ozone nonattainment areas with three years of clean data for the 8-hour ozone NAAQS that have not submitted a maintenance plan and that EPA has determined are not subject to the Clean Air Act reasonable further progress and attainment demonstration requirement for the 8-hour ozone NAAQS must satisfy one of the following requirements:

(a) the budget test and/or interim emissions tests are required by Sections 20.2.99.137 NMAC and 20.2.99.138 NMAC and as described in Paragraph (2) of Subsection E of this section (20.2.99.128 NMAC);

(b) the budget test as required by Section 20.2.99.137 NMAC, using the adequate or approved motor vehicle emission budgets in the submitted or applicable control strategy implementation plan for the 8-hour ozone NAAQS (subject to the timing requirements of Paragraph (1) of Subsection E of 20.2.99.128 NMAC; or

(c) the budget test as required by Section 20.2.99.137 NMAC, using the motor vehicle emissions of ozone precursors in the most recent year of clean data as motor vehicle emissions budgets, if such budgets are established by the EPA rulemaking that determines that the area has clean data for the 8-hour ozone NAAQS.

[~~D~~]**F.** CO nonattainment and maintenance areas. In addition to the criteria listed in Table 1 in Subsection B of 20.2.99.128 NMAC that are required to be satisfied at all times, in CO nonattainment and maintenance areas conformity determinations must include a demonstration that the hot spot, budget and/or interim emissions [~~reduction~~] tests are satisfied as described in the following.

(1) FHWA/FTA projects in CO nonattainment or maintenance areas must satisfy the hot spot test required by Subsection A of 20.2.99.135 NMAC at all times. Until a CO attainment demonstration or maintenance plan is approved by US EPA, FHWA/FTA projects must also satisfy the hot spot test required by Subsection B of 20.2.99.135 NMAC.

(2) In CO nonattainment and maintenance areas the budget test must be satisfied as required by 20.2.99.137 NMAC for conformity determinations made on or after:

(a) [~~Forty-five (45) days after a control strategy implementation plan revision or maintenance plan has been submitted to US EPA, unless US EPA has declared the motor vehicle emissions budget inadequate for transportation conformity purposes; or~~] the effective date of EPA's finding that a motor vehicle emissions budget in a submitted control strategy implementation plan revision or maintenance plan is adequate for transportation conformity purposes;

(b) [~~After US EPA has declared that the motor vehicle emissions budget in a submitted control strategy implementation plan revision or maintenance plan is adequate for transportation conformity purposes.~~] the publication date of EPA's approval of such a budget in the federal register; or

(c) the effective date of EPA's approval of such a budget in the federal register, if such approval is completed through direct final rulemaking.

(3) Except as provided in Paragraph (4) of Subsection [~~D~~] F of 20.2.99.128 NMAC, in CO nonattainment areas the interim emissions [~~reduction~~] tests must be satisfied as required by 20.2.99.138 NMAC for conformity determinations made when there is no approved motor vehicle emissions budget from an applicable implementation plan and no adequate motor vehicle emissions budget from a submitted control strategy implementation plan revision or maintenance plan.

[~~**(a)** During the first forty-five (45) days after a control strategy implementation plan revision or maintenance plan has been submitted to US EPA, unless US EPA has declared a motor vehicle emissions budget adequate for transportation conformity purposes; or~~

~~**(b)** If US EPA has declared the motor vehicle emissions budget in a submitted control strategy implementation plan revision or maintenance plan inadequate for transportation conformity purposes, and there is no previously established motor vehicle emissions budget in the approved implementation plan or a previously submitted control strategy implementation plan revision or maintenance plan.~~]

(4) CO nonattainment areas that have not submitted a maintenance plan and that are not required to submit an attainment demonstration (e.g., moderate CO areas with a design value of 12.7 ppm or less or not classified CO areas) must satisfy one of the following requirements:

(a) the interim emissions [~~reduction~~] tests required by 20.2.99.138 NMAC; or

(b) the department shall submit to US EPA an implementation plan revision that contains motor vehicle emissions budget(s) and an attainment demonstration, and the budget test required by 20.2.99.137 NMAC must be satisfied using the [~~submitted~~] adequate or approved motor vehicle emissions budget(s) (as described in Paragraph (2) of Subsection [~~D~~] F of 20.2.99.128 NMAC).

[~~E~~]**G.** PM10 nonattainment and maintenance areas. In addition to the criteria listed in Table 1 in Subsection B of 20.2.99.128 NMAC that are required to be satisfied at all times, in PM10 nonattainment and maintenance areas conformity determinations must include a demonstration that the hot spot, budget and/or interim emissions [~~reduction~~] tests are satisfied as described in the following.

(1) FHWA/FTA projects in PM10 nonattainment or maintenance areas must satisfy the hot spot test required by 20.2.99.135 NMAC.

(2) In PM10 nonattainment and maintenance areas the budget test must be satisfied as required by 20.2.99.137 NMAC for conformity determinations made on or after:

(a) [~~forty-five (45) days after a control strategy implementation plan revision or maintenance plan has been submitted to US EPA, unless US EPA has declared the motor vehicle emissions budget inadequate for transportation conformity purposes; or~~] the effective date of EPA's finding that a motor vehicle emissions budget in a submitted control strategy implementation plan revision or maintenance plan is adequate for transportation conformity purposes;

(b) [~~After US EPA has declared that the motor vehicle emissions budget in a submitted control strategy implementation plan revision or maintenance plan is adequate for transportation conformity purposes.~~] the publication date of EPA's approval of such a budget in the federal register; or

(c) the effective data of EPA's approval of such a budget in the federal register, if such approval is completed through

direct final rulemaking.

(3) In PM10 nonattainment areas the interim emissions [~~reduction~~] tests must be satisfied as required by 20.2.99.138 NMAC for conformity determinations made:

(a) [~~During the first forty-five (45) days after a control strategy implementation plan revision or maintenance plan has been submitted to US EPA, unless US EPA has declared a motor vehicle emissions budget adequate for transportation conformity purposes~~] if there is no approved motor vehicle emissions budget from an applicable implementation plan and no adequate motor vehicle emissions budget from a submitted control strategy implementation plan revision or maintenance plan; or

[~~(b) If US EPA has declared the motor vehicle emissions budget in a submitted control strategy implementation plan revision or maintenance plan inadequate for transportation conformity purposes, and there is no previously established motor vehicle emissions budget in the approved implementation plan or a previously submitted control strategy implementation plan revision or maintenance plan; or~~]

[~~(c)~~]**(b)** if the submitted implementation plan revision is a demonstration of impracticability under CAA Section 189(a)(1)(B)(ii) and does not demonstrate attainment.

[~~F~~]**H.** NO2 nonattainment and maintenance areas. In addition to the criteria listed in Table 1 in Subsection B of 20.2.99.128 NMAC that are required to be satisfied at all times, in NO2 nonattainment and maintenance areas conformity determinations must include a demonstration that the budget and/or interim emissions [~~reduction~~] tests are satisfied as described in the following.

(1) In NO2 nonattainment and maintenance areas the budget test must be satisfied as required by 20.2.99.137 NMAC for conformity determinations made on or after:

(a) [~~Forty-five (45) days after a control strategy implementation plan revision or maintenance plan has been submitted to US EPA, unless US EPA has declared the motor vehicle emissions budget inadequate for transportation conformity purposes; or~~] the effective date of EPA's finding that a motor vehicle emissions budget in a submitted control strategy implementation plan revision or maintenance plan is adequate for transportation conformity purposes.

(b) [~~After US EPA has declared that the motor vehicle emissions budget in a submitted control strategy implementation plan revision or maintenance plan is adequate for transportation conformity purposes.~~] the publication date of EPA's approval of such a budget in the federal register; or

(c) the effective data of EPA's approval of such a budget in the federal register, if such approval is completed through direct final rulemaking.

(2) In NO2 nonattainment areas the interim emissions [~~reduction~~] tests must be satisfied as required by 20.2.99.138 NMAC for conformity determinations made when there is no approved motor vehicle emissions budget from an applicable implementation plan and no adequate motor vehicle emissions budget from a submitted control strategy implementation plan revision or maintenance plan.[~~:~~]

[~~**(a)** During the first forty-five (45) days after a control strategy implementation plan revision or maintenance plan has been submitted to US EPA, unless US EPA has declared a motor vehicle emissions budget adequate for transportation conformity purposes; or~~

~~**(b)** If US EPA has declared the motor vehicle emissions budget in a submitted control strategy implementation plan revision or maintenance plan inadequate for transportation conformity purposes, and there is no previously established motor vehicle emissions budget in the approved implementation plan or a previously submitted control strategy implementation plan revision or maintenance plan.~~]

I. PM2.5 nonattainment and maintenance areas. In addition to the criteria listed in Table 1 in Subsection B of Section 20.2.99.128 NMAC that are required to be satisfied at all times, in PM2.5 nonattainment and maintenance areas conformity determinations must include a demonstration that the budget and/or interim emissions tests are satisfied as described in the following:

(1) in PM2.5 nonattainment and maintenance areas the budget in a submitted control strategy implementation plan revision or maintenance plan is adequate for transportation conformity purposes;

(a) the effective date of EPA's finding that a motor vehicle emissions budget in a submitted control strategy implementation plan revision or maintenance plan is adequate for transportation conformity purposes;

(b) the publication date of EPA's approval of such a budget in the federal register; or

(c) the effective data of EPA's approval of such a budget in the rederal register, if such approval is completed through direct final rulemaking.

(2) In PM2.5 nonattainment areas the interim emissions tests must be satisfied as required by Section 20.2.99.138 NMAC for conformity determinations made if there is no approved motor vehicle emissions budget from an applicable implementation plan and no adequate motor vehicle emissions budget from a submitted control strategy implementation plan revision or maintenance plan.

J. Areas with limited maintenance plans. Notwithstanding the other paragraphs of this section, an area is not required to satisfy the regional emissions analysis for Sections 20.2.99.137 NMAC and/or 20.2.99.138 NMAC for a given pollutant and NAAQS, if the area has an adequate or approved limited maintenance plan would have to demonstrate that it would be unreasonable to expect that such an area would experience enough motor vehicle emissions growth for a NAAQS violations to occur. A conformity determination that meets other applicable criteria in Table 1 or Subsection B of this section (20.2.99.128 NMAC) is still required, including the hot-spot requirements for projects in CO and PM10 areas.

K. Areas with insignificant motor vehicle emissions. Notwithstanding the other Subsections in this section (20.2.99.128 NMAC), and area is not required to satisfy a regional emissions analysis for Sections 20.2.99.137 NMAC and/or 20.2.99.138 NMAC for a given pollutant/precursor and NAAQS, if EPA finds through the adequacy or approval process that a SIP demonstrates that regional motor vehicle emissions are an insignificant contributor to the air quality problem for that pollutant/precursor and NAAQS. The SIP would have to demonstrate that it would be unreasonable to expect that such an area would experience enough motor vehicle emissions growth in that pollutant/precursor for a NAAQS violation to occur. Such a finding would be based on a number of factors, including the percentage of motor vehicle emissions in the context of the total SIP inventory, the current state of air quality as determined by monitoring data for that NAAQS, the absence of SIP motor vehicle control measures, and historical trends and future projections of the growth of motor vehicle emissions. A conformity determination that meets other applicable criteria in Table 1 or Subsection B of this section (20.2.99.128 NMAC) is still required, including regional emissions analyses for Sections 20.2.99.137 NMAC and/or 20.2.99.138 NMAC for other pollutants/precursors and NAAQS that apply. Hot-spot requirements for projects in CO PM10 area in Section 20.2.99.135 NMAC must also be satisfied, unless EPA determined that the SIP also demonstrates that projects will not create new localized violations and/or increase the severity or number of existing violations of such NAAQS. If EPA subsequently finds that motor vehicle emissions of a given pollutant/precursor are significant, this subsection would no longer apply for future conformity determinations for that pollutant/precursor and NAAQS.

[~~G~~]**L.** Isolated rural nonattainment and maintenance areas. This subsection applies to any nonattainment or maintenance area (or portion thereof) which does not have a metropolitan transportation plan or TIP and whose projects are not part of the emissions analysis of any MPO's metropolitan transportation plan or TIP. This subsection does not apply to "donut" areas which are outside the metropolitan planning boundary and inside the nonattainment/maintenance area boundary.

(1) FHWA/FTA projects in all isolated rural nonattainment and maintenance areas must satisfy the requirements of 20.2.99.129 NMAC through 20.2.99.131 NMAC, Subsection D of 20.2.99.132 NMAC, 20.2.99.135 NMAC, and 20.2.99.136 NMAC. Until US EPA approves the control strategy implementation plan or maintenance plan for a rural CO nonattainment or maintenance area, FHWA/FTA projects must also satisfy the requirements of Subsection B of 20.2.99.135 NMAC ("Localized CO and PM10 violations (hot spots)").

(2) Isolated rural nonattainment and maintenance areas are subject to the budget and/or interim emissions [~~reduction~~] tests as described in Subsections C through [~~F~~] K of 20.2.99.128 NMAC, with the following modifications:

(a) when the requirements of 20.2.99.137 NMAC and 20.2.99.138 NMAC apply to isolated rural nonattainment and maintenance areas, references to "transportation plan" or "TIP" should be taken to mean those projects in the statewide transportation plan or statewide TIP which are in the rural nonattainment or maintenance area.

(b) in isolated rural nonattainment and maintenance areas that are subject to 20.2.99.137 NMAC, FHWA/FTA projects must be consistent with motor vehicle emissions budget(s) for the years in the timeframe of the attainment demonstration or maintenance plan. For years after the attainment year (if a maintenance plan has not been submitted) or after the last year of the maintenance plan, FHWA/FTA projects must satisfy one of the following requirements:

(i) 20.2.99.137 NMAC;

(ii) 20.2.99.138 NMAC (including regional emissions analysis for NOx in all ozone nonattainment and maintenance areas, notwithstanding Paragraph (2) of Subsection [~~D~~] F of 20.2.99.138 NMAC; or

(iii) as demonstrated by the air quality dispersion model or other air quality modeling technique used in the attainment demonstration or maintenance plan, the FHWA/FTA project, in combination with all other regionally significant projects expected in the area in the timeframe of the statewide transportation plan, must not cause or contribute to any new violation of any standard in any areas; increase the frequency or severity of any existing violation of any standard in any area; or delay timely attainment of any standard or any required interim emission reductions or other milestones in any area; control measures assumed in the analysis must be enforceable.

(c) the choice of requirements in Subparagraph (b) of Paragraph (2) of Subsection G of 20.2.99.128 NMAC and the methodology used to meet the requirements of item (iii) of Subparagraph (b) of Paragraph (2) of Subsection G of 20.2.99.128 NMAC must be determined through the interagency consultation process required in Paragraph (6) of Subsection B of 20.2.99.117 NMAC and Paragraph (5) of Subsection C of 20.2.99.117 NMAC through which the relevant recipients of title 23 U.S.C. or federal transit laws funds, [~~the NMSHTD~~] NMDOT, the department, or the local air quality agency should reach consensus about the option and methodology selected; US EPA and US DOT must be consulted through this process as well; in the event of unresolved disputes, conflicts may be escalated to the governor consistent with the procedure in 20.2.99.123 NMAC, which applies to department comments on a conformity determination.

[12/14/94; 11/23/98; 20.2.99.128 NMAC - Rn, 20 NMAC 2.99.128 10/31/02; A, 10/15/05]

20.2.99.129 CRITERIA AND PROCEDURES - LATEST PLANNING ASSUMPTIONS.

A. Except as provided in this paragraph, [~~F~~]the conformity determination, with respect to all other applicable criteria in 20.2.99.130 NMAC through 20.2.99.138 NMAC, must be based upon the most recent planning assumptions in force at the time [~~of~~] the conformity [~~determination~~] analysis begins. The conformity determination must satisfy the requirements of Subsections B through F of 20.2.99.129 NMAC using the planning assumptions available at the time the conformity analysis begins as determined through the interagency consultation process required Subparagraph (a) of Paragraph (1) of Subsection C of Section 20.2.99.116 NMAC. The "time the conformity analysis begins" for a transportation plan or TIP determination in the point at which the MPO or the other designated agency begins to model the impact of the proposed transportation plan or TIP on travel and/or emissions. New data that becomes available after an analysis begins is required to be used in the conformity determination only if a significant delay in the analysis has occurred, as determined through interagency consultation.

B. Assumptions (including, but not limited to, vehicle miles traveled per capita or per household, trip generation per household, vehicle occupancy, household size, vehicle fleet mix, vehicle ownership, and the geographic distribution of population growth) must be derived from the estimates of current and future population, employment, travel, and congestion most recently developed by the MPO, or other agency authorized to make such estimates and approved by the MPO. The conformity determination must also be based on the latest assumptions about current and future background concentrations.

C. The conformity determination for each transportation plan and TIP must discuss how transit operating policies (including fares and service levels) and assumed transit ridership have changed since the previous conformity determination.

D. The conformity determination must include reasonable assumptions about transit service and increases in transit fares and road and bridge tolls over time.

E. The conformity determination must use the latest existing information regarding the effectiveness of the TCMs and other implementation plan measures which have already been implemented.

F. Key assumptions shall be specified and included in the draft documents and supporting materials used for the interagency and public consultation required by 20.2.99.116 NMAC through 20.2.99.124 NMAC.

[12/14/94; 11/23/98; 20.2.99.129 NMAC - Rn, 20 NMAC 2.99.129 10/31/02; A, 10/15/05]

20.2.99.135 CRITERIA AND PROCEDURES - LOCALIZED CO AND PM10 VIOLATIONS (HOT SPOTS).

A. This paragraph applies at all times. The FHWA/FTA project must not cause or contribute to any new localized CO or PM10 violations or increase the frequency or severity of any existing CO or PM10 violations in CO and PM10 nonattainment and maintenance areas. This criterion is satisfied if it is demonstrated that during the time frame of the transportation plan (or regional emissions analysis) [~~that~~] no new local violations will be created and the severity or number of existing violations will not be increased as a result of the project. The demonstration shall be performed according to the consultation requirements of Subsection A of 20.2.99.120 NMAC and

the methodology requirements of 20.2.99.146 NMAC.

B. This paragraph applies for CO nonattainment areas as described in Paragraph (1) of Subsection [~~D~~] F of 20.2.99.128 NMAC. Each FHWA/FTA project must eliminate or reduce the severity and number of localized CO violations in the area substantially affected by the project (in CO nonattainment areas). This criterion is satisfied with respect to existing localized CO violations if it is demonstrated that during the time frame of the transportation plan (or regional emissions analysis) existing localized CO violations will be eliminated or reduced in severity and number as a result of the project. The demonstration must be performed according to the consultation requirements of Subsection A of 20.2.99.120 NMAC and the methodology requirements of 20.2.99.146 NMAC.

[12/14/94; 11/23/98; 20.2.99.135 NMAC - Rn, 20 NMAC 2.99.135 10/31/02; A, 10/15/05]

20.2.99.136 CRITERIA AND PROCEDURES - COMPLIANCE WITH PM10 and PM2.5 CONTROL MEASURES. The FHWA/FTA project must comply with PM10 and PM2.5 control measures in the applicable implementation plan. This criterion is satisfied if the project-level conformity determination contains a written commitment from the project sponsor to include in the final plans, specifications, and estimates for the project those control measures (for the purpose of limiting PM10 and PM2.5 emissions from the construction activities and/or normal use and operation associated with the project) that are contained in the applicable implementation SIP.

[12/14/94; 11/23/98; 20.2.99.136 NMAC - Rn, 20 NMAC 2.99.136 10/31/02; A, 10/15/05]

20.2.99.137 CRITERIA AND PROCEDURES - MOTOR VEHICLE EMISSIONS BUDGET.

A. The transportation plan, TIP, and project not from a conforming transportation plan and TIP must be consistent with the motor vehicle emissions budget(s) in the applicable control strategy implementation plan (or implementation plan submission). This criterion applies as described in Subsections C through [~~G~~] L of 20.2.99.128 NMAC. This criterion is satisfied if it is demonstrated that emissions of the pollutants or pollutant precursors described in Subsection C of 20.2.99.137 NMAC are less than or equal to the motor vehicle emissions budget(s) established in the applicable implementation plan or implementation plan submission.

B. Consistency with the motor vehicle emissions budget(s) must be demonstrated for each year for which the applicable (and/or submitted) implementation plan specifically establishes motor vehicle emissions budget(s), for the attainment year (if it is within the time frame of the transportation plan) for the last year of the transportation plan's forecast period, and for any intermediate years as necessary so that the years for which consistency is demonstrated are no more than ten years apart, as follows.

(1) Until a maintenance plan is submitted:

(a) emissions in each year (such as milestone years and the attainment year) for which the control strategy implementation plan revision establishes motor vehicle emissions budget(s) must be less than or equal to that year's motor vehicle emissions budget(s); and

(b) emissions in years for which no motor vehicle emissions budget(s) are specifically established must be less than or equal to the motor vehicle emissions budget(s) established for the most recent prior year; for example, emissions in years after the attainment year for which the implementation plan does not establish a budget must be less than or equal to the motor vehicle emissions budget(s) for the attainment year.

(2) When a maintenance plan has been submitted:

(a) emissions must be less than or equal to the motor vehicle emissions budget(s) established for the last year of the maintenance plan, and for any other years for which the maintenance plan establishes motor vehicle emissions budgets; if the maintenance plan does not establish motor vehicle emissions budgets for any years other than the last year of the maintenance plan, the demonstration of consistency with the motor vehicle emissions budget(s) must be accompanied by a qualitative finding that there are no factors which would cause or contribute to a new violation or exacerbate an existing violation in the years before the last year of the maintenance plan; the interagency consultation process required by 20.2.99.116 NMAC through 20.2.99.124 NMAC shall determine what must be considered in order to make such a finding;

(b) for years after the last year of the maintenance plan, emissions must be less than or equal to the maintenance plan's motor vehicle emissions budget(s) for the last year of the maintenance plan; [~~and~~]

(c) if an approved and/or submitted control strategy implementation plan has established motor vehicle emissions budgets for years in the timeframe of the transportation plan, emissions in these years must be less than or equal to the control strategy implementation plan's motor vehicle emissions budget(s) for these years[~~.~~] : and

(d) for any analysis years before the last year of the maintenance plan, emissions must be less than or equal to the motor vehicle emissions budget(s) established for the most recent prior year.

C. Consistency with the motor vehicle emissions budget(s) must be demonstrated for each pollutant or pollutant precursor in Subsection B of 20.2.99.109 NMAC (or 20.2.99.101 NMAC) for which the area is in nonattainment or maintenance and for which the applicable implementation plan (or implementation plan submission) establishes a motor vehicle emissions budget.

D. Consistency with the motor vehicle emissions budget(s) must be demonstrated by including emissions from the entire transportation system, including all regionally significant projects contained in the transportation plan and all other regionally significant highway and transit projects expected in the nonattainment or maintenance area in the timeframe of the transportation plan.

(1) Consistency with the motor vehicle emissions budget(s) must be demonstrated with a regional emissions analysis that meets the requirements of 20.2.99.141 NMAC through [~~20.2.99.145~~] 20.2.99.147 NMAC and 20.2.99.120 NMAC.

(2) The regional emissions analysis may be performed for any years in the timeframe of the transportation plan provided they are not more than ten years apart and provided the analysis is performed for the attainment year (if it is in the timeframe of the transportation plan) and the last year of the plan's forecast period. Emissions in years for which consistency with motor vehicle emissions budgets must be demonstrated, as required in Subsection B of 20.2.99.137 NMAC, may be determined by interpolating between the years for which the regional emissions analysis is performed.

E. Motor vehicle emissions budgets in submitted control strategy implementation plan revisions and submitted maintenance plans.

(1) Consistency with the motor vehicle emissions budgets in submitted control strategy implementation plan revisions or maintenance plans must be demonstrated if US EPA has declared the motor vehicle emissions budget(s) adequate for transportation conformity purposes, [~~or beginning forty-five (45) days after the control strategy implementation plan revision or maintenance plan has been submitted (unless US EPA has declared the motor vehicle emissions budget(s) inadequate for transportation conformity purposes).~~] and the adequacy finding is effective. However, motor vehicle emissions budgets in submitted implementation plans do not supersede

the motor vehicle emissions budgets in approved implementation plans for the same Clean Air Act requirement and the period of years addressed by the previously approved implementation plan, unless US EPA specifies otherwise in its approval of a SIP.

(2) If US EPA has not declared an implementation plan submission's motor vehicle emissions budget(s) [~~in~~]adequate for transportation conformity purposes, the [~~inadequate~~] budget(s) shall not be used to satisfy the requirements of this section. Consistency with the previously established motor vehicle emissions budget(s) must be demonstrated. If there are no previously approved implementation plans or implementation plan submissions with adequate motor vehicle emissions budgets, the interim emissions [~~reduction~~] tests required by 20.2.99.138 NMAC must be satisfied.

(3) If US EPA declares an implementation plan submission's motor vehicle emissions budget(s) inadequate for transportation conformity purposes [~~more than forty-five (45) days after its submission to US EPA,~~] after US EPA had previously found the budget(s) adequate, and conformity of a transportation plan or TIP has already been determined by US DOT using the budget(s), the conformity determination will remain valid. Projects included in that transportation plan or TIP could still satisfy 20.2.99.133 NMAC and 20.2.99.134 NMAC, which require a currently conforming transportation plan and TIP to be in place at the time of a project's conformity determination and that projects come from a conforming transportation plan and TIP.

(4) US EPA will not find a motor vehicle emissions budget in a submitted control strategy implementation plan revision or maintenance plan to be adequate for transportation conformity purposes unless the following minimum criteria are satisfied:

(a) the submitted control strategy implementation plan revision or maintenance plan was endorsed by the governor (or his or her designee) and was subject to a state public hearing;

(b) before the control strategy implementation plan or maintenance plan was submitted to US EPA, consultation among federal, state, and local agencies occurred; full implementation plan documentation was provided to US EPA; and US EPA's stated concerns, if any, were addressed;

(c) the motor vehicle emissions budget(s) is clearly identified and precisely quantified;

(d) the motor vehicle emissions budget(s), when considered together with all other emissions sources, is consistent with applicable requirements for reasonable further progress, attainment, or maintenance (whichever is relevant to the given implementation plan submission);

(e) the motor vehicle emissions budget(s) is consistent with and clearly related to the emissions inventory and the control measures in the submitted control strategy implementation plan revision or maintenance plan; and

(f) revisions to previously submitted control strategy implementation plans or maintenance plans explain and document any changes to previously submitted budgets and control measures; impacts on point and area source emissions; any changes to established safety margins (see Subsection [~~AI~~] AO of 20.2.99.7 NMAC for definition); and reasons for the changes (including the basis for any changes related to emission factors or estimates of vehicle miles traveled).

(5) Before determining the adequacy of a submitted motor vehicle emissions budget, US EPA will review the department's compilation of public comments and response to comments that are required to be submitted with any implementation plan. US EPA will document its consideration of such comments and responses in a letter to the department indicating the adequacy of the submitted motor vehicle emissions budget.

(6) When the motor vehicle emissions budget(s) used to satisfy the requirements of this section are established by an implementation plan submittal that has not yet been approved or disapproved by US EPA, the MPO and US DOT's conformity determinations will be deemed to be a statement that the MPO and US DOT are not aware of any information that would indicate that emissions consistent with the motor vehicle emissions budget will cause or contribute to any new violation of any standard; increase the frequency or severity of any existing violation of any standard; or delay timely attainment of any standard or any required interim emission reductions or other milestones.

F. Adequacy review process for implementation plan submissions. US EPA will use the procedure listing in Paragraph (1) of Subsection F of this section (20.2.99.137 NMAC) to review the adequacy of an implementation plan.

(1) When US EPA reviews the adequacy of an implementation plan submission prior to EPA's final action on the implementation plan:

(a) US EPA will notify the public through US EPA's website when US EPA receives an implementation plan submission that will be reviewed for adequacy;

(b) the public will have a minimum of 30 days to comment on the adequacy of the implementation plan submission; if the complete implementation plan is not accessible electronically through the internet and a copy is requested within fifteen (15) days of the date of the website notice, the comment period will be extended 30 days from the date that a copy of the implementation plan is mailed;

(c) after the public comment period closes, US EPA will inform the department in writing whether US EPA has found the submission adequate or inadequate for use in transportation conformity, including response to any comments submitted directly and review of comments submitted through the department process, or US EPA will include the determination of adequacy or inadequacy in a proposed or final action approving or disapproving the implementation plan under Subparagraph (c) of Paragraph (2) of Subsection F of this section (20.2.99.137 NMAC);

(d) US EPA will publish a federal register notice to inform the public of US EPA's finding; if EPA finds the submission adequate, the effective date of this finding will be fifteen (15) days from the date the notice is published as established in the federal register notice, unless US EPA is taking a final approval action on the SIP as described in Subparagraph (c) of Paragraph (2) for Subsection F for this section (20.2.99.137 NMAC);

(e) US EPA will announce whether the implementation plan submission is adequate or inadequate for use in transportation conformity on US EPA's website; the website will also include US EPA's response to comments of any comments were received during the public comments period;

(f) if after US EPA has found a submission adequate, US EPA has cause to reconsider this finding, US EPA will repeat actions described in Subparagraphs (a) through (e) of Paragraph (1) of Subsection F or Paragraph (2) of Subsection F of 20.2.99.137 NMAC unless US EPA determines that there is no need for additional public comment given the deficiencies of the implementation plan submission; in all cases where US EPA reverses its previous finding to a finding of inadequacy under Paragraph (1) of Subsection F of 20.2.99.137 NMAC, such a finding will become effective immediately upon the date of US EPA's letter to the department;

(g) if after EPA has found a submission inadequate, US EPA has cause to reconsider the adequacy of that budget, US EPA will repeat actions described in Subparagraphs (a) through (e) of Paragraph (1) of this section (20.2.99.137 NMAC).

(2) When US EPA reviews the adequacy of an implementation plan submission simultaneously with US EPA's approval or disapproval of the implementa-

tion plan:

(a) US EPA's federal register notice of proposed or direct final rulemaking will serve to notify the public that US EPA will be reviewing the implementation plan submission for adequacy;

(b) the publication of the notice of proposed rulemaking will start a public comment period of at least thirty (30) days;

(c) US EPA will indicate whether the implementation plan submission is adequate and thus can be used for conformity either in US EPA's final rulemaking or through the process described in Subparagraphs (c) through (e) of Paragraph (1) of Subsection F of this section (20.2.99.137 NMAC); if US EPA makes an adequacy finding through a final rulemaking that approves the implementation plan submission, such a finding will become effective upon the publication date of US EPA's approval in the federal register, or upon the effective date of US EPA's approval if such action is conducted through direct final rulemaking; US EPA will respond to comments received directly and review comments submitted through the department process and include the response to comments in the applicable docket.

[12/14/94; 11/23/98; 20.2.99.137 NMAC - Rn, 20 NMAC 2.99.137 10/31/02; A, 10/15/05]

20.2.99.138 CRITERIA AND PROCEDURES - [~~EMISSION REDUCTIONS~~] INTERIM EMISSIONS IN AREAS WITHOUT MOTOR VEHICLE EMISSIONS BUDGETS.

A. The transportation plan, TIP, and project not from a conforming transportation plan and TIP must [~~contribute to emissions reductions~~] satisfy the interim emissions test(s) as described in Subsections C through L of 20.2.99.128 NMAC. This criterion applies [~~as described in Subsections C through G of 20.2.99.128 NMAC. It applies~~] to the net effect of the action (transportation plan, TIP, or project not from a conforming transportation plan and TIP) on motor vehicle emissions from the entire transportation system.

B. Ozone areas. The requirements of this subsection (Subsection B of 20.2.99.138 NMAC) apply to all 1-hour ozone and 8-hour ozone NAAQS areas, except for certain requirements as indicated. This criterion may be met.

(1) [~~i~~]In moderate and above ozone nonattainment areas that are subject to the reasonable further progress requirements of CAA Section 182(b)(1) [~~and in moderate with design value greater than 12.7 ppm and serious CO nonattainment areas~~] if a regional emissions analysis that satisfies the requirements of 20.2.99.141 NMAC through [~~20.2.99.145~~] 20.2.99.147 NMAC and Subsections [~~E~~] G through [~~H~~] L of 20.2.99.138 NMAC demonstrates that for each analysis year and for each of the pollutants described in Subsection [~~D~~] F of 20.2.99.138 NMAC:

[~~(1)~~]**(a)** the emissions predicted in the "action" scenario are less than the emissions predicted in the "baseline" scenario, and this can be reasonably expected to be true in the periods between the analysis years; and

[~~(2)~~]**(b)** the emissions predicted in the "action" scenario are lower than 1990 emissions by any nonzero amount, in areas for the 1-hour ozone NAAQS as described in Subsection C of section 20.2.99.128 NMAC; or the 2002 emissions by any nonzero amount, in areas for the 8-hour ozone NAAQS as described in Subsections D and E of 20.2.99.128 NMAC.

(2) In marginal and below ozone nonattainment areas and other ozone nonattainment areas that are not subject to the reasonable further progress requirements of the Clean Air Act Section 182(b)(1) if a regional emissions analysis that satisfies the requirements of Section 20.2.99.141 NMAC through 20.2.99.147 NMAC and Subsection G through J of 20.2.99.138 NMAC demonstrates that for each analysis year and for each of the pollutants described in Subsection F of 20.2.99.138 NMAC:

(a) the emissions predicted in the "action" scenario are not greater than the emissions predicted in the "baseline" scenario, and this can be reasonably expected to be true in the periods between the analysis years; or

(b) the emissions predicted in the "action" scenario are not greater than the 1990 emissions, in areas for the 1-hour NAAQS as described in Subsection C of 20.2.99.128 NMAC ; or the 2002 emissions, in areas for the 8-hour ozone NAAQS as described in Subsections D and E for 20.2.99.128 NMAC.

C. CO areas. This criterion may be met:

(1) in moderate areas with design values greater than 12.7 ppm and serious CO nonattainment areas that are subject to Clean Air Act Section 187(a)(7) if a regional emissions analysis that satisfies they requirements of Sections 20.2.99.141 NMAC through 20.2.99.147 NMAC and Subsections G through J of 20.2.99.138 NMAC demonstrates that for each analysis year and for each of the pollutants described in Subsection F of 20.2.99.138 NMAC:

(a) the emissions predicted in the "action" scenario are less than the emissions predicted in the "baseline" scenario, and this can be reasonably expected to be true in the periods between the analysis years; and

(b) the emissions predicted in the "action" scenario are lower than 1990 emissions by any nonzero amount.

(2) in moderate areas with design values less than 12.7 ppm and not classified CO nonattainment areas if a regional emissions analysis that satisfies the requirements of Sections 20.2.99.141 NMAC through 20.2.99.147 NMAC and Subsections G through J of 20.2.99.138 NMAC demonstrates that for each analysis year and for each of the pollutants described in Subsection F of 20.2.99.138 NMAC:

(a) the emissions predicted in the "action" scenario are not greater than the emissions predicted in the "baseline" scenario, and this can be reasonably expected to be true in the periods between the analysis years; or

(b) the emissions predicted in the "action" scenario are not greater than 1990 emissions.

[~~C~~]**D.** PM10 and NO2 areas. This criterion may be met in PM10 and NO2 nonattainment areas[~~; marginal and below ozone nonattainment areas and other ozone nonattainment areas that are not subject to the reasonable further progress requirements of CAA Section 182(b)(1); and moderate with design value less than 12.7 ppm and below CO nonattainment areas~~] if a regional emissions analysis that satisfies the requirements of 20.2.99.141 NMAC through [~~20.2.99.145~~] 20.2.99.147 NMAC and Subsections [~~E~~] G through [~~H~~] J of 20.2.99.138 NMAC demonstrates that for each analysis year and for each of the pollutants described in Subsection [~~D~~] F of 20.2.99.138 NMAC, one of the following requirements is met:

(1) the emissions predicted in the "action" scenario are [~~less~~] not greater than the emissions predicted in the "baseline" scenario, and this can be reasonably expected to be true in the periods between the analysis years; or

(2) the emissions predicted in the "action" scenario are not greater than baseline emissions; baseline emissions are those estimated to have occurred during calendar year 1990, unless the conformity implementation plan revision required by 40 CFR 51.390 defines the baseline emissions for a PM10 area to be those occurring in a different calendar year for which a baseline emissions inventory was developed for the purpose of developing a control strategy implementation plan.

E. PM2.5 areas. This criterion maybe met in PM2.5 nonattainment areas if a regional emissions analysis that satisfies the requirements of Sections 20.2.99.141 NMAC through 20.2.99.147 NMAC and Subsections G through J of 20.2.99.138 NMAC demonstrates that for each analysis year and for each of the pollutants described in Subsection F of 20.2.99.138 NMAC, one of the following requirements is met:

(1) the emissions predicated in

the "action" scenario are not greater than the emissions predicted in the "baseline" scenario, and this can be reasonably expected to be true in the periods between the analysis years; or

(2) the emissions predicted in the "action" scenario are not greater that 2002 emissions.

[~~D~~]**F.** Pollutants. The regional emissions analysis must be performed for the following pollutants:

(1) VOC in ozone areas;

(2) NOx in ozone areas, unless the US EPA administrator determines that additional reductions of NOx would not contribute to attainment;

(3) CO in CO areas;

(4) PM10 in PM10 areas;

(5) [~~Transportation related precursors of PM10 in PM10 nonattainment and maintenance~~] VOC and/or NOx in PM10 areas if the US EPA regional administrator or the department has made a finding that such precursor emissions from within the area are a significant contributor to the PM10 nonattainment problem and has so notified the MPO and US DOT; [~~and~~]

(6) NOx in NO2 areas;

(7) PM2.5 areas; and

(8) reentrained road dust in PM2.5 areas only if the US EPA regional administrator or the department has made a finding that emissions from reentrained road dust within the area are a significant contributor to the PM2.5 nonattainment problem and has so notified the MPO and US DOT.

[~~E~~]**G.** Analysis years[~~:~~] .

(1) The regional emissions analysis must be performed for analysis years that are no more than ten (10) years apart. The first analysis year must be no more than five (5) years beyond the year in which the conformity determination is being made. The last year of transportation plan's forecast period must also be an analysis year.

(2) For areas using Subparagraph (a) of Paragraph (2) of Subsection B of Section 20.2.99.138 NMAC, Subparagraph (a) of Paragraph (2) of Subsection C of Section 20.2.99.138 NMAC, Paragraph (1) of Subsection D of Section 20.2.99.138 NMAC, and Paragraph (1) of Subsection E of Section 20.2.99.138 NMAC, a regional emissions analysis that satisfies the requirements of Sections 20.2.99.141 NMAC through 20.2.99.147 NMAC and Subsections G through J of Section 20.2.99.138 would not be required for analysis years in which the transportation projects and planning assumptions in the "action" and "baseline" scenarios are exactly the same. In such a case, Subsection A of Section 20.2.99.138 NMAC can be satisfied by documenting that the transportation projects and planning assumptions in both scenarios are exactly the same, and consequently, the emissions predicted in the "action" scenario are not greater than the emissions predicted in the "baseline" scenario for such analysis years.

[~~F~~]**H.** "Baseline" scenario. The regional emissions analysis required by Subsections B and [~~C~~] E of 20.2.99.138 NMAC must estimate the emissions that would result from the "baseline" scenario in each analysis year. The "baseline" scenario must be defined for each of the analysis years. The "baseline" scenario is the future transportation system that will result from current programs, including the following (except that exempt projects listed in Subsection A of 20.2.99.149 NMAC and projects exempt from regional emissions analysis as listed in Subsection B of 20.2.99.149 NMAC need not be explicitly considered):

(1) all in-place regionally significant highway and transit facilities, services and activities;

(2) all ongoing travel demand management or transportation system management activities; and

(3) completion of all regionally significant projects, regardless of funding source, which are currently under construction or are undergoing right-of-way acquisition (except for hardship acquisition and protective buying); come from the first year of the previously conforming transportation plan and/or TIP; or have completed the NEPA process.

[~~G~~]**I.** "Action" scenario. The regional emissions analysis required by Subsections B and [~~C~~] E of 20.2.99.138 NMAC must estimate the emissions that would result from the "action" scenario in each analysis year. The "action" scenario must be defined for each of the analysis years. The "action" scenario is the transportation system that would result from the implementation of the proposed action (transportation plan, TIP, or project not from a conforming transportation plan and TIP) and all other expected regionally significant projects in the nonattainment area. The "action" scenario must include the following (except that exempt projects listed in Subsection A of 20.2.99.149 NMAC and projects exempt from regional emissions analysis as listed in Subsection B of 20.2.99.149 NMAC need not be explicitly considered):

(1) all facilities, services, and activities in the "baseline" scenario;

(2) completion of all TCMs and regionally significant projects (including facilities, services, and activities) specifically identified in the proposed transportation plan which will be operational or in effect in the analysis year, except that regulatory TCMs may not be assumed to begin at a future time unless the regulation is already adopted by the enforcing jurisdiction or the TCM is identified in the applicable implementation plan;

(3) all travel demand management programs and transportation system management activities known to the MPO, but not included in the applicable implementation plan or utilizing any federal funding or approval, which have been fully adopted and/or funded by the enforcing jurisdiction or sponsoring agency since the last conformity determination;

(4) the incremental effects of any travel demand management programs and transportation system management activities known to the MPO, but not included in the applicable implementation plan or utilizing any federal funding or approval, which were adopted and/or funded prior to the date of the last conformity determination, but which have been modified since then to be more stringent or effective;

(5) completion of all expected regionally significant highway and transit projects which are not from a conforming transportation plan and TIP; and

(6) completion of all expected regionally significant non-FHWA/FTA highway and transit projects that have clear funding sources and commitments leading toward their implementation and completion by the analysis year.

[~~H~~]**J.** Projects not from a conforming transportation plan and TIP. For the regional emissions analysis required by Subsections B and [~~C~~] E of 20.2.99.138 NMAC, if the project which is not from a conforming transportation plan and TIP is a modification of a project currently in the plan or TIP, the "baseline" scenario must include the project with its original design concept and scope, and the "action" scenario must include the project with its new design concept and scope.

[12/14/94; 11/23/98; 20.2.99.138 NMAC - Rn, 20 NMAC 2.99.138 10/31/02; A, 10/15/05]

20.2.99.139 CONSEQUENCES OF CONTROL STRATEGY IMPLEMENTATION PLAN FAILURES.

A. Disapprovals.

(1) If US EPA disapproves any submitted control strategy implementation plan revision (with or without a protective finding), the conformity status of the transportation plan and TIP shall lapse on the date that highway sanctions as a result of the disapproval are imposed on the nonattainment area under Section 179(b)(1) of the CAA. No new transportation plan, TIP, or project may be found to conform until another control strategy implementation plan revision fulfilling the same CAA requirements is submitted and conformity

to this submission is determined.

(2) If US EPA disapproves a submitted control strategy implementation plan revision without making a protective finding, [~~then beginning one hundred twenty (120) days after such disapproval,~~] only projects in the first three (3) years of the currently conforming transportation plan and TIP may be found to conform. This means that beginning [~~one hundred twenty (120) days after disapproval without a protective finding~~] on the effective date of a disapproval without a protective finding, no transportation plan, TIP, or project not in the first three (3) years of the currently conforming plan and TIP may be found to conform until another control strategy implementation plan revision fulfilling the same Clean Air Act requirements is submitted [~~and conformity to this submission is determined. During the first one hundred twenty (120) days following US EPA's disapproval without a protective finding, transportation plan, TIP, and project conformity determinations shall be made using the motor vehicle emissions budget(s) in the disapproved control strategy implementation plan, unless another control strategy implementation plan revision has been submitted and its motor vehicle emissions budget(s) applies for transportation conformity purposes, pursuant to 20.2.99.128 NMAC.~~], US EPA finds its motor vehicle emissions budget(s) adequate pursuant to Section 20.2.99.137 NMAC or approves the submission, and conformity to the implementation plan revision is determined.

(3) In disapproving a control strategy implementation plan revision, US EPA would give a protective finding where a submitted plan contains adopted control measures or written commitments to adopt enforceable control measures that fully satisfy the emissions reductions requirements relevant to the statutory provision for which the implementation plan revision was submitted, such as reasonable further progress or attainment.

B. Failure to submit and incompleteness. In areas where US EPA notifies the department, MPO, and US DOT of the department's failure to submit a control strategy implementation plan or submission of an incomplete control strategy implementation plan revision (either of which initiates the sanction process under CAA Sections 179 or 110(m)), the conformity status of the transportation plan and TIP shall lapse on the date that highway sanctions are imposed on the nonattainment area for such failure under Section 179(b)(1) of the CAA, unless the failure has been remedied and acknowledged by a letter from the US EPA regional administrator.

C. Federal implementation plans. If US EPA promulgates a federal implementation plan that contains motor vehicle emissions budget(s) as a result of a department failure, the conformity lapse imposed by 20.2.99.139 NMAC because of the department failure is removed.

[12/14/94; 11/23/98; 20.2.99.139 NMAC - Rn, 20 NMAC 2.99.139 10/31/02; A, 10/15/05]

20.2.99.140 REQUIREMENTS FOR ADOPTION OR APPROVAL OF PROJECTS BY OTHER RECIPIENTS OF FUNDS DESIGNATED UNDER TITLE 23 U.S.C. OR THE FEDERAL TRANSIT LAWS

A. Except as provided in Subsection B of 20.2.99.140 NMAC, no recipient of federal funds designated under title 23 U.S.C. or the federal transit laws shall adopt or approve a regionally significant highway or transit project, regardless of funding source, unless the recipient finds that the requirements of one of the following are met:

(1) the project [~~was included in the first three (3) years of the most recently~~] comes from the currently conforming transportation plan and TIP[~~(or the conformity determination's regional emissions analyses), even if conformity status is currently lapsed;~~] and the project's design concept and scope [~~has~~] have not changed significantly from those analyses for that transportation plan and TIP; or

(2) the project is included in the regional emissions analysis for the currently conforming transportation plan and TIP conformity determination (even if the project is not strictly included in the transportation plan or TIP for the purpose of MPO project selection or endorsement) and the project's design concept and scope have not changed significantly form those which were included in the regional emissions analysis; or

[~~(2)~~]**(3)** [~~There is a currently conforming transportation plan and TIP, and~~] a new regional emissions analysis including the project and the currently conforming transportation plan and TIP demonstrates that the transportation plan and TIP would still conform if the project were implemented (consistent with the requirements of 20.2.99.137 NMAC and/or 20.2.99.138 NMAC for a project not from a conforming transportation plan and TIP).

B. In isolated rural nonattainment and maintenance areas subject to Subsection G of 20.2.99.128 NMAC, no recipient of federal funds designated under title 23 U.S.C. or the federal transit laws shall adopt or approve a regionally significant highway or transit project, regardless of funding source, unless the recipient finds that the requirements of one of the following are met:

(1) the project was included in the regional emissions analysis supporting the most recent conformity determination [~~for the~~] that reflects the portion of the statewide transportation plan and TIP which are in the nonattainment or maintenance area, and the project's design concept and scope has not changed significantly; or

(2) a new regional emissions analysis including the project and all other regionally significant projects expected in the nonattainment or maintenance area demonstrates that those projects in the statewide transportation plan and statewide TIP which are in the nonattainment or maintenance area would still conform if the project were implemented (consistent with the requirements of 20.2.99.137 NMAC and/or 20.2.99.138 NMAC for projects not from a conforming transportation plan and TIP).

C. Notwithstanding Subsections A and B of Section 20.2.99.140 NMAC, in nonattainment and maintenance areas subject to Subsections J or K of Section 20.2.99.128 NMAC for a given pollutant/precursor and NAAQS, no recipient of federal funds designated under title 20 U.S.C. or the federal transit laws shall adopt or approve a regionally significant highway or transit project, regardless of funding source. Unless the recipient finds that the requirements of one of the following are met for that pollutant/precursor and NAAQS:

(1) the project was included in the most recent conformity determination for the transportation plan and TIP and the project's design concept and scope has not changed significantly; or

(2) the project as included in the most recent conformity determination that reflects the portions of the statewide transportation plan and statewide TIP which are in the nonattainment or maintenance area, and the project's design concept and scope has not changed significantly.

[12/14/94; 11/23/98; 20.2.99.140 NMAC - Rn, 20 NMAC 2.99.140 10/31/02; A, 10/15/05]

20.2.99.143 PROCEDURES FOR DETERMINING REGIONAL TRANSPORTION- RELATED POLLUTION EMISSIONS – TWO-YEAR GRACE PERIOD FOR REGIONAL EMISSIONS ANALYSIS REQUIREMENTS IN CERTAIN OZONE AND CO AREAS. The requirements of 20.2.99.142 NMAC apply in such areas or portions of such areas that have not previously been required to meet these requirements for any existing NAAQS two years from the following:

A. the effective date of US EPA's reclassification of an ozone or CO nonattainment area that have an urbanized area population greater than 200,000 to serious or above;

B. the official notice by the census bureau that determines the

urbanized area population of a serious or above ozone or CO nonattainment area to be greater than 200,000; or

C. the effective date of US EPA's action that classifies a newly designated ozone or CO nonattainment area that has an urbanized area population greater than 200,000 as serious or above.

[12/14/94; 11/23/98; 20.2.99.143 NMAC - Rn, 20 NMAC 2.99.143, 10/31/02; 20.2.99.143 NMAC - N, 10/15/05]

[~~20.2.99.143~~] 20.2.99.144 PROCEDURES FOR DETERMINING REGIONAL TRANSPORTATION-RELATED POLLUTANT EMISSIONS — AREAS WHICH ARE NOT SERIOUS, SEVERE OR EXTREME OZONE NONATTAINMENT AREAS OR SERIOUS CARBON MONOXIDE AREAS. In all areas not otherwise subject to 20.2.99.142 NMAC, regional emissions analyses must use those procedures described in 20.2.99.142 NMAC if the use of those procedures has been the previous practice of the MPO. Otherwise, areas not subject to 20.2.99.142 NMAC may estimate regional emissions using any appropriate methods that account for VMT growth by, for example, extrapolating historical VMT or projecting future VMT by considering growth in population and historical growth trends for VMT per person. These methods must also consider future economic activity, transit alternatives, and transportation system policies.

[12/14/94; 11/23/98; 20.2.99.144 NMAC - Rn, 20 NMAC 2.99.144, 10/31/02; 20.2.99.144 NMAC - Rn, 20.2.99.143 NMAC, 10/15/05]

[~~20.2.99.144~~] 20.2.99.145 PROCEDURES FOR DETERMINING REGIONAL TRANSPORTATION-RELATED POLLUTANT EMISSIONS — PM10 FROM CONSTRUCTION-RELATED FUGITIVE DUST.

A. For areas in which the implementation plan does not identify construction-related fugitive PM10 as a contributor to the nonattainment problem, the fugitive PM10 emissions associated with highway and transit project construction are not required to be considered in the regional emissions analysis.

B. In PM10 nonattainment and maintenance areas with implementation plans which identify construction-related fugitive PM10 as a contributor to the nonattainment problem, the regional PM10 emissions analysis shall consider construction-related fugitive PM10 and shall account for the level of construction activity, the fugitive PM10 control measures in the SIP, and the dust-producing capacity of the proposed activities.

[12/14/94; 11/23/98; 20.2.99.145 NMAC - Rn, 20 NMAC 2.99.145, 10/31/02; 20.2.99.145 NMAC - Rn, 20.2.99.144 NMAC, 10/15/05]

20.2.99.146 PROCEUDURES FOR DETERMINING REGIONAL TRANSPORTATION - RELATED POLLUTANT EMISSIONS — PM2.5 FROM CONSTRUCTION - RELATED FUGITIVE DUST.

A. For PM2.5 areas in which the implementation plan does not identify construction-related fugitive PM2.5 as a significant contributor to the nonattainment problem, the fugitive PM2.5 emissions associated with highway and transit project construction are not required to be considered on the regional emissions analysis.

B. In PM2.5 nonattainment and maintenance areas with implementation plans which identify construction-related fugitive PM2.5 as a significant contributor to the nonattainment problem, the regional PM2.5 emissions analysis shall consider construction-related fugitive PM2.5 and shall account for the level of construction activity, the fugitive PM2.5 control measures in the applicable implementation plan, and the dust-producing capacity of the proposed activities.

[12/14/94; 11/23/98; 20.2.99.146 NMAC - Rn, 20 NMAC 2.99.146, 10/31/02; 20.2.99.146 NMAC - N, 10/15/05]

[~~20.2.99.145~~] 20.2.99.147 PROCEDURES FOR DETERMINING REGIONAL TRANSPORTATION-RELATED POLLUTANT EMISSIONS — RELIANCE ON PREVIOUS REGIONAL EMISSIONS ANALYSIS.

A. [~~The~~] Conformity determinations for a new transportation plan and/or TIP may be demonstrated to satisfy the requirements of Section 20.2.99.137 NMAC ("Motor vehicle emissions budget") or Section 20.2.99.138 NMAC ("Emission reductions in areas without motor vehicle emissions budgets") without new regional emissions analysis if the regional emissions analysis [~~already performed for the plan~~] if the previous regional emissions analysis also applies to the new plan and/or TIP. This requires a demonstration that:

(1) the new plan and/or TIP contains all projects which must be started in the plan and TIP's timeframes in order to achieve the highway and transit system envisioned by the transportation plan;

(2) all plan and TIP projects which are regionally significant are included in the transportation plan with design concept and scope adequate to determine their contribution to the transportation plan's and/or TIP's regional emissions at the time of the [~~transportation plan's conformity~~] previous conformity determination; and

(3) the design concept and scope of each regionally significant project in the new plan and/or TIP [~~is~~] are not significantly different from that described in the previous transportation plan[~~.~~]; and

(4) the previous regional emissions analysis is consistent with the requirements of Section 20.2.99.137 NMAC (including that conformity to all currently applicable budgets is demonstrated) and/or Section 20.2.99.138 NMAC, as applicable.

B. A project which is not from a conforming transportation plan and a conforming TIP may be demonstrated to satisfy the requirements of 20.2.99.137 NMAC or 20.02.99.138 NMAC without additional regional emissions analysis if allocating funds to the project will not delay the implementation of projects in the transportation plan or TIP which are necessary to achieve the highway and transit system envisioned by the transportation plan, the previous regional emissions analysis is still consistent with the requirements of Section 20.2.99.137NMAC (including that conformity to all currently applicable budgets is demonstrated) and/or Section 20.2.99.138 NMAC, as applicable, and if the project is either:

(1) not regionally significant; or

(2) included in the conforming transportation plan (even if it is not specifically included in the latest conforming TIP) with design concept and scope adequate to determine its contribution to the transportation plan's regional emissions at the time of the transportation plan's conformity determination, and the design concept and scope of the project is not significantly different from that described in the transportation plan.

C. A conformity determination that relies on this section (20.2.99.147 NMAC) does not satisfy the frequency requirements of Sections 20.2.99.112 NMAC and 20.2.99.113 NMAC.

[12/14/94; 11/23/98; 20.2.99.147 NMAC - Rn, 20 NMAC 2.99.147, 10/31/02; 20.2.99.147 NMAC - Rn, 20.2.99.145 NMAC & A, 10/15/05]

[~~20.2.99.146~~] 20.2.99.148 PROCEDURES FOR DETERMINING LOCALIZED CO AND PM10 CONCENTRATIONS (HOT-SPOT ANALYSIS).

A. CO Hot-spot Analysis.

(1) The demonstrations required by 20.2.99.135 NMAC shall be based on quantitative analysis using the applicable air quality models, data bases, and other requirements specified in 40 CFR part 51 appendix W ("Guideline on Air Quality

Models"). These procedures shall be used in the following cases, unless, different procedures developed through the interagency consultation process required in 20.2.99.116 NMAC through 20.2.99.124 NMAC and approved by the EPA region 6 administrator are used:

(a) for projects in or affecting locations, areas, or categories of sites which are identified in the SIP as sites of violation or possible violation;

(b) for projects affecting intersections that are at level-of-service D, E, or F, or those that will change to level-of-service D, E, or F because of increased traffic volumes related to the project;

(c) for any project affecting one or more of the intersections which the SIP identifies as the top three intersections in the nonattainment or maintenance area based on the highest traffic volumes; and

(d) for any project affecting one or more of the intersections which the SIP identifies as the top three intersections in the nonattainment or maintenance area based on the worst level of service.

(2) In cases other than those described in Paragraph (1) of Subsection A of 20.2.99.146 NMAC, the demonstrations required by 20.2.99.135 NMAC may be based on either:

(a) quantitative methods that represent reasonable and common professional practice; or

(b) a qualitative consideration of local factors, if this can provide a clear demonstration that the requirements of 20.2.99.135 NMAC are met.

B. PM10 Hot-spot Analysis.

(1) The hot-spot demonstration required by 20.2.99.135 NMAC shall be based on quantitative analysis methods for the following types of projects:

(a) projects which are located at sites at which violations have been verified by monitoring;

(b) projects which are located at sites which have vehicle and roadway emission and dispersion characteristics that are essentially identical to those of sites with verified violations (including sites near one at which a violation has been monitored); and

(c) new or expanded bus and rail terminals and transfer points which increase the number of diesel vehicles congregating at a single location.

(2) Where quantitative analysis methods are not required, the demonstration required by 20.2.99.135 NMAC may be based on a qualitative consideration of local factors.

(3) The identification of the sites described in Subparagraphs (a) and (b) of Paragraph (1) of Subsection B of 20.2.99.146 NMAC and other cases where quantitative methods are appropriate, shall be determined through the interagency consultation process required in 20.2.99.116 NMAC through 20.2.99.124 NMAC. US DOT may choose to make a categorical conformity determination on bus and rail terminals or transfer points based on appropriate modeling of various terminal sizes, configurations, and activity levels.

(4) The requirements of this Subsection B of 20.2.99.146 NMAC for quantitative analysis will not take effect until EPA releases modeling guidance on this subject and announces in the federal register that these requirements are in effect.

C. General Requirements.

(1) Estimated pollutant concentrations shall be based on the total emissions burden which may result from the implementation of the project, summed together with future background concentrations. The total concentration shall be estimated and analyzed at appropriate receptor locations in the area substantially affected by the project.

(2) Hot-spot analyses shall include the entire project, and may be performed only after the major design features which will significantly impact concentrations have been identified. The future background concentration should be estimated by multiplying current background by the ratio of future to current traffic and the ratio of future to current emission factors.

(3) Hot-spot analysis assumptions shall be consistent with those in the regional emissions analysis for those inputs which are required for both analyses.

(4) PM10 or CO mitigation or control measures shall be assumed in the hot-spot analysis only where there are written commitments from the project sponsor or operator to implement such measures, as required by Subsection A of 20.2.99.148 NMAC.

(5) CO and PM10 hot-spot analyses are not required to consider construction-related activities which cause temporary increases in emissions. Each site which is affected by construction- related activities shall be considered separately, using established "Guideline" methods. Temporary increases are defined as those which occur only during the construction phase and last five years or less at any individual site.

[12/14/94; 11/23/98; 20.2.99.148 NMAC - Rn, 20 NMAC 2.99.148, 10/31/02; 20.2.99.148 NMAC - Rn, 20.2.99.146, 10/15/05]

[~~20.2.99.147~~] 20.2.99.149 USING THE MOTOR VEHICLE EMISSIONS BUDGET IN THE SIP (OR IMPLEMENTATION PLAN SUBMISSION).

A. In interpreting an SIP (or implementation plan submission) with respect to its motor vehicle emissions budget(s), the MPO (or [~~the NMSHTD~~] NMDOT in the absence of an MPO) and the US DOT may not infer additions to the budget(s) that are not explicitly intended by the implementation plan (or submission). Unless the implementation plan explicitly quantifies the amount by which motor vehicle emissions could be higher while still allowing a demonstration of compliance with the milestone, attainment, or maintenance requirement and explicitly states an intent that some or all of this additional amount should be available to the MPO (or [~~the NMSHTD~~] NMDOT in the absence of an MPO), and the US DOT, in the emission budget for conformity purposes, neither the MPO (or [~~the NMSHTD~~] NMDOT in the absence of an MPO) nor US DOT may interpret the budget to be higher than the implementation plan's estimate of future emissions. This applies in particular to SIPs (or submissions) which demonstrate that after implementation of control measures in the implementation plan:

(1) emissions from all sources will be less than the total emissions that would be consistent with a required demonstration of an emissions reduction milestone;

(2) either emissions from all sources will result in achieving attainment prior to the attainment deadline, and/or ambient concentrations in the attainment deadline year will be lower than needed to demonstrate attainment; or

(3) emissions will be lower than needed to provide for continued maintenance.

[~~B. If an applicable SIP submitted before November 24, 1993, demonstrates that emissions from all sources will be less than the total emissions that would be consistent with attainment and quantifies that "safety margin," the Department may submit an implementation plan revision which assigns some or all of this safety margin to highway and transit mobile sources for the purposes of conformity. Such an implementation plan revision, once it is endorsed by the Governor and has been subject to a public hearing, may be used for the purposes of transportation conformity before it is approved by US EPA.~~]

[~~C~~]**B.** A conformity demonstration shall not trade emissions among budgets which the SIP (or implementation plan submission) allocates for different pollutants or precursors, or among budgets allocated to motor vehicles and other sources, unless the implementation plan establishes appropriate mechanisms for such trades.

[~~D~~]**C.** If the applicable SIP (or implementation plan submission) estimates future emissions by geographic subarea of

the nonattainment area, the MPO (or [~~the NMSHTD~~] NMDOT in the absence of an MPO), and the US DOT are not required to consider this to establish subarea budgets, unless the SIP (or implementation plan submission) explicitly indicates an intent to create such subarea budgets for the purposes of conformity.

[~~E~~]**D.** If a nonattainment area includes more than one MPO, the applicable SIP may establish motor vehicle emissions budgets for each MPO. Otherwise, the MPOs shall collectively make a conformity determination for the entire nonattainment area.

[12/14/94; 11/23/98; 20.2.99.149 NMAC - Rn, 20 NMAC 2.99.149, 10/31/02; 20.2.99.149 NMAC - Rn, 20.2.99.147 NMAC & A, 10/15/05]

[~~20.2.99.148~~] 20.2.99.150 ENFORCEABILITY OF DESIGN CONCEPT AND SCOPE AND PROJECT-LEVEL MITIGATION AND CONTROL MEASURES.

A. Prior to determining that a transportation project is in conformity, the MPO, other recipient of funds designated under title 23 U.S.C. or the federal transit laws, FHWA, or FTA must obtain from the project sponsor and/or operator written commitments to implement in the construction of the project and operation of the resulting facility or service any project-level mitigation or control measures which are identified as conditions for NEPA process completion with respect to local PM10 or CO impacts. Before a conformity determination is made, written contractual commitments must also be obtained for project-level mitigation or control measures which are conditions for making conformity determinations for a transportation plan or TIP and included in the project design concept and scope which is used in the regional emissions analysis required by 20.2.99.137 NMAC and 20.2.99.138 NMAC or used in the project-level hot-spot analysis required by 20.2.99.135 NMAC.

B. Project sponsors voluntarily committing to mitigation measures to facilitate positive conformity determinations shall provide written contractual commitments and must comply with the obligations of such commitments.

C. Written contractual commitments to mitigation or control measures shall be obtained prior to a positive conformity determination, and project sponsors must comply with such commitments.

D. If the MPO or project sponsor believes the mitigation or control measure is no longer necessary for conformity, the project sponsor or operator may be relieved of its obligation to implement the mitigation or control measure if it can demonstrate that the applicable hot-spot requirements of 20.2.99.135 NMAC, emission budget requirements of 20.2.99.137 NMAC, and [~~emission reduction~~] interim emissions requirements of 20.2.99.138 NMAC are satisfied without the mitigation or control measure, and so notifies the agencies involved in the interagency consultation process required under 20.2.99.116 NMAC through 20.2.99.124 NMAC. The MPO (or [~~the NMSHTD~~] NMDOT in the absence of an MPO) and US DOT must find that the transportation plan and TIP still satisfy the applicable requirements of 20.2.99.137 NMAC and 20.2.99.138 NMAC and that the project still satisfies the requirements of 20.2.99.135 NMAC and therefore that the conformity determinations for the transportation plan, TIP, and project are still valid. This finding is subject to the applicable public consultation requirements in 20.2.99.124 NMAC for conformity determinations for projects.

[12/14/94; 11/23/98; 20.2.99.150 NMAC - Rn, 20 NMAC 2.99.150, 10/31/02; 20.2.99.150 NMAC - Rn, 20.2.99.148 NMAC & A, 10/15/05]

[~~20.2.99.149~~] 20.2.99.151 EXEMPTIONS.

A. Exempt projects. Notwithstanding the other requirements of this part, highway and transit projects of the types listed in Table 2 of this section are exempt from the requirement to determine conformity. Such projects may proceed toward implementation even in the absence of a conforming transportation plan and TIP. A particular action of the type listed in Table 2 (of this section) is not exempt if the MPO in consultation with other agencies (e.g. the department, see Subsection C of 20.2.99.120 NMAC, the US EPA, and the FHWA (in the case of a highway project) or the FTA (in the case of a transit project)) concur that it has potentially adverse emissions impacts for any reason. [~~The NMSHTD~~] NMDOT and the MPO, in consultation with the department, as appropriate, must assure that exempt projects do not interfere with TCM implementation. Table 2 follows. Table 2. Exempt Projects.

(1) Safety:

(a) railroad/highway crossing;

(b) hazard elimination program;

(c) safer non-federal-aid system roads;

(d) shoulder improvements;

(e) increasing sight distance;

(f) safety improvement program;

(g) traffic control devices and operating assistance other than signalization projects;

(h) railroad/highway crossing warning devices;

(i) guardrails, median barriers, crash cushions;

(j) pavement resurfacing or rehabilitation;

(k) pavement marking demonstration;

(l) emergency relief (23 U.S.C. 125);

(m) fencing;

(n) skid treatments;

(o) safety roadside rest areas;

(p) adding medians;

(q) truck climbing lanes outside the urbanized area;

(r) lighting improvements;

(s) widening narrow pavements or reconstructing bridges (no additional travel lanes);

(t) emergency truck pullovers.

(2) Mass transit:

(a) operating assistance to transit agencies;

(b) purchase of support vehicles;

(c) rehabilitation of transit vehicles (In PM10 nonattainment or maintenance areas, only if projects are in compliance with control measures in the SIP.);

(d) purchase of office, shop, and operating equipment for existing facilities;

(e) purchase of operating equipment for vehicles (e.g., radios, fareboxes, lifts, etc.);

(f) construction or renovation of power, signal, and communications systems;

(g) construction of small passenger shelters and information kiosks;

(h) reconstruction or renovation of transit buildings and structures (e.g., rail or bus buildings, storage and maintenance facilities, stations, terminals, and ancillary structures);

(i) rehabilitation or reconstruction of track structures, track, and trackbed in existing rights-of-way;

(j) purchase of new buses and rail cars to replace existing vehicles or for minor expansions of the fleet (In PM10 nonattainment or maintenance areas, such projects are exempt only if projects are in compliance with control measures in the SIP.);

(k) construction of new bus or rail storage/maintenance facilities categorically excluded in 23 CFR 771.

(3) Air quality:

(a) continuation of ride-sharing and van-pooling promotion activities at current levels;

(b) bicycle and pedestrian facilities.

(4) Other:

(a) specific activities which do not involve or lead directly to construction, such as:

(i) planning and technical studies;

(ii) grants for training

and research programs;

(iii) planning activities conducted pursuant to titles 23 and 49 U.S.C.; or

(iv) federal-aid systems revisions;

(b) engineering to assess social, economic, and environmental effects of the proposed action or alternatives to that action;

(c) noise attenuation;

(d) emergency or hardship advance land acquisitions (23 CFR [~~712~~] 710 [~~204(d)~~] 503);

(e) acquisition of scenic easements;

(f) plantings, landscaping, etc.;

(g) sign removal;

(h) directional and informational signs;

(i) transportation enhancement activities (except rehabilitation and operation of historic transportation buildings, structures, or facilities);

(j) repair of damage caused by natural disasters, civil unrest, or terrorist acts, except projects involving substantial functional, locational, or capacity changes.

B. Projects exempt from regional emissions analyses. Notwithstanding the other requirements of this part, highway and transit projects of the types listed in Table 3 of this section are exempt from regional emissions analysis requirements. The local effects of these projects with respect to CO or PM10 concentrations must be considered to determine if a hot-spot analysis is required prior to making a project-level conformity determination. These projects may then proceed to the project development process even in the absence of a conforming transportation plan and TIP. A particular action of the type listed in Table 3 (of this section) is not exempt from regional emissions analysis if the MPO in consultation with other agencies (e.g. the department, see Subsection C of 20.2.99.120 NMAC), the US EPA, and the FHWA (in the case of a highway project) or the FTA (in the case of a transit project) concur that it has potential regional impacts for any reason. Table 3 follows. Table 3. Projects Exempt from Regional Emissions Analyses:

(1) intersection channelization projects;

(2) intersection signalization projects at individual intersections;

(3) interchange reconfiguration projects;

(4) changes in vertical and horizontal alignment;

(5) truck size and weight inspection stations;

(6) bus terminals and transfer points.

[12/14/94; 11/23/98; 20.2.99.151 NMAC - Rn, 20 NMAC 2.99.151, 10/31/02; 20.2.99.151 NMAC - Rn, 20.2.99.149 NMAC & A, 10/15/05]

[~~20.2.99.150~~] **20.2.99.152 TRAFFIC SIGNAL SYNCHRONIZATION PROJECTS.** Traffic signal synchronization projects may be approved, funded, and implemented without satisfying the requirements of this part. However, all subsequent regional emissions analyses required by 20.2.99.137 NMAC and 20.2.99.138 NMAC for transportation plans, TIPs, or projects not from a conforming plan and TIP must include such regionally significant traffic signal synchronization projects.

[20.2.99.152 NMAC - Rn, 20.2.99.150 NMAC, 10/15/05]

20.2.99.153 SPECIAL EXEMPTIONS FROM CONFORMITY REQUIREMENTS FOR PILOT PROGRAM AREAS. EPA and NMDOT may exempt no more than six areas for no more than three years from certain requirements of this subpart if these areas are selected to participate in a conformity pilot program and have developed alternative requirements that have been approved by EPA as an implementation plan revision in accordance with 40 CFR part 51.390. For the duration of the pilot program, areas selected to participate in the pilot program must comply with the conformity requirements of the pilot area's implementation plan revision for §51.390 of this chapter and all other requirements in 40 CFR parts 51 and 93 that are not covered by the pilot area's implementation plan revision for 40 CFR part 51.390. The alternative conformity requirements in conjunction with any applicable state and/or federal conformity requirements must be proposed to fulfill all of the requirements of and achieve results equivalent to or better than Section 176(c) of the Clean Air Act. After the three-year duration of the pilot program has expired, areas will again be subject to all of the requirements of this subpart and 40 CFR part 51, subpart T, and/or to the requirements of any implementation plan revision that was previously approved by EPA in accordance with 40 CFR part 51.390.

[20.2.99.153 NMAC - N, 10/15/05]

[~~20.2.99.151~~] **20.2.99.154 SAVINGS PROVISION.** The federal conformity rules under 40 CFR part 93 subpart A, in addition to any existing applicable state requirements, establish the conformity criteria and procedures necessary to meet the requirements of CAA Section 176(c) until such time as this conformity implementation plan revision is approved by EPA. Following EPA approval of this revision to the SIP (or a portion thereof) the approved (or approved portion of the) department's criteria and procedures would govern conformity determinations and the federal conformity regulations contained in 40 CFR part 93 would apply only for the portion, if any, of the department's conformity provisions that is not approved by EPA. In addition, any previously applicable SIP requirements relating to conformity remain enforceable until the department revises its SIP to specifically remove them and that revision is approved by EPA.

[20.2.99.154 NMAC - Rn, 20.2.99.151 NMAC, 10/15/05]

NEW MEXICO DEPARTMENT OF GAME AND FISH

This is an amendment to 19.31.3 NMAC, Section 11, Subsection N, effective September 30, 2005.

19.31.3.11 RESTRICTIONS:

A. One license per big game species per year: It shall be unlawful for anyone to hold more than one permit or license for any one big game species during the current license year unless otherwise allowed by rule.

B. Valid dates of license or permit: All permits or licenses shall be valid only for the specified dates, legal sporting arms, bag limit and area. Except that a permit or license will be valid on the contiguous deeded land of private property that extends into an adjacent GMU or AMU, that is open to hunting for that species, when the license holder is in possession of current, valid written permission from the appropriate landowner. This exception shall only apply when the adjacent unit has the same restrictions as to weapon type, bag limit, season dates and license availability.

C. Rocky Mountain bighorn sheep - once-in-a-lifetime hunts: It shall be unlawful for anyone to apply for a Rocky Mountain bighorn sheep license if one has previously held a license to hunt Rocky Mountain bighorn sheep in New Mexico, including the youth-only bighorn hunt. However, a person that has received the youth-only license is allowed to apply for the regular once-in-a lifetime bighorn hunts as long as they are eligible. Exception: An applicant is eligible to submit a bid for the special bighorn auction and raffle licenses whether or not he/she has previously held a license to hunt Rocky Mountain or desert bighorn sheep in New Mexico.

D. Desert bighorn sheep-

once-in-a-lifetime: It shall be unlawful for anyone to apply for a desert mountain bighorn sheep license if one has previously held a license to hunt desert mountain bighorn sheep in New Mexico. Exception: An applicant is eligible to submit a bid for the special bighorn auction and raffle licenses whether or not he/she has previously held a license to hunt Rocky Mountain or desert bighorn sheep in New Mexico.

E. [RESERVED]

F. Ibex - once-in-a-lifetime: It shall be unlawful for anyone to apply for a once in a lifetime ibex license if he/she ever held a once in a lifetime license to hunt ibex. Youth ibex hunts, year-round off -mountain hunts, and hunts for female or immature (FIM) ibex, as designated in 19.31.8 NMAC, are not once-in-a-lifetime hunts.

G. Oryx - once-in-a lifetime: It shall be unlawful, beginning April 1, 1993, for anyone to apply for an oryx license if he/she ever held a "once-in-a-lifetime" license to hunt oryx. Exception: Depredation population reduction oryx hunts, youth oryx hunts and incentive hunts are not once-in-a-lifetime hunts.

H. Valle Vidal (as described in Subsection A of 19.30.4.11 NMAC):

(1) It shall be unlawful for anyone to apply for a license to hunt bull elk on the Valle Vidal if he/she has ever held a license allowing them to take a bull elk on the Valle Vidal since 1983. This restriction applies to all licenses valid for a bag limit of mature bull (MB) , either sex (ES) or mature bull/antlerless (MB/A). It shall be unlawful for anyone to apply for a license to hunt antlerless elk on the Valle Vidal if he/she has ever held a Valle Vidal elk license valid for a bag limit of antlerless since 1983. Either sex (ES) or mature bull/antlerless (MB/A) shall not be considered as an "antlerless" license for this restriction. Persons who have held a Valle Vidal elk license through any incentive program are exempt from this restriction.

(2) It shall be unlawful to hunt bear on the Valle Vidal except for properly licensed bear hunters that possess a Valle Vidal elk hunting muzzleloader, bow, or rifle license and only during the dates of the elk hunt specified. Use of dogs shall not be allowed for bear hunting on the Valle Vidal.

I. Transfer of permits or licenses: It shall be unlawful to transfer permits or licenses to other persons, areas, or other hunt periods except as permitted by regulation adopted by the state game commission.

J. Refunds will not be made for any license or permit after it has been awarded or issued except as permitted by regulation adopted by the state game commission.

K. More than one application: It shall be unlawful to submit more than one application per species for any license issued through a special drawing, unless otherwise permitted by regulation. Exception: An individual may apply for both a population reduction hunt on public or private land and a special drawing hunt. However, an applicant shall follow the application procedures outlined in 19.31.3.8 NMAC.

L. Deer hunts: It shall be unlawful for any person who is issued a deer hunting permit:

(1) to hunt with any sporting arms type other than that for which his/her deer permit is validated;

(2) to hunt during any season other than that for which his/her deer permit is validated;

(3) to hunt in any GMU other than that for which his/her deer permit is validated;

(4) to hunt deer on public land in any GMU with a private land deer permit, except in conjunction with this subsection, if it is on state land where there is a valid agreement for unitizing state leased and privately owned or leased lands; or

(5) to hunt private property without possessing a valid deer permit, the proper deer license and written permission.

M. Handicapped fishing or handicapped general hunting license qualifications: To hold a handicapped fishing or handicapped general hunting license, the individual must be a resident of New Mexico and must show proof of a severe disability by reason of one or more physical disabilities resulting from amputation, arthritis, blindness, burn injury, cancer, cerebral palsy, cystic fibrosis, muscular dystrophy, musculoskeletal disorders, neurological disorders, paraplegia, quadriplegia and other spinal cord conditions, sickle cell anemia, and end-stage renal disease, or who has a combination of permanent disabilities which cause comparable substantial functional limitation. Reasonable accommodation will be made, relating to these licenses, upon request.

N. [~~Handicapped~~] **Mobility impaired (MI) deer, elk or antelope license qualifications:** To hold a [~~handicapped~~] **mobility impaired deer,** elk or antelope license, [~~any individual must show proof of a permanent~~] **a person must submit verifiable documentation on the proper department form that is attested to by a certified medical physician that the individual has a** mobility restriction which limits their activity to a walker, wheelchair, or two crutches, or severely restricts the movement in both arms or who has a combination of permanent disabilities which cause comparable substantial functional limitation **and then obtain department approval for MI hunt eligibility.**

(1) Every person qualified as MI shall have their card/eligibility expire 48 months from the department's approval date or issuance date, whichever is later, and must resubmit their application and obtain department approval as required above prior to being eligible to apply for any MI hunt.

(2) All current MI card holders shall have their card expire on March 15, 2007 and must resubmit on the proper department form and obtain department approval prior to being eligible to apply for MI designated hunt codes.

O. One deer permit per year: It shall be unlawful for anyone to hold more than one deer permit during the current license year.

P. Youth hunts: Only applicants who have not reached their 18th birthday by the opening day of the hunt are eligible to apply for or participate in a youth only hunt. Applicant for firearm hunts must provide hunter education certificate number on application.

Q. Bear entry hunt: It shall be unlawful to hunt bear in designated wildlife areas without having a valid bear entry permit and a valid license in the hunter's possession. Bear entry hunters shall be allowed to hunt any other bear hunt provided they have a valid license and tag.

R. An individual making license application shall supply the department on the appropriate form with all required personal information including, but not limited to name, address, date-of-birth, last four digits of his/her social security number prior to an application form being processed or a license being awarded.

S. It shall be unlawful to hunt pheasant in Valencia county without possessing a valid pheasant permit, the proper license and written permission.

(1) Exception: A hunter with a Valencia county pheasant north hunt or south hunt area permit is not required to have written permission for these specific hunt areas.

(2) It is unlawful for a hunter that successfully draws a Valencia county pheasant north hunt or south hunt to hunt any other area or property outside of the designated hunt area in Valencia county that same season.

T. GMU 4 and 5A private land only hunts: Deer hunt applicants in GMUs 4 and 5A must obtain a special application from landowner. GMU 4 and 5A landowners may be required to provide proof of land ownership to obtain special application forms.

U. Military only hunts:

Applicants must be full time active military and proof of military status must accompany application.
[19.31.3.11 NMAC - Rp, 19.31.3.11 NMAC, 12-30-04; A, 6-30-05; A, 9-30-05]

NEW MEXICO GAMING CONTROL BOARD

This is an amendment to 15.4.1 NMAC, Sections 1 and 7. This action also renumbers and reformats, as required by the current NMAC requirements, Regulation 2B-3 (filed by Department of Alcoholic Beverage Control, Bingo and Raffle Division on 03/21/1984). The amendment, renumbering and reformatting become effective 9/30/05.

15.4.1.1 ISSUING AGENCY: [~~Department of Alcoholic Beverage Control, Bingo and Raffle Division~~] New Mexico Gaming Control Board.
[15.4.1.1 NMAC - Rn, Regulation 2B-3 & A, 9/30/05]

15.4.1.7 DEFINITIONS: Definition of bingo and raffle terms relating to Section 60-2B-3 NMSA 1978: as used in the Bingo and Raffle Act and regulations promulgated there under:

[~~D.~~] A. "approved record" means those records required by the Bingo and Raffle Act, or regulations promulgated there under which must be maintained on forms approved or furnished by the [~~department of alcoholic beverage control~~] board;

B. "board" means the New Mexico gaming control board;

[~~H.~~] C. "cash operating fund" means the cash used by the licensee to start the bingo and jar raffle operations on each date;

[~~G.~~] D. "change fund" means the cash given to each bingo worker to use for making change;

[~~B.~~] E. "extra cards" means other cards sold at the door along with the master card; this card is controlled by a separate color or size from the master card; this does not include special or paper disposable cards;

[~~E.~~] F. "gross receipts" means, as a supplement to the statutory definition, the total amount of money collected on sales from all bingo, raffles and jar raffles, broken down into gross for master cards, gross for extra cards, gross for specials, gross for raffles and gross for jar raffles; a written record of all bingo players shall be compiled for each separate occasion for one (1) year from the date of the occasion; (to include total cards purchased and monies received from said purchases);

[~~I.~~] G. "house rules" means rules established by each licensee for items not covered by the Bingo and Raffle Act, or regulations promulgated there under; the licensee shall not adopt rules in conflict with the Bingo and Raffle Act, regulations promulgated under the Bingo and Raffle Act or other provisions of law; before any licensed organization enacts or adopts any "house rules", they must be submitted to [~~this department~~] the board and approved by [~~this department~~] the board;

[~~J.~~] H. "jar raffles" or "pull tabs" means printed tickets that have a pull-tab or seal to be opened by the purchaser where a winning combination is printed on each ticket or on a separate card;

I. "licensee" means an entity holding a license to operate games of chance pursuant to the Bingo and Raffle Act;

[~~A.~~] J. "master card" means the main bingo card in use for the occasion that each player is required to have in his possession to play bingo; this is sometimes referred to as the door or admission card. This card is usually controlled by using only one color or size card;

K. "method of payment" means no licensee, its members or managers conducting, or in any way participating in any game of chance, as defined in the Bingo and Raffle Act, shall allow a person to play on credit; any consideration charged for the privilege of playing shall be fully collected in advance; short or bad checks are the licensee's responsibility, and none of the losses will be charged to bingo, raffles or jar raffle activities;

L. "premises" for the conduct of games of chance do not permit the service of alcohol; no alcoholic beverages or mixture thereof are allowed on the premises of a licensed bingo/raffle organization; if the premises where bingos and raffles are held are completely separate from the lounge area, the alcoholic beverages may be served in the lounge only;

[~~F.~~] M. "prizes" means cash or merchandise awarded to the winner of bingo games, raffles or jar raffles;

[~~C.~~] N. "special" or "paper disposable card" means a card used for a specific game or games which is controlled by a separate color, serial number and manufacturer's identification number.
[15.4.1.7 NMAC - Rn, Regulation 2B-3 & A, 9/30/05]

NEW MEXICO GAMING CONTROL BOARD

This is an amendment to 15.4.2 NMAC, Sections 1, 8, 9, 10, and 14. This action also renumbers and reformats, as required by the current NMAC requirements, Regulation 2B-8(F), Regulation No. 2B-8(K), Regulation No. 2B-8(O), Regulation No. 2B-8(Q), Regulation No. 2B-8(R), Regulation No, 2B-8(S) (filed by Department of Alcoholic Beverage Control, Bingo and Raffle Division on 03/21/1984) and Regulation No. 2B-8(B) (filed by Department of Alcoholic Beverage Control, Bingo and Raffle Division on 03/29/1984). The amendment, renumbering and reformatting become effective 9/30/05.

15.4.2.1 ISSUING AGENCY: [~~Department of Alcoholic Beverage Control, Bingo and Raffle Division~~] New Mexico Gaming Control Board.
[15.4.2.1 NMAC - Rn, Regulation 2B-8(F) & A, 9/30/05]

15.4.2.8 GAME MANAGER AND BINGO GAME CONTROLS:

A. Games managers shall not play and no licensee shall allow an employee to play a game of chance while that employee is on duty.

B. The game manager or his appointed assistant shall establish the following controls at all bingo games where the patrons exceed fifty players in number.

(1) Each employee selling specials or disposable bingo cards shall be assigned a number and a matching numbered box. The assigned number shall be recorded by name on the duty record.

(2) Each employee shall be furnished a change fund.

(3) The game manager or his appointed assistant shall issue specials to the employees. These specials or disposable bingo cards shall be controlled by manufacturers' identification number and consecutive serial number as listed in "use of disposable bingo cards" of these rules and regulations. The exact number of specials or disposable bingo cards given each worker shall be recorded.

(4) When an employee completes selling cards for a special game, he shall place the unsold specials and the money from such sales and change fund in his assigned box. The games manager or appointed assistant shall count the money, subtract the original change fund, and compare cards apparently sold against the cash turned in. Any shortage in the cash shall not be deducted from the gross, but shall be reported as income.

(5) The above procedure shall be followed throughout each special game or where disposable cards are used.

(6) One or more individuals shall be assigned the duty of paying off bingo winners. Winners shall not be paid by individuals selling specials from their change fund or money they have in their possession from sale of specials. After the money from each special has been turned in and counted, it may be used to make prize pay-offs.

(7) No gambling other than bingo or raffles is allowed on the premises of a licensed bingo or raffle organization, except that a licensed bingo and raffle organization that is a gaming operator's licensee under the New Mexico Gaming Control Act may also conduct gaming pursuant to that act.

(8) The same person shall not be employed as game manager for more than one licensed organization.

(9) A game manager must have been an active member of the licensed organization at least six months prior to beginning his or her duties as game manager.

(10) Each licensee may have only one game manager and only one assistant game manager. These two names will appear on the physical license.

[15.4.2.8 NMAC - Rn, Regulation No. 2B-8(B) & A, 9/30/05]

15.4.2.9 INSPECTION OF PREMISES, RECORDS, MACHINES AND DEVICES, RELATING TO SECTION 60-2B-8(F) NMSA 1978:

A. At any time any authorized representative of the [~~department of alcoholic beverage control~~] department of public safety or the board may enter a licensee's premises without advance notice. During bingo occasions, walking space shall be left behind players and between tables to allow authorized representatives to walk down each row of tables and inspect bingo cards in play.

B. Authorized representatives may perform all or any of the following:

(1) make a count of all monies received during the operation of the licensed activities in the premises, inspect income received by the licensee and inspect records of prizes paid out;

(2) examine any of the other bingo and raffle records of the licensee;

(3) examine all pieces of equipment or parts thereof, or devices of any nature which are being used to conduct the licensed activities and to require the licensee to dismantle equipment, if necessary, except during operation of a game.

[15.4.2.9 NMAC - Rn, Regulation 2B-8(F) & A, 9/30/05]

15.4.2.10 CONDUCT DURING BINGO GAMES, RELATING TO SECTION 60-2B-8(O) NMSA 1978:

A. Conduct during bingo games.

(1) Authorized equipment and cards, including all bingo related items used in the conduct of bingo, shall be maintained in good repair and sound working condition. Authorized representatives of the department of public safety or the board may order that any equipment, cards or related items immediately be repaired or replaced, if after examination, they are found to be defective.

(2) All seventy-five (75) balls used during bingo games shall be present in the receptacle before each game, and shall be checked by one bingo player immediately prior to the first game of the occasion.

(3) All numbers and letters announced shall be clearly audible and repeated twice to all players present.

(4) Once a ball is removed from the machine, it may not be returned to the receptacle until the conclusion of the game.

(5) No ball will be pushed back in the machine at any time after the first ball has been called until that game is completed.

(6) The master board, which is the rack in which the balls are placed, is the only official scorer. A lighted display board may be used, but is not official.

(7) Immediately following the calling of each number in a bingo game, the caller shall turn the portion of the ball, which shows the number and the letter to the participants in the game so the participants may know that the proper number has been called out.

(8) If the bingo caller discovers that he has called the wrong number, he will immediately stop the game and inform the players of the mistake. He will then announce, "I am reading the correct number, please correct your card. The caller will then correct the board, and continue with the game.

(9) Each bingo game will be closed with the following procedure:

(a) the game must be stopped after the winning combination has been signaled from a player or workers;

(b) the ball the caller has in his hand, or has started to call will not be called; this ball will be held by the caller until the bingo has been verified and then returned to the machine, unless there is a visible posted house rule to the contrary;

(c) if a game is stopped for a bingo which proves not to be a valid one, the caller will then call the ball he was holding at the time the game was stopped;

(d) the caller will only hold or have one ball at a time in his hand;

(e) the last number called is not a requirement for a good bingo, unless there is a visibly posted house rule to the contrary;

(f) the worker on the floor must place the bingo card to be checked as a winner in front of at least one other player, with that player being given an opportunity to confirm that the bingo is in fact a valid bingo by watching the card as the numbers are called;

(g) the worker on the floor must call the numbers of the winning combination to the bingo caller, or, in case of a "cover-all" bingo, the caller may call the numbers that have not been called;

(h) the bingo caller must then ask the players, "are there any other bingos?"; if no one answers, the caller must announce, "this game is completed";

(i) no balls with creases, holes or are otherwise damaged will be used during any bingo game.

(10) No bingo cards shall be sold in the same area where bingo games are being conducted.

(11) When any type of machine, device or holder for dispensing pull-tabs is used for the sale of pull-tabs, all pull-tabs in the individual package or deal must be placed in the dispenser. No additional pull-tabs may be placed in the "dispenser" until all previously placed tabs are sold. All tabs must have the same serial number, color description, and must be the same kind and type. The complete individual package or deal must be placed in the dispenser at one time.

(12) No employee, paid or volunteer, may accept any type of gift, tip, percentage of winnings, money or a thing of value from any player or any person associated with the player of the game of chance.

B. Fraud or deception prohibited: No licensee or any of its members operating any licensed activity shall directly or indirectly in the course of such operations:

(1) employ any device, scheme or artifice to defraud or deceive;

(2) make any untrue or misleading statement; or

(3) engage in any act, practice or course of operation that would operate as a fraud or deceit upon any person.

C. Use of disposable bingo cards. Disposable bingo cards may be used in all bingo games, including specials, provided that:

(1) each set of disposable cards used is consecutively numbered from the first card to the last and each card contains, on its face, both its individual consecutive serial number and the identification number assigned by the manufacturer to that set of disposable cards;

(2) each disposable card sold must represent a specific amount of money (i.e., 25 cents each or 5 for $1.00 — 10 cents each or 3 for 25 cents), which has been paid to the licensee, and which amount has been clearly posted or verbally disclosed to all players in advance of any player participating in the game;

(3) the bingo caller shall be furnished, prior to starting each game on disposable cards, the manufacturer's identifi-

cation number and the serial numbers of all cards offered for sale for that particular game; upon a player having completed a bingo, the caller shall require the worker on the floor checking the bingo to read off the manufacturer's identification number and serial number of each winning card; payment shall not be made unless both numbers were among those offered for sale for that game.

D. Sale and use of bingo cards.

(1) Bingo cards shall be sold, and paid for, prior to being placed in play.

(2) All sales of bingo cards shall take place upon the premises and at the time of that bingo game.

(3) No bingo cards shall be set aside or reserved for any person.

(4) No person shall be allowed to play in a bingo game for free, or without first paying the licensee's normal and usual charge.

(5) If a master card or admittance card is required in order to play bingo, then no special or disposable cards will be sold to a player who has not purchased such master card.

(6) All master and extra cards will be sold at a set price. The price of each type of card will be posted.

(7) If each person playing bingo is required to have master cards and is allowed to play extra cards in the same game, then the cash prize to be awarded on the master card and the extra cards shall be posted by the licensee at the beginning of each game.

(8) Players are not to be allowed to select their own cards for special games. Selection of cards is limited to regular and extra cards sold at the door.

(9) No free cards shall be issued or redeemed by any licensee.

[15.4.2.10 NMAC - Rn, Regulation No. 2B-8(O) & A, 9/30/05]

15.4.2.14 TIMES OF OCCASIONS, RELATING TO SECTION 60-2B-8(K) NMSA 1978: No bingo game may [~~be held~~] begin later than 10:30 p.m., and no bingo game may begin prior to 9:00 a.m.

[15.4.2.14 NMAC - Rn, Regulation No. 2B-8(K) & A, 9/30/05]

NEW MEXICO GAMING CONTROL BOARD

This is an amendment to 15.4.3 NMAC, Sections 1, 8, 9, and 10. This action also renumbers and reformats, as required by the current NMAC requirements, Regulation No. 2B-4, Regulation No. 2B-7 and Regulation No. 2B-5 (filed by Department of Alcoholic Beverage Control, Bingo and Raffle Division on 03/21/1984). The amendment, renumbering and reformatting become effective 9/30/05.

15.4.3.1 ISSUING AGENCY: [~~Department of Alcoholic Beverage Control, Bingo and Raffle Division~~] New Mexico Gaming Control Board.

[15.4.3.1 NMAC - Rn, Regulation 2B-4, Regulation 2B-5, Regulation 2B-7 & A, 9/30/05]

15.4.3.8 RESPONSIBILITY TO POST AND HAVE IN ITS POSSESSION CERTAIN MATERIALS, RELATING TO SECTION 60-2B-4 NMSA 1978:

A. A licensee shall have current copies of the Bingo and Raffle Act, rules and regulations promulgated there under, and its house rules in its possession at all times during the game of chance. These documents shall be made available to any person so requesting. Prior to the start of the first bingo game the public shall be advised that copies of the Bingo and Raffle Act, and the regulations promulgated there under may be obtained from the [~~department of alcoholic beverage control~~] board.

B. The licensee shall post a sign with at least one (1) inch letters in two (2) or more conspicuous places stating: any supplier who furnishes bingo equipment, jar raffle or pull tab tickets or any other equipment used in any game of chance must keep records of his transactions with New Mexico bingo and raffle license holders. These records must be produced for inspection upon demand by any authorized representative of the department of [~~alcoholic beverage control~~] public safety or the board.

C. Copies of the Bingo and Raffle Act and rules and regulations promulgated there under, and the house rules may be obtained from the games manager for any player to read.

[15.4.3.8 NMAC - Rn, Regulation No. 2B-4 & A, 9/30/05]

15.4.3.9 DISPLAY OF LICENSEE'S NAME, RELATING TO SECTION 60-2B-7 NMSA 1978:

A. Bingo and raffle licensees shall clearly display the name of the organization holding a bingo game in an area adjacent to the caller. The name shall be in letters at least six (6) inches high.

B. The name displayed shall be the name of the organization sponsoring the bingo game followed by the word bingo or raffle, and the licensee shall not assume or display any other "trade" or "fictitious" name within or without the building.

C. The licensed organization must notify the [~~gaming division, department of alcoholic beverage control~~] board at least ten (10) calendar days prior to the permanent or temporary suspension of the "games of chance" license by the organization.

D. If the premises are rented or used by more than one (1) organization, only the organization playing at that time and date will display its license.

E. Should any license be lost or destroyed by the licensee, the game manger shall submit to the [~~department~~] board a notarized affidavit, bearing the signature of the game manager and officers of the organization, stating the circumstances under which the license was lost or destroyed, and a certification that, in fact, said license was lost or destroyed.

[15.4.3.9 NMAC - Rn, Regulation No. 2B-7 & A, 9/30/05]

15.4.3.10 LOCATION OF GAMES, RELATING TO SECTION 60-2B-5 NMSA 1978:

A. Licensed organizations are restricted in conducting "games" to locations within the same county where the organization is located.

B. No license is transferable from the location shown on the physical license or listed in the original application without:

(1) a written request made by the licensee to the [~~department~~] board; and

(2) written approval from the [~~department~~] board to the licensee prior to any move; no license may be borrowed from one organization to another.

C. Licensee shall submit to the [~~director~~] board a written application, in the form prescribed by the [~~director~~] board and stating the information required by the [~~director~~] board, together with a non-refundable application fee of one hundred dollars ($100.00).

[15.4.3.10 NMAC - Rn, Regulation No. 2B-5 & A, 9/30/05]

NEW MEXICO GAMING CONTROL BOARD

This is an amendment to 15.4.4 NMAC, Sections 1, 8, 9, and 10. This action also renumbers and reformats, as required by the current NMAC requirements, Regulation No. 2B-9, Expenses and Reporting Relating to Section 60-2B-9 NMSA 1978 (filed 3/29/84); Regulation No. 2B-9(A), Records - Bingo Games (filed 3/21/84); and ABC Regulation No. 2B-4A.(2), Inspection of Suppliers Records, Relating to Section 60-2B-4A(2) NMSA 1978 (filed 2/11/83). The amendment, renumbering and reformatting become effective 9/30/05.

15.4.4.1 ISSUING AGENCY: [~~Department of Alcoholic Beverage Control, Bingo and Raffle Division~~] New Mexico Gaming Control Board.

[15.4.4.1 NMAC - Rn, Regulation No. 2B-9, Regulation No. 2B-9(A), ABC Regulation No. 2B-4A.(2) & A, 9/30/05]

15.4.4.8 EXPENSES AND REPORTING RELATING TO SECTION 60-2B-9 NMSA 1978:

A. Any licensee whose game of chance is the subject of a crime requiring a police report shall, in addition to notifying the proper police agency, notify the department of [~~alcoholic beverage control~~] public safety and the board in writing within seventy-two (72) hours of the date, time, nature of the offense and the police agency notified.

B. Upon termination of a license, financial report, form BLO-6, must be complied and submitted to the [~~gaming division, department of alcoholic beverage control~~] board within seventy-two hours.

C. Attorneys fees cannot be paid for with bingo or raffle proceeds.

D. No employee of a bingo or raffle licensee shall be paid for other services, i.e., rent of premises rent of equipment, janitorial service, bookkeeping, etc.

E. No vendor of premises or equipment may be involved in any way or manner in the bingo or raffle operation.

F. Door prizes cannot be deducted from bingo or raffle gross. Door prizes in excess of $100.00 in value must receive written approval from the [~~alcoholic beverage control department~~] board prior to offering said door prize.

[15.4.4.8 NMAC - Rn, Regulation No. 2B-9 & A, 9/30/05]

15.4.4.9 RECORDS - BINGO GAMES:

A. In addition to any other requirements set forth in the Bingo and Raffle Act, a licensee shall prepare an approved record covering each bingo game. This approved record shall disclose the following information and shall be retained for a period of not less than three years:

(1) the gross receipts collected for each master card, door admission card and each extra card sold for each game;

(2) the gross receipts collected for each special bingo game of any kind including, but not limited to, "early bird,"' "three way," four corners," "round robin," "picture frame," "stand up," "postage stamp," "cover all," and "winner take all" games;

(3) the gross amount paid out on each separate bingo game;

(4) the cash on hand at the commencement of each occasion and the cash on hand at the conclusion of each game;

(5) the signature of the game manager for the licensee on that game;

(6) the name, signature, and assigned duties of each member for each game.

B. All persons responsible for or assisting in the holding, operation or conducting of any game of bingo must sign the roster, form BLO-4, prior to beginning any duties. Use of a person who has not signed, or has signed a fictitious name shall subject the licensee to suspension pending a hearing by the [~~alcoholic beverage control department~~] board.

[15.4.4.9 NMAC - Rn, Regulation No. 2B-9(A) & A, 9/30/05]

15.4.4.10 INSPECTION OF SUPPLIERS RECORDS, RELATING TO SECTION 60-2B-4A.(2) NMSA 1978: Any supplier who furnishes bingo equipment, jar raffle or pull tab tickets or any other equipment used in any game of chance must keep records of his transactions with New Mexico bingo and raffle license holders. These records must be produced for inspection upon demand by any authorized representative of the department of [~~alcoholic beverage control~~] public safety or the board.

[15.4.4.10 NMAC - Rn, ABC Regulation No. 2B-4A.(2) & A, 9/30/05]

NEW MEXICO GAMING CONTROL BOARD

This is an amendment to 15.4.6 NMAC, Sections 1 and 8. This action also renumbers and reformats, as required by the current NMAC requirements, Regulation No. 2B-4(F), Penalties for Violations of Bingo & Raffle Act or Regulations, Interpreting and Exemplifying Section 60-2B-4(F) NMSA 1978 (filed 3/21/84). The amendment, renumbering and reformatting become effective 9/30/05.

15.4.6.1 ISSUING AGENCY: [~~Department of Alcoholic Beverage Control, Bingo and Raffle Division~~] New Mexico Gaming Control Board.

[15.4.6.1 NMAC - Rn, Regulation No. 2B-4(F) & A, 9/30/05]

15.4.6.8 PENALTIES FOR VIOLATIONS OF BINGO AND RAFFLE ACT OR REGULATIONS, INTERPRETING AND EXEMPLIFYING SECTION 60-2B-4(F) NMSA 1978.

A. Whenever a licensee pleads guilty or *nolo contendere* to a charge brought by the [~~department~~] board against the licensee, or is found guilty of such charge by the appointed hearing officer, the licensee shall be subject to the following penalties:

(1) the [~~department~~] board or hearing officer shall order a suspension of business activities of not more than sixty (60) days; or

(2) the board or hearing officer shall issue his order of revocation of the license.

B. The [~~department~~] board or hearing officer, exercising discretion, may hold in abeyance the first one-half of a penalty prescribed. If any penalty, or portion thereof, is held in abeyance, it shall be predicated upon no further violations of the Bingo and Raffle Act or Regulations for a period of six (6) months from the date of the violation.

[15.4.6.1 NMAC - Rn, Regulation No. 2B-4(F) & A, 9/30/05]

NEW MEXICO GAMING CONTROL BOARD

This is an amendment to 15.4.7 NMAC, Sections 1 and 8. This action also renumbers and reformats, as required by the current NMAC requirements, Regulation No. 2B-6, Documentation Regarding Rented Premises - Relating to Section 60-2B-6, NMSA 1978 (filed 5/14/84) and Regulation No. 2B-9(E), Agreement Based Upon Percentage of Receipts Prohibited (filed 3/29/84). The amendment, renumbering and reformatting become effective 9/30/05.

15.4.7.1 ISSUING AGENCY: [~~Department of Alcoholic Beverage Control, Bingo Raffle Division~~] New Mexico Gaming Control Board.

[15.4.7.1 NMAC - Rn, Regulation No. 2B-6, Regulation No. 2B-9(E) & A, 9/30/05]

15.4.7.8 DOCUMENTATION REGARDING RENTED PREMISES, RELATING TO SECTION 60-2B-6 NMSA 1978: Documentation (or affidavits) of all persons involved in furnishing the rented premises must be filed with the [~~department of alcoholic beverage control~~] board and upon demand other information necessary must be supplied to the [~~department of alcoholic beverage control~~] board.

[15.4.7.8 NMAC - Rn, Regulation No. 2B-6 & A, 9/30/05]

NEW MEXICO GAMING CONTROL BOARD

This is an amendment to 15.4.8 NMAC, Sections 1 and 8. This action also renumbers and reformats, as required by the current NMAC requirements, Regulation No. 2B-8, Raffles - Relating to Section 60-2B-8, NMSA 1978 (filed 3/21/84). The amendment, renumbering and reformatting become effective 9/30/05.

15.4.8.1 ISSUING AGENCY: [~~Department of Alcoholic Beverage~~

~~Control, Bingo and Raffle Division~~] New Mexico Gaming Control Board.
[15.4.8.1 NMAC - Rn, Regulation No. 2B-8 & A, 9/30/05]

15.4.8.8 RAFFLES, RELATING TO SECTION 60-2B NMSA 1978:

A. Raffle ticket requirements when prizes exceed $100.00.

(1) All tickets sold in any raffle shall have the state license number, the word "raffle" and the date, time, and place of drawing printed on each ticket. A valid copy of a raffle ticket for each raffle conducted by a licensee must be filed with the [~~department of alcoholic beverage control~~] board prior to selling such tickets.

(2) All tickets for use in any raffle shall be consecutively numbered. All raffles conducted shall have the major cash or merchandise prizes conspicuously printed on the raffle ticket. The cost of each ticket shall be printed on the front of each and every ticket. If the word "donation," gift," or similar term is used, the proceeds shall be reported as income under the raffles act.

(3) If the ticket holder is required to be present at a raffle drawing in order to be eligible for the prize, a statement setting forth this condition shall be conspicuously printed on each raffle ticket and on all promotional material concerning the raffle.

(4) The state license number is not required on any jar raffle ticket or pull tab tickets sold by any licensee. Each deal of jar raffle tickets or pull tabs must have their own serial number.

B. All raffle tickets sold to be available for drawing: No drawing shall be held in connection with any raffle unless each and every ticket stub sold, and only such ticket stubs, shall first have been placed in the receptacle out of which the winning ticket stubs are to be drawn. Such receptacles shall be designed so that each ticket stub placed therein has an equal opportunity with every other ticket stub to be the one withdrawn.

C. Jar raffle: pull tab operation.

(1) No licensee shall permit the display or operation of any jar raffles or pull tabs which may have in any manner been marked, defaced, tampered with or otherwise placed in a condition, or operated in a manner which may deceive the public.

(2) No licensee shall knowingly obtain, possess, or allow upon the licensee's premises, a series of jar raffles or pull tabs, or portion thereof, with the same series number and color code combination, as any other series of jar raffles or pull tabs or portion thereof in licensee's possession or on the licensee's premises.

(3) Each licensee shall retain all winning tickets over five dollars from each series until that particular series of jar raffles or pull tabs has been sold. At the time that series is completed the licensee shall check to insure that the proper number of winners have been turned in to the licensee. If it is determined that the number of winners turned in is more or less than the proper number, the tickets must be retained by the licensee for not less than six months. If more than three such series are found in any one quarter, the licensee must notify the [~~alcoholic beverage control department~~] board in writing at the time of filing the quarterly report for that quarter.

(4) All winning jar raffle or pull tab tickets must be voided at the time of prize payout. They shall be voided by marking through the winning combination in ink, or by punching a hole or series of holes through the winning combination.

D. Control of prizes.

(1) Jar raffles or pull tab licensees shall award all prizes in cash or merchandise, except that winning cash tickets may be exchanged for new tickets.

(2) Prior to the start of the game, all bingo prizes or prize money must be on hand on the premises of the licensed organization. The licensee shall display all merchandise prizes in the immediate vicinity of the jar raffles or pull tab device and such prizes shall be in full view of any person prior to that person purchasing the opportunity to play. When a prize is cash, then the money itself does not have to be displayed. A card or sign designating the cash amount to be given as a prize shall be posted in any display which also includes merchandise prizes. The cash prizes to be awarded in connection with jar raffles or pull tabs, in which only cash prizes are awarded, shall be clearly and fully described or represented by a card or sign attached to or accompanying the jar raffle or pull tab series. The licensee shall display and arrange merchandise prizes so that a player can easily determine which prizes are available from any jar raffle or pull tab series in play. Any organization raffling any item or offering any item as a prize for a bingo game, must have documented proof of ownership of said item, free from any and all liens, mortgages and encumbrances prior to the sale of any tickets or bingo cards. This documented evidence of ownership must be made available to the [~~gaming division,~~] department of [~~alcoholic beverage control~~] public safety or the board, upon demand.

(3) Upon determining a winner, the licensee shall remove the merchandise prize won immediately from display and it shall be presented to the winner. Cash prizes shall be awarded immediately.

(4) No person selling jar raffle tickets, and no person managing or working in any capacity at any bingo game or other place where jar raffle tickets are sold, shall state, imply, or in any way indicate to the purchaser of jar raffle tickets the number or type of tickets that have been redeemed or that remain in the container.

E. Specific information required on jar raffles or pull tab invoices: Each licensee will require its supplier or distributor to place on each invoice of jar raffles or pull tab tickets, the form or catalog number, title or ticket and color code identification. Each licensee shall list the serial number of each jar raffle on the report.

F. All assisting members (i.e., caller, floor workers, game manager, etc.) must have a name plate stating the organization's name and the person's name must be visible at all times during the games.

G. Should any officer, game manager or assisting member be served with a criminal or civil action, the organization must advise the [~~department~~] board, in writing, within ten (10) calendar days after said member is served. The criminal or civil action does not include traffic violations or dissolutions of marriage, but does include all other actions and counter claims.
[15.4.8.8 NMAC - Rn, Regulation No. 2B-8 & A, 9/30/05]

NEW MEXICO GAMING CONTROL BOARD

This is an amendment to 15.4.9 NMAC, Sections 1, 2, 9, 12, 13, 14, 15, 16, 17, 18, and 19. This action also renumbers and reformats, as required by the current NMAC requirements, AGD 94-1, Emergency Regulations Governing the Conduct of Pull Tab Game of Change (filed 1/3/95). The amendment, renumbering and reformatting becomes effective 9/30/05.

15.4.9.1 ISSUING AGENCY: [~~Regulation and Licensing Department, Alcohol and Gaming Division, Gaming Bureau~~] New Mexico Gaming Control Board.
[15.4.9.1 NMAC - Rn, AGD 94-1 & A, 9/30/05]

15.4.9.2 S C O P E : Applicability: These emergency regulations apply to the paper and video pull tabs games of chance. [~~Regulation and licensing department~~] Board regulations governing the conduct of bingo and raffle games remain in effect until amended pursuant to Section 9-16-6 NMSA 1978 (1994 Repl.) and Section 60-2B-4 NMSA 1978 (1991 Repl.) except provisions that conflict with or are superseded by these emergency regulations.
[15.4.9.2 NMAC - Rn, AGD 94-1 & A, 9/30/05]

15.4.9.9 PROHIBITED GAMES OF CHANCE AND EQUIPMENT:

A. Video games commonly known as "eight liners" that allow the player to increase or manipulate the size of the deal are prohibited.

B. Video pull tab machines shall be used only to play video versions of paper pull tab games. Any machine which simulates the game of video pull tabs without conforming to these regulations is prohibited.

C. Any games of chance not expressly allowed under the Bingo and Raffle Act are prohibited. Any video games that simulate any games of chance or skill other than pull tabs, including, without limitation, poker, black jack, 21, craps, roulette, slot machines, solitaire, baccarat, backgammon, cribbage, rummy, and gin are prohibited.

D. Notwithstanding any other provision of this rule, licensees also holding gaming operator licenses pursuant to the Gaming Control Act may operate gaming machines pursuant to that act.

[15.4.9.9 NMAC - Rn, AGD 94-1 & A, 9/30/05]

15.4.9.12 LOSS, THEFT, MECHANICAL FAILURE, INOPERATION DESTRUCTION OR MALFUNCTION:

A. The responsible officer shall report to the [~~licensing authority~~] board each instance that a machine in play malfunctions and each instance when play is disrupted or ceases operation regardless of the reason or length of time of disruption or malfunction. The responsible officer shall report the malfunction or disruption in play whether or not there is a monetary loss.

B. If the gross income report for a machine has been reduced to reflect a loss resulting from a theft from the machine, (the term theft includes the physical break-in or entry into the video pull tab machine, or manipulation of the machine by external means resulting in the accumulation of credits available for redemption without the insertion of money) the licensee shall submit the following information to the board, together with the quarterly report:

(1) documentation from a law enforcement agency verifying that the theft was reported;

(2) a letter signed by the licensees business insurance agent indicating the amount paid or to be paid, if any, by the insurer to cover the loss resulting from the theft; and

(3) the last access accounting ticket generated before the theft occurred and the first access accounting ticket generated after the theft occurred; the tickets will be used by the [~~licensing authority~~] board to calculate the maximum amount that may be deducted for a loss resulting from a theft less any sums recovered from any sources.

[15.4.9.12 NMAC - Rn, AGD 94-1 & A, 9/30/05]

15.4.9.13 GENERAL DUTIES OF LICENSEES: The general duties required of all licensees are as follows:

A. conduct their all gaming operations in a manner that does not pose a threat to the public health, safety and welfare of the citizens of New Mexico or reflect adversely on the security or integrity of charitable gaming;

B. maintain all records required by the [~~licensing authority~~] board;

C. provide immediate access to all records and the physical premises of the licensee for inspection at the request of the [~~licensing authority, the special investigations division of the~~] department of public safety, the board and other law enforcement agencies;

D. keep current in all payments and obligations to the [~~licensing authority~~] board and suppliers and distributors of gaming equipment and lessors of premises;

E. a licensee will not allow any lessor of premises or supplier or distributor of gaming equipment, goods or services to extend credit to the licensee for a period of more than thirty days from the date of the invoice. Invoices shall be dated on the date the item is delivered to the licensee; "credit" includes acceptance by a supplier of a postdated check as payment for facilities, equipment or supplies;

F. a licensee will provide a secure premise for the holding, operating or conducting of all authorized games of chance;

G. a licensee will allow no one to tamper with or interfere with the conduct or operation of any game of chance; no licensee, employee, agent, or person working in any capacity in the holding, operating, or conducting of any game of chance shall attempt to or in any way direct or induce a player to participate in pull tab games or steer or direct a player to a particular machine by stating or implying, directly or indirectly, a payout other than required disclosures as defined in these regulations;

H. a licensee will not extend credit to a player to play or participate in any game of chance;

I. a licensee will immediately pay all credits upon presentment of a valid winning ticket or valid ticket voucher;

J. a licensee shall not enter into any agreement with providers of equipment or services, including lessors of premises, which imposes restrictions on the licensee with respect to the use of net proceeds;

K. each licensee will require its supplier or distributor to place on each invoice for paper pull tab tickets, the form or catalog number, title or ticket and color code identification; each licensee shall list the serial number of each deal of pull tabs on the report; at each licensed premises, the organization shall maintain a copy of the distributor's invoice for each paper pull tab deal in play and for each paper pull tab deal on the premises and shall make the invoices available for inspection by the licensing authority or special agents of the special investigations division;

L. the licensee shall separately account for the gross receipts from pull tabs and other games of chance; the expenses of any other game of chance shall not be deducted from gross receipts from pull tabs; only those expenses specifically authorized in the Bingo and Raffle Act may be deducted from the receipts from pull tabs; each licensee shall maintain separate deposit accounts for all games of chance, which shall contain all gaming receipts and disbursements for allowable expenses; bingo and pull tab receipts shall not be comingled with other funds of the licensee;

M. the licensee shall provide the [~~licensing authority~~] board with the following information:

(1) the name and address of the bank, the account number for the bank account; and

(2) the names of members authorized as signatories and a copy of the bank signature card showing the identity of the officers authorized to withdraw funds from the account;

(3) changes in the information must be submitted to the [~~licensing authority~~] board at least ten days before the change is made;

(4) the receipts must be deposited into the bank account on the next banking day of completion of the gaming activity;

(5) deposit records must be sufficient to allow determination of deposits made from each occasion or game.

N. the licensee shall remain current in payment of all taxes required pursuant to the Bingo and Raffle Act.

[15.4.9.13 NMAC - Rn, AGD 94-1 & A, 9/30/05]

15.4.9.14 REGISTRATION REQUIREMENTS:

A. The licensee shall register each electronic pull tab machine with the [~~licensing authority~~] board on forms prescribed by the [~~licensing authority~~] board. A separate registration form must be

completed for each machine used by each licensee. A machine may be registered and used by more than one licensee.

B. Each licensee shall register each machine prior to use. Each form must be signed by the responsible officer of the licensee. Registration forms are available upon request from the [~~licensing authority~~] board.

C. The registration form shall include the following information:

(1) manufacturer;

(2) serial number;

(3) date of manufacture;

(4) location of premises;

(5) owner or lessor of the machine;

(6) maintenance provider;

(7) model;

(8) type.

D. The licensee shall notify the [~~licensing authority~~] board any time it discontinues use of any machine registered with the [~~licensing authority~~] board.

[15.4.9.14 NMAC - Rn, AGD 94-1 & A, 9/30/05]

15.4.9.15 ON LINE ACCESS: The electronic video pull tab machine must be capable of providing on-line access to the [~~licensing authority~~] board to check the following:

A. monitoring of machine to include name of licensee;

B. location of the machine;

C. time of day in hours and minutes in which machine is in play;

D. machine serial number;

E. serial number of deal in play;

F. size of deal.

[15.4.9.15 NMAC - Rn, AGD 94-1 & A, 9/30/05]

15.4.9.16 REPORT REQUIREMENTS:

A. The licensee shall report to the board any malfunction or disruption of any machine as required by these regulations.

B. At the exhaustion of any pull tab game of chance, the licensee shall report to the board the following information:

(1) serial number of deal;

(2) size of deal;

(3) gross receipts from the deal;

(4) net proceeds;

(5) number of winning or losing credits within the deal.

C. The licensee shall reconcile each deal separately.

D. The report must be delivered to the [~~licensing authority~~] board no later than April 15, July 15, October 15 and January 15th and shall cover the preceding calendar quarter or portion thereof.

E. The video pull tab machine must have the capability of providing a daily audit report or detailed tape that provides the following information: mechanical and electronic meter readings must be taken at the same time and recorded for the report at the close of each business day in the reporting quarter. The readings must be supported by the original printed accounting ticket. The report is due on each machine registered.

[15.4.9.16 NMAC - Rn, AGD 94-1 & A, 9/30/05]

15.4.9.17 RECORD RETENTION REQUIREMENTS:

A. Machine operation records, including audit printouts for each deal, must be retained for three years and made available for inspection by the [~~licensing authority~~] board or the department of public safety upon request. The records must provide all necessary information the [~~licensing authority~~] board or department of public safety may require to ensure operation of machines in compliance with the law and regulations.

B. The records must include:

(1) audit printouts or readings of each machine's mechanical meters at least once every business day;

(2) documentation of total actual cash counted for the licensee, including bank deposit slips.

[15.4.9.17 NMAC - Rn, AGD 94-1 & A, 9/30/05]

15.4.9.18 GENERAL SPECIFICATIONS OF VIDEO PULL TAB MACHINES:

A. The [~~licensing authority~~] board or the [~~special investigations division of the~~] department of public safety may inspect any machine used by licensees. The [~~licensing authority~~] board or the [~~special investigations division~~] department of public safety must be allowed immediate access to each machine. Keys to allow access to a machine for purposes of inspection may be provided to the [~~licensing authority~~] board and, the [~~special investigations division~~] department of public safety or must be immediately available at the premise.

B. Machines may not have any switches, jumpers, wire posts, or other means of manipulation that could affect the operation or outcome of a game. The machine may not have any functions or parameters adjustable by and through any separate video display or input codes except for the adjustment of features that are wholly cosmetic or other operations parameters as approved by the licensing authority. This is to include devices known as "knockoff switches".

C. Machines may offer only those games of chance authorized by the Bingo and Raffle Act and these regulations.

D. The machine must be capable of printing a ticket voucher for all credits owed the player. A valid ticket must contain the following information:

(1) the name of the licensed establishment;

(2) the name of the city, town. or county in which the license is located;

(3) the machine serial number;

(4) the time of day in hours and minutes in a 24-hour format;

(5) the current date;

(6) the value of the prize in numbers;

(7) the value of the prize in words.

E. The printing mechanism must be located in a locked area of the machine to insure the safekeeping of the audit copy. The printing mechanism must have a paper sensing device that upon sensing a 'low paper" condition will allow the machine to finish printing the ticket and prevent further play. The machine must recognize a printer power loss occurrence and cease play until power has been restored to the printer and the machine is capable of producing a valid ticket.

F. The machine must have non re-settable mechanical meters housed in a readily accessible locked machine area. These meters must be in a configuration prescribed by the [~~licensing authority~~] board. The mechanical meters must be manufactured in such a way as to prevent access to the internal parts without destroying the meter. Meters must be hardwired (no quick connects will be allowed in the meter wiring system). The [~~licensing authority~~] board may require[~~d~~] and provide a validating identification sticker to attach to the mechanical meters to verify the meters are assigned to a specific licensed machine. The meters must keep a permanent record of:

(1) total credits accepted by the machine;

(2) total credits played;

(3) total credits won;

(4) total credits paid.

G. The machine must contain electronic metering, using meters that record and display the following on the video screen in a format prescribed by the licensing authority:

(1) total credits in mechanism(s);

(2) total credits, total credits played, total credits won and total credits paid;

(3) total games played and total games won.

H. Whenever electronic meters are reset, each machine must produce a full accounting ticket both before

and after each resetting. The tickets must be in the format approved by the licensing authority and contain:

(1) the name of the licensee;

(2) the name of the city, town, or county in which the licensee is located;

(3) the machine serial number;

(4) the time of day in hours and minutes in a 24-hour format;

(5) the current date;

(6) the program name and revision number; and

(7) the electronic meter readings required by the licensing authority.

I. The machine and any peripheral electronic device must have an identification tag permanently affixed to the machine by the manufacturer. The tag must be at a location approved by the [~~licensing authority~~] board and must include the following information.

(1) manufacturer;

(2) serial number;

(3) model;

(4) date of manufacture; and

J. The machine shall be equipped with a surge protector that will feed all A.C. electrical current to the machine and a backup power supply capable of maintaining for a 30-day period the accuracy of all electronic *meters, date, and time during power fluctuations and loss. The battery must be in a state of charge during normal operation of the machine.*

K. The [~~licensing authority~~] board may initiate proceedings to suspend or revoke a license if it finds that any machine or machine, machine component, or video pull tab game does not comply with the rules governing video pull tab machines.

[15.4.9.18 NMAC - Rn, AGD 94-1 & A, 9/30/05]

15.4.9.19 INSPECTION AND SEIZURE OF MACHINES: *The [~~licensing authority~~] board or the [~~special investigations division of the~~] department of public safety has the right at all times to make an examination of any machine being used to play or simulate video pulltabs. Such right of inspection includes immediate access to all machines and unlimited inspection of all machine parts. The [~~licensing authority~~] board or the [~~special investigations division~~] department of public safety may immediately seize and remove an machine or device which violates these rules.*

A. Given reasonable cause, the [~~licensing authority~~] board or the [~~special investigations division~~] department of public safety may remove a machine or parts from a machine for laboratory testing and analysis;

B. The [~~licensing authority~~] board or the department of public safety may seal any machine left on the licensee's premises pending an investigation[~~s~~]. The breaking or removal of the [~~licensing authority's~~] seal will subject the licensee to seizure of the entire machine and suspension or revocation of any permit or license issued by the [~~licensing authority~~] board.

[15.4.9.19 NMAC - Rn, AGD 94-1 & A, 9/30/05]

NEW MEXICO GENERAL SERVICES DEPARTMENT
STATE PURCHASING DIVISION

The Office of the State Purchasing Agent of the General Services Division repeals it rule 1.4.1 NMAC entitled: Procurement Code Regulations, (filed 11-01-2001), repealed effective 09-30-2005.

NEW MEXICO GENERAL SERVICES DEPARTMENT
STATE PURCHASING DIVISION

TITLE 1 GENERAL GOVERNMENT ADMINISTRATION
CHAPTER 4 STATE PROCUREMENT
PART 1 PROCUREMENT CODE REGULATIONS

1.4.1.1 ISSUING AGENCY: General Services Department - State Purchasing Division

[1.4.1.1 NMAC - Rp, 1.4.1.1NMAC, 09-30-05]

1.4.1.2 SCOPE: All executive branch state agencies

A. Except as otherwise provided in the Procurement Code, Sections 13-1-28 through 13-1-199 NMSA 1978, the Code applies to every expenditure by state agencies and local public bodies for the procurement of items of tangible personal property, services and construction.

B. General. Except as otherwise provided in this section, this rule applies to every agency and to every transaction to which the Procurement Code applies except the following:

(1) procurement of highway construction or reconstruction by the state highway and transportation department;

(2) procurement by the judicial branch of state government;

(3) procurement by the legislative branch of state government;

(4) procurement by the boards of regents of state educational institutions named in Article 12 Section 11 of the constitution of New Mexico;

(5) procurement by the state fair commission of tangible personal property, services and construction under five thousand dollars ($5,000);

(6) purchases from the instructional material fund;

(7) procurement by all local public bodies;

(8) procurement by regional education cooperatives;

(9) procurement by charter schools; and

(10) procurement by each state health care institution that provides direct patient care and that is, or a part of which is, medicaid certified and participating in the New Mexico medicaid program.

(11) Procurement of professional services.

[1.4.1.2 NMAC - Rp, 1.4.1.2 NMAC, 09-30-05]

1.4.1.3 STATUTORY AUTHORITY: NMSA 1978, 9-17-5, Laws of 1983, Chapter 301, Section 5; and 13-1-95, Laws of 1984, Chapter 65, Section 68 (Repl. Pamp. 1997). Subject to the authority of the secretary of the general services department, Section 13-1-95 NMSA 1978 designates the state purchasing agent as both the administrator and chief executive of the state purchasing division. The cite further designates the state purchasing agent and purchasing division shall be responsible for the procurement of items of tangible personal property, services and construction for all state agencies except as otherwise provided in the Procurement Code, Sections 13-1-28 through 13-1-199 NMSA 1978, and shall administer the Code for those state agencies not excluded from the requirement of procurement through the state purchasing agent. Among the statutory duties and responsibilities afforded the state purchasing agent is to recommend procurement regulations to the secretary of the general services department.

[1.4.1.3 NMAC - Rp, 1.4.1.3 NMAC, 09-30-05]

1.4.1.4 DURATION: Permanent.

[1.4.1.4 NMAC - Rp, 1.4.1.4 NMAC, 09-30-05]

1.4.1.5 EFFECTIVE DATE: September 30, 2005, unless a later date is cited at the end of a section.

[1.4.1.5 NMAC - Rp, 1.4.1.5 NMAC, 09-30-05]

1.4.1.6 OBJECTIVE: Section 13-1-29 C NMSA 1978 states that, the purposes of the Procurement Code are to provide for the fair and equal treatment of all persons involved in public procurement, to maximize the purchasing value of public funds and to provide safeguards for maintaining a procurement system of quality and integrity. The objective of this rule is to

have the force and effect of law to implement, interpret or make statute law specific as it applies to the Procurement Code, Sections 13-1-28 through 13-1-199 NMSA 1978 and the purposes stated therein.
[1.4.1.6 NMAC - Rp, 1.4.1.6 NMAC, 09-30-05]

1.4.1.7 DEFINITIONS:

A. Most of the terms which appear in this rule are defined in the Procurement Code.

B. In these rules and regulations the following definitions apply:

(1) "Chief information officer" means the administrative head of the office on information and communications management.

(2) "Information systems resources" means computer voice and data communications hardware and software including imaging systems, terminals, radio and communications networks and facilities as well as information system services and professional services contracts required for the implementation, operation, maintenance or support of an executive branch state agency computer or communication system.

(3) "Procurement manager" means the person or designee authorized by the state purchasing agent or state agency to manage a procurement requiring the evaluation of competitive sealed proposals.

(4) "Determination" means the written documentation of a decision of a procurement officer including findings of fact to support a decision. A determination becomes part of the procurement file to which it pertains.
[1.4.1.7 NMAC - Rp, 1.4.1.7 NMAC, 09-30-05]

1.4.1.8 CENTRALIZATION OF PROCUREMENT ACTIVITY (Sections 1.4.1.8 - 1.4.1.13 NMAC):

A. State purchasing agent. All procurement for state agencies shall be performed by the state purchasing agent except the following:

(1) professional services that are not related to information systems resources;

(2) small purchases having a value not exceeding twenty thousand dollars ($20, 000);

(3) emergency procurements; and

(4) the types of procurement specified in Subsection B of 1.4.1.2 NMAC.

B. Central purchasing offices. All procurement for state agencies excluded from the requirement of procurement through the state purchasing agent shall be performed by a central purchasing office designated by statute, the governing authority of that state agency or as otherwise provided in the Procurement Code.

C. Cooperative procurement. Nothing in this section should be interpreted as limiting the ability of state agencies to make procurements under existing contracts or enter into cooperative procurement agreements.
[1.4.1.8 NMAC - Rp, 1.4.1.8 NMAC, 09-30-05]

1.4.1.9 INSPECTION OF PUBLIC RECORDS: The inspection of public records is governed by the Inspection of Public Records Act, Sections 14-2-1 through 14-2-12 NMSA 1978. To the extent that any provision of this rule conflicts with the Inspection of Public Records Act, as interpreted by the courts of this state, that act shall control. Furthermore, no obligation to keep data confidential which is contained in this rule is intended to create any liability that would not otherwise exist under state law.
[1.4.1.9 NMAC - Rp, 1.4.1.9 NMAC, 09-30-05]

1.4.1.10 DOLLAR AMOUNTS: Whenever a dollar amount appears in this rule, such amount is exclusive of applicable gross receipts and local option taxes as the term is defined in Section 7-9-3 (Q) NMSA 1978.
[1.4.1.10 NMAC - Rp, 1.4.1.10 NMAC, 09-30-05]

1.4.1.11 INDEMNIFICATION AND INSURANCE:

A. Tort liability. Except as provided for in the Tort Claims Act, Sections 41-4-1 through 41-4-27 NMSA 1978, no contract governed by this rule shall contain any provision whereby a state agency agrees to indemnify or provide tort liability insurance for any contractor. The indemnification and insurance provisions of contracts provided for in the Tort Claims Act shall be approved in writing by GSD's risk management division before they become effective.

B. Other risks. No contract governed by this rule shall contain any provision whereby a state agency agrees to indemnify or provide a contractor with insurance for non-tort risks unless the provision has been approved in writing by GSD's risk management division.

C. Contract provisions void. Any indemnification or insurance provision in any contract executed in violation of this section shall be void and of no effect.
[1.4.1.11 NMAC - Rp, 1.4.1.11 NMAC, 09-30-05]

1.4.1.12 [RESERVED]

1.4.1.13 SEVERABILITY: If any provision of this rule, or any application thereof, to any person or circumstance, is held invalid, such invalidity shall not affect any other provision or application of this rule which can be given effect without the invalid provision or application.
[1.4.1.13 NMAC - Rp, 1.4.1.13 NMAC, 09-30-05]

1.4.1.14 APPLICATION (COMPETITIVE SEALED BIDS; Sections 1.4.1.14 -1.4.1.28 NMAC):
The provisions of Sections 1.4.1.14 through 1.4.1.28 NMAC apply to every procurement made by competitive sealed bids.
[1.4.1.14 NMAC - Rp, 1.4.1.14 NMAC, 09-30-05]

1.4.1.15 COMPETITIVE SEALED BIDS REQUIRED: All procurement shall be achieved by competitive sealed bids except procurement achieved pursuant to the following methods:

A. competitive sealed proposals;

B. small purchases;

C. sole source procurement;

D. emergency procurement;

E. procurement under existing contracts; and

F. purchases from anti-poverty program businesses.
[1.4.1.15 NMAC - Rp, 1.4.1.15 NMAC, 09-30-05]

1.4.1.16 INVITATION FOR BIDS ("IFB"):

A. General. The invitation for bids ("IFB") is used to initiate a competitive sealed bid procurement. The IFB shall include the following:

(1) the specifications for the services, construction or items of tangible personal property to be procured;

(2) all contractual terms and conditions applicable to the procurement;

(3) the term of the contract and conditions of renewal or extension, if any;

(4) instructions and information to bidders, including the location where bids are to be received and the date, time and place of the bid opening;

(5) a notice that the IFB may be canceled and that any and all bids may be rejected in whole or in part when it is in the best interest of the state of New Mexico; and

(6) a notice that reads substantially as follows: The Procurement Code, Sections 13-1-28 through 13-1-199 NMSA 1978, imposes civil and misdemeanor criminal penalties for its violation. In addition, the New Mexico criminal statutes impose felony penalties for bribes, gratuities and kick-backs.

B. Incorporation by reference. The IFB may incorporate documents by reference, provided that the IFB speci-

fies where such documents can be obtained.

C. Evaluation criteria. The IFB shall set forth the evaluation criteria that will be used to determine acceptability such as inspection, testing, quality, workmanship, delivery and suitability for a particular purpose. Those criteria such as discounts, transportation costs and total or lifecycle costs that will affect the bid price shall be objectively measurable. No criteria may be used in bid evaluation that are not set forth in the IFB.

D. Bid form. The IFB shall provide a form which shall include space in which the bid price shall be inserted and which the bidder shall sign and submit along with all other necessary submissions. A bidder may submit a reasonable facsimile of the bid form. Oral, telephonic and telegraphic bids except as provided in this subsection are invalid and shall not be considered. Telegraphic or bids sent via FAX to a third party and delivered in a sealed envelope to the location where bids are to be received by the date and time shown in the bid, will be accepted for consideration.

E. Bid samples and descriptive literature:

(1) "Descriptive literature" means information available in the ordinary course of business that shows the characteristics, construction, or operation of an item.

(2) "Bid sample" means a sample furnished by a bidder that shows the characteristics of an item offered in the bid.

(3) Bid samples or descriptive literature may be required when it is necessary to evaluate required characteristics of the item bid.

(4) Bid samples, when required, shall be furnished free of expense to the state and prior to the time set for the opening of bids. Samples not destroyed or mutilated in testing will be returned upon request by mail, express or freight, collect. Each sample must be labeled to clearly show the bid number and the bidder's name.

F. Bidding time. Bidding time is the period of time between the date of distribution of the IFB and the time and date set for receipt of bids. In each case bidding time shall be set to provide bidders a reasonable time to prepare their bids. In no case shall the bidding time be shorter than the time required for publication under Section 1.4.1.17 of this rule.

[1.4.1.16 NMAC - Rp, 1.4.1.16 NMAC, 09-30-05]

1.4.1.17 PUBLIC NOTICE INVITATION FOR BID: Publication. The IFB or notice thereof shall be published not less than ten calendar days prior to the date set for the opening of bids. The IFB or notice must be published once in at least three newspapers of general circulation in this state.

A. These requirements of publication are in addition to any other procedures that may be adopted by the state purchasing agent to notify prospective bidders that bids will be received, including but not limited to publication in trade journals, if available.

B. Bidder lists. The state purchasing agent shall send copies of the notice or IFB involving the expenditure of more than twenty thousand dollars ($20,000) to those businesses which have signified in writing an interest in submitting bids for particular categories of items of tangible personal property, construction and services and which have paid any required fees. (13-1-104 NMSA 1978). Reference is also given to Section 1.4.1.48 of this rule.

C. Public availability. A copy of the IFB shall be made available for public inspection at the office of the state purchasing agent.

[1.4.1.17 NMAC - Rp, 1.4.1.17 NMAC, 09-30-05]

1.4.1.18 PRE-BID CONFERENCES: Pre-bid conferences may be conducted to explain the procurement requirements. They shall be announced to all prospective bidders known to have received the IFB. The conference should be held long enough after the IFB has been issued to allow bidders to become familiar with it, but sufficiently before bid opening to allow consideration of the conference results in preparing their bids. Nothing stated at the pre-bid conference shall change the IFB unless a change is made by written amendment as provided in this rule.

[1.4.1.18 NMAC - Rp, 1.4.1.18 NMAC, 09-30-05]

1.4.1.19 AMENDMENTS TO THE INVITATION FOR BIDS:

A. Form. An amendment to the IFB shall be identified as such and shall require that bidders acknowledge its receipt. The amendment shall refer to the portions of the IFB it amends.

B. Distribution. Amendments shall be sent to all prospective bidders known to have received the IFB.

C. Timeliness. Amendments shall be distributed within a reasonable time to allow prospective bidders to consider them in preparing their bids. If the time and date set for receipt of bids will not permit such preparation, the time shall be increased to the extent possible in the amendment or, if necessary, by telegram or telephone or by other electronic means and confirmed in the amendment.

D. Use of amendments. Amendments should be used to:

(1) make any changes in the IFB such as changes in quantity, purchase descriptions, delivery schedules, and opening dates;

(2) correct defects or ambiguities; or

(3) furnish to other bidders information given to one bidder if such information will assist the other bidders in submitting bids or if the lack of such information would prejudice the other bidders.

[1.4.1.19 NMAC - Rp, 1.4.1.19 NMAC, 09-30-05]

1.4.1.20 PRE-OPENING MODIFICATION OR WITHDRAWAL OF BIDS:

A. Procedure. A bid may be modified or withdrawn by a bidder prior to the time set for bid opening by delivering written or telegraphic notice to the location designated in the IFB as the place where bids are to be received.

B. Disposition of bid security. If a bid is withdrawn in accordance with this section, the bid security, if any, shall be returned to the bidder.

C. Records. All documents relating to the modification or withdrawal of bids shall be made a part of the appropriate procurement file.

[1.4.1.20 NMAC - Rp, 1.4.1.20 NMAC, 09-30-05]

1.4.1.21 LATE BIDS, LATE WITHDRAWALS AND LATE MODIFICATIONS:

A. Definition. Any bid or any withdrawal or modification of a bid received after the time and date for opening of bids at the place designated for opening is late.

B. General rule. No late bid, late modification, or late withdrawal will be considered unless received before contract award, and the bid, modification, or withdrawal would have been timely but for the action or inaction of state personnel directly serving the procurement activity.

C. Records. All documents relating to late bids, late modifications, or late withdrawals shall be made a part of the appropriate procurement file.

[1.4.1.21 NMAC - Rp, 1.4.1.21 NMAC, 09-30-05]

1.4.1.22 BID OPENING:

A. Receipt. Upon its receipt, each bid and modification shall be time-stamped but not opened and shall be stored in a secure place until the time and date set for bid opening.

B. No bids received. Except as provided in Sections 1.4.1.68 through 1.4.1.72 of this rule, if no bids are received or if all bids received are rejected in accordance with the provisions of

Sections 1.4.1.68 through 1.4.1.72 of this rule, a new IFB shall be issued. If upon re-bidding with no change in specifications from the first IFB, the bids received are unacceptable, or if no bids are secured, the state purchasing agent may purchase (i.e., as opposed to procure) the items of tangible personal property, construction or services in the open market at the best obtainable price.

C. Opening and recording. Bids and modifications shall be opened publicly in the presence of one or more witnesses at the time and place designated in the IFB. The name of each bidder, the amount of each bid and each bid item, if appropriate, the names and addresses of the required witnesses, and such other relevant information as may be specified by the state purchasing agent shall be recorded. The record shall be open for public inspection. Each bid, except those portions for which a bidder has made a written request for confidentiality, shall also be open to public inspection. Any data, which a bidder believes should be kept confidential shall accompany the bid and shall be readily separable from the bid in order to facilitate public inspection of the non-confidential portion of the bid. Prices and makes and models or catalogue numbers of the items offered, deliveries, and terms of payment shall be publicly available at the time of bid opening regardless of any designation to the contrary.

[1.4.1.22 NMAC - Rp, 1.4.1.22 NMAC, 09-30-05]

1.4.1.23 MISTAKES IN BIDS:

A. Consideration for award. Bids shall be unconditionally accepted for consideration for award without alteration or correction, except as authorized in Sections 1.4.1.14 through 1.4.1.28 of this rule.

B. General principles. Correction or withdrawal of a bid because of an inadvertent, nonjudgmental mistake in the bid requires careful consideration to protect the integrity of the competitive bidding system, and to assure fairness. If the mistake is attributable to an error in judgment, the bid may not be corrected. Bid correction or withdrawal by reason of a nonjudgmental mistake is permissible but only to the extent authorized in Sections 1.4.1.14 through 1.4.1.28 of this rule.

C. Mistakes discovered before opening. A bidder may correct mistakes discovered before bid opening by withdrawing or correcting the bid as provided in Section 1.4.1.20 of this rule.

D. Confirmation of bid. When the procurement officer knows or has reason to conclude that a mistake has been made in the low bid, the procurement officer should request the low bidder to confirm the bid. Situations in which confirmation should be requested include obvious, apparent errors on the face of the low bid or a bid unreasonably lower than the other bids submitted. If the low bidder alleges mistake, the bid may be corrected or withdrawn if the conditions set forth in Subsection E of this section are met.

E. Mistakes discovered after opening. This subsection sets forth procedures to be applied in three situations in which mistakes in bids are discovered after the time and date set for bid opening.

(1) Technical irregularities. Technical irregularities are matters of form rather than substance evident from the bid document, or insignificant mistakes that can be waived or corrected without prejudice to other bidders; that is, when there is no effect on price, quality or quantity. The procurement officer may waive such irregularities or allow the low bidder to correct them if either is in the best interest of the state. Examples include the failure of the low bidder to:

(a) return the number of signed bids required by the IFB;

(b) sign the bid, but only if the unsigned bid is accompanied by other material indicating the low bidder's intent to be bound; or

(c) acknowledge receipt of an amendment to the IFB, but only if:

(i) it is clear from the bid that the low bidder received the amendment and intended to be bound by its terms; or

(ii) the amendment involved had no effect on price, quality or quantity.

(2) Mistakes where intended correct bid is evident. If the mistake and the intended correct bid are clearly evident on the face of a bid document, the bid shall be corrected to the intended correct bid and may not be withdrawn. Examples of mistakes that may be clearly evident on the face of a bid document are typographical errors, errors in extending unit prices, transposition errors, and arithmetical errors. It is emphasized that mistakes in unit prices cannot be corrected.

(3) Mistakes where intended correct bid is not evident. A low bidder alleging a material mistake of fact which makes the bid non-responsive may be permitted to withdraw the bid if:

(a) a mistake is clearly evident on the face of the bid document but the intended correct bid is not; or

(b) the low bidder submits evidence which clearly and convincingly demonstrates that a mistake was made.

(4) Written determination. When a bid is corrected or withdrawn, or a correction or withdrawal is denied, the procurement officer shall prepare a written determination showing that the relief was granted or denied in accordance with this section.

[1.4.1.23 NMAC - Rp, 1.4.1.23 NMAC, 09-30-05]

1.4.1.24 BID EVALUATION AND AWARD:

A. General. A contract solicited by competitive sealed bids shall be awarded with reasonable promptness by written notice to the lowest responsible bidder. The IFB shall set forth the requirements and criteria that will be used to determine the lowest responsive bid. No bid shall be evaluated for any requirement or criterion that is not disclosed in the IFB. Contracts solicited by competitive sealed bids shall require that the bid amount exclude the applicable state gross receipts tax or local option tax but that the contracting agency shall be required to pay the tax including any increase in the tax becoming effective after the contract is entered into. The tax shall be shown as a separate amount on each billing or request for payment made under the contract.

B. Product acceptability. The IFB shall set forth all evaluation criteria to be used in determining product acceptability. It may require the submission of bid samples, descriptive literature, technical data, or other material. It may also provide for accomplishing any or all of the following prior to award:

(1) inspection or testing of a product for such characteristics as quality or workmanship;

(2) examination of such elements as appearance, finish, taste or feel; or

(3) other examinations to determine whether it conforms with other purchase description requirements.

C. Purpose of acceptability evaluation. An acceptability evaluation is not conducted for the purpose of determining whether one bidder's item is superior to another's but only to determine that a bidder's offering is acceptable as set forth in the IFB. Any bidder's offering which does not meet the acceptability requirements shall be rejected as non-responsive.

D. Brand-name or equal specification. Where a brand-name or equal specification is used in a solicitation, the solicitation shall contain explanatory language that the use of a brand name is for the purpose of describing the standard of quality, performance and characteristics desired and is not intended to limit or restrict competition. When bidding an "or equal" the burden of persuasion is on the supplier or manufacturer who has not been specified to convince the procurement officer that their product is, in fact, equal to the one specified. The procurement officer is given the responsibility and judgement for making a final determination on whether a proposed

substitution is an "or equal".

E. Determination of lowest bidder. Following determination of product acceptability as set forth in Subsections B, C and D of this section, if any is required, bids will be evaluated to determine which bidder offers the lowest cost to the state in accordance with the evaluation criteria set forth in the IFB. Only objectively measurable criteria that are set forth in the IFB shall be applied in determining the lowest bidder. Examples of such criteria include, but are not limited to, discounts, transportation costs and ownership or life-cycle formulas. Evaluation factors need not be precise predictors of actual future costs, but to the extent possible the evaluation factors shall be reasonable estimates based upon information the state has available concerning future use.

(1) Prompt payment discounts. Prompt payment discounts shall not be considered in computing the low bid. Such discounts may be considered after award of the contract.

(2) Trade discounts. Trade discounts shall be considered in computing the low bid. Such discounts may be shown separately, but must be deducted by the bidder in calculating the unit price quoted.

(3) Quantity discounts. Quantity discounts shall be included in the price of an item. Such discounts may not be considered where set out separately unless the IFB so specifies.

(4) Transportation costs. Transportation costs shall be considered in computing the low bid. Such costs may be computed into the bid price or be listed as a separate item.

(5) Total or life-cycle costs. Award may be determined by total or life-cycle costing if so indicated in the IFB. Lifecycle cost evaluation may take into account operative, maintenance, and money costs, other costs of ownership and usage and resale or residual value, in addition to acquisition price, in determining the lowest bid cost over the period the item will be used.

(6) Energy efficiency. Award may be determined by an evaluation consisting of acquisition price plus the cost of energy consumed over a projected period of use.

F. Restrictions. Nothing in Section 1.4.1.24 of this rule shall be deemed to permit contract award to a bidder submitting a higher quality item than designated in the IFB unless the bidder is also the lowest bidder as determined under Subsection E of this section. Further, except as provided in this subsection, Section 1.4.1.24 of this rule does not permit negotiations with any bidder. If the lowest responsive bid has otherwise qualified, and if there is no change in the original terms and conditions, the lowest responsible bidder may negotiate with the purchaser (i.e., this exception applies only to purchases and does not apply to procurements generally) for a lower total bid to avoid rejection of all bids for the reason that the lowest bid was up to ten percent higher than budgeted project funds. Such negotiation shall not be allowed if the lowest bid was more than ten percent over budgeted project funds.

G. Documentation of award. Following award, a record showing the basis for determining the successful bidder shall be made a part of the procurement file.

H. Publicizing awards. Written notice of award shall be sent to the successful bidder. Notice of award shall also be posted at the state purchasing agent's office.

[1.4.1.24 NMAC - Rn 1.4.1.24 NMAC, 09-30-05]

1.4.1.25 STATUTORY PREFERENCES: Statutory preferences to be applied in determining low bidder. New Mexico law provides certain statutory preferences to resident businesses, resident manufacturers, New York state business enterprises, and for recycled content goods (Sections 13-1-21 and 13-1-22 NMSA 1978). The statute further provides a preference to resident construction contractors and New York state business enterprises (Sections 13-4-1 through 13-4-3 NMSA 1978) which must be applied in determining the lowest bidder.

[1.4.1.25 NMAC - Rp, 1.4.1.25 NMAC, 09-30-05]

1.4.1.26 IDENTICAL LOW BIDS:

A. Definition. Identical low bids are low responsive bids, from responsible bidders, which are identical in price after the application of the preferences referred to in Section 1.4.1.25 of this rule and which meet all the requirements and criteria set forth in the IFB.

B. Award. When two or more identical low bids are received, the state purchasing agent may:

(1) award pursuant to the multiple source award provisions of Sections 13-1-153 and 13-1-154 NMSA 1978;

(2) award to a resident business or a New York state business enterprise if the identical low bids are submitted by a resident business or a New York state business enterprise and a nonresident business;

(3) award to a resident manufacturer if the identical low bids are submitted by a resident manufacturer and a resident business or New York business enterprise;

(4) award to a bidder offering recycled content goods if the identical low bids are for recycled content goods and virgin goods;

(5) award by lottery to one of the identical low bidders; or

(6) reject all bids and re-solicit bids or proposals for the required services, construction or items of tangible personal property.

[1.4.1.26 NMAC - Rp, 1.4.1.26 NMAC, 09-30-05]

1.4.1.27 MULTI-STEPSEALED BIDS:

A. General. Multi-step bidding is a variant of the competitive sealed bidding method. This method may be utilized when the state purchasing agent or a central purchasing office makes a determination that it is impractical initially to prepare specifications to support an award based on price, or that specifications are inadequate or are too general to permit full and free competition without technical evaluation and discussion.

B. Phased process. Multi-step bidding is a phased process which combines elements of both the competitive sealed proposal method, seeking necessary information or unpriced technical offers in the initial phase; and regular competitive sealed bidding, inviting bidders who submitted technically acceptable offers in the initial phase, to submit competitive sealed price bids on the technical offers in the final phase. The contract shall be awarded to the lowest responsible bidder. If time is a factor, the state purchasing agent or a central purchasing office may require offerors to submit a separate sealed bid during the initial phase to be opened after the technical evaluation.

C. Public notice. Whenever multi-step sealed bids are used, public notice for the first phase shall be given in accordance with Section 1.4.1.17of this rule. Public notice is not required for the second phase.

[1.4.1.27 NMAC - Rp, 1.4.1.27 NMAC, 09-30-05]

1.4.1.28 PAYMENTS FOR PURCHASES: Contract clause. All contracts resulting from an invitation for bids shall contain a clause allowing for late payment charges against the state agency in the amount and under the conditions set forth in Section 13-1-158 NMSA 1978.

[1.4.1.28 NMAC - Rp, 1.4.1.28 NMAC, 09-30-05]

1.4.1.29 APPLICATION (COMPETITIVE SEALED PROPOSALS; SECTIONS 1.4.1.29-1.4.1.47 NMAC):

A. General. Except as provided in Subsections B and C of this sec-

tion , the provisions of Sections 1.4.1.29 through 1.4.1.47 of this rule apply to every procurement made by competitive sealed proposals.

B. Architects, engineers, landscape architects and surveyors. The provisions of Sections 1.4.1.29 through 1.4.1.47 of this rule do not apply to the procurement of professional services of architects, engineers, landscape architects and surveyors for state public works projects or local public works projects. Except that when procuring such professional services for state public works projects or local public works projects state agencies and local public bodies shall comply with Sections 13-1-120 through 13-1-124 NMSA 1978.

C. Procurement of professional services by state agencies with rule-making authority. A state agency with rule making authority may adopt its own regulations for the procurement of professional services by competitive sealed proposals under the following conditions:

(1) the state agency must receive prior written authorization from the GSD secretary;

(2) the state agency's proposed regulations must provide that RFPs or notices thereof having a value exceeding thirty thousand dollars ($30,000) will be provided to the state purchasing agent for distribution to prospective offerors who have registered with the state purchasing agent's office in accordance with the terms of Subsection B of 1.4.1.17 and Subsection A of Section 1.4.1.32 of this rule;

D. "Professional services" are defined in Section 13-1-76 NMSA 1978. The section of statute acknowledges the difficulty of any attempt made to recognize and list each and every service that could conceivably fall within the definition of "professional services". Instead, the statute provides in relevant part that "...other persons or businesses providing similar professional services to those listed may be designated as such by a determination issued by the state purchasing agent or a central purchasing office." In instances where "...other persons or businesses providing similar professional services...", as cited in Section 13-1-76, NMSA 1978, is not clearly defined, state agencies shall submit a written request to the state purchasing agent for issuance of a determination and a finding that the service is to be designated as a professional service. State agencies shall not make such a determination independent of the state purchasing agent.

[1.4.1.29 NMAC - Rp, 1.4.1.29 NMAC, 09-30-05]

1.4.1.30 GENERAL DISCUSSION:

A. Use of competitive sealed proposals. When a state agency procures professional services that are not related to a design and build project delivery system in accordance with Section 13-1-119.1 NMSA 1978, or when the state purchasing agent or a designee makes a determination that the use of competitive sealed bids is either not practicable or not advantageous to the state, a procurement shall be effected by competitive sealed proposals. Note well: Section 13-1-111 NMSA 1978 only authorizes state agencies other than the state purchasing agent to procure professional services by means of competitive sealed proposals. Section 13-1-111 NMSA 1978 does not authorize state agencies to avoid centralized purchasing through the state purchasing agent by issuing RFPs for items of tangible personal property, or non-professional services.

B. Definitions. The words "practicable" and "advantageous" are to be given ordinary dictionary meanings. The term "practicable" denotes what may be accomplished or put into practical application. "Advantageous" denotes a judgmental assessment of what is in the state's best interest. The use of competitive sealed bids may be practicable, that is, reasonably possible, but not necessarily advantageous, that is, in the state's best interest.

C. Proposals offer flexibility. The key element in determining advantageousness is the need for flexibility. The competitive sealed proposal method differs from the competitive sealed bid method in two important ways:

(1) it permits discussions with competing offerors and changes in their proposals including price; and;

(2) it allows comparative judgmental evaluations to be made when selecting among acceptable proposals for award of a contract.

D. Determinations by category. The state purchasing agent may make determinations by category of services or items of tangible personal property that it is either not practicable or not advantageous to procure specified types of service or items of tangible personal property by competitive sealed bids in which case competitive sealed proposals shall be utilized. The state purchasing agent may modify or revoke such determinations at any time.

[1.4.1.30 NMAC - Rp, 1.4.1.30 NMAC, 09-30-05]

1.4.1.31 REQUEST FOR PROPOSALS ("RFP"):

A. Initiation. The request for proposals ("RFP") is used to initiate a competitive sealed proposal procurement. All state agencies shall follow published guidelines and procedures issued by the state purchasing agent from development stage through award of RFP-based procurements. At a minimum the RFP shall include the following:

(1) the specifications for the services or items of tangible personal property to be procured;

(2) all contractual terms and conditions applicable to the procurement;

(3) instructions concerning the submission and response to questions;

(4) the term of the contract and conditions of renewal or extension, if any;

(5) instructions and information to offerors, including the location where proposals are to be received and the date, time and place where proposals are to be received and reviewed;

(6) all of the evaluation factors, and the relative weights to be given to the factors in evaluating proposals;

(7) a statement that discussions may be conducted with offerors who submit proposals determined to be reasonably susceptible of being selected for award, but that proposals may be accepted without such discussions;

(8) a notice that the RFP may be canceled and that any and all proposals may be rejected in whole or in part when it is in the best interest of the state of New Mexico; and

(9) a statement of how proposed costs should be submitted;

(10) a notice that reads substantially as follows: The Procurement Code, Sections 13-1-28 through 13-1-199 NMSA 1978, imposes civil and misdemeanor criminal penalties for its violation. In addition, the New Mexico criminal statutes impose felony penalties for bribes, gratuities and kick-backs.

B. Incorporation by reference. The RFP may incorporate documents by reference, provided that the RFPspecifies where such documents can be obtained.

C. Form of proposal. The manner in which proposals are to be submitted, including any forms for that purpose, should be designated in the RFP.

D. Proposal preparation time. Thirty calendar days between the date of issue and the proposal due date is the recommended minimum proposal preparation time. A longer preparation time may be required for complex procurements or for procurements that require substantial offeror resources to prepare an acceptable proposal.

[1.4.1.31 NMAC - Rp, 1.4.1.31 NMAC, 09-30-05]

1.4.1.32 PUBLIC NOTICE REQUEST FOR PROPOSAL:

A. Procurements by the state purchasing agent. The state purchasing agent shall give public notice of the RFP in the same manner as provided in Section 1.4.1.17 of this rule. However, an RFP or a

notice shall be published not less than twenty (20) days prior to the date set for receipt of proposals unless a shorter time frame is requested and approval granted by the state purchasing agent.

B. Procurements of all tangible personal property or services.

(1) The procurement manager shall deliver to the state purchasing agent or designee the following listed items no later than fifteen calendar days prior to the proposed issue date:

(a) a one-page notice suitable for distribution that contains the procurement title, purpose statement, the issue date, the name of the agency conducting the procurement, the place where a copy of the RFPdocument may be obtained, the date and location of the pre-proposal conference, if one is held, the name, address and phone number of the procurement manager and the deadline for submission of proposals;

(b) a completed state of New Mexico purchase document, Form SPD101A;

(c) a list containing the names and addresses of suggested sources, if any;

(d) a copy of the complete RFP document. For large or complex procurements, the draft RFP document shall be delivered to the state purchasing agent for review at least thirty days prior to the proposed issue date.

C. Procurements of professional services by other central purchasing offices. When procuring professional services, central purchasing offices other than the state purchasing agent shall provide the following notice:

(1) The RFP or a notice thereof shall be published not less than ten (10) calendar days prior to the date set for the receipt of proposals. It is recommended, however, that the time period between the published date and the date set for receipt of proposals be no less than twenty (20) days. The RFP or notice shall be published at least once in a newspaper of general circulation in the area in which the central purchasing office is located. If there is no newspaper of general circulation in the area, such other notice may be given as is commercially reasonable; and

(2) A copy of the RFP and notice shall be delivered to the state purchasing agent not less than fifteen calendar days prior to the date set for the issuance. The state purchasing agent shall distribute the RFP or notice to prospective offerors who have registered with the state purchasing agent's office in accordance with the terms of Subsection B of Section 1.4.1.17 of this rule and Subsection A of this section; and

(3) A copy of the RFP shall be made available for public inspection at the central purchasing office.

D. Additional notice. The requirements of Subsections A, B and C of this section are in addition to any other procedures which may be adopted by the state purchasing agent or central purchasing offices to notify prospective offerors that proposals will be received, including but not limited to publication in professional journals, if available.

[1.4.1.32 NMAC - Rn 1.4.1.32 NMAC, 09-30-05]

1.4.1.33 PRE-PROPOSAL CONFERENCES: Pre-proposal conferences may be conducted in accordance with Section 1.4.1.18 of this rule. Any such conference should be held prior to submission of initial proposals.

[1.4.1.33 NMAC - Rp, 1.4.1.33 NMAC, 09-30-05]

1.4.1.34 AMENDMENTS TO THE REQUEST FOR PROPOSALS:

A. Prior to submission of proposals. Prior to submission of proposals, amendments to the RFP may be made in accordance with Section 1.4.1.19 of this rule.

B. After submission of proposals. After submission of proposals, amendments to the RFP shall be distributed only to short-listed offerors. The short-listed offerors shall be permitted to submit new proposals or to amend those submitted. If in the opinion of the procurement officer or procurement manager, a contemplated amendment will significantly change the nature of the procurement, the RFP shall be canceled in accordance with Sections 1.4.1.68 through 1.4.1.72 of this rule, and a new RFP issued.

[1.4.1.34 NMAC - Rp, 1.4.1.34 NMAC, 09-30-05]

1.4.1.35 MODIFICATION OR WITHDRAWAL OF PROPOSALS: Proposals may be modified or withdrawn prior to the established due date in accordance with Section 1.4.1.20 of this rule. The established due date is either the time and date announced for receipt of proposals or receipt of modifications to proposals, if any; or, if discussions have begun, it is the time and date by which best and final offers must be submitted by short-listed offerors.

[1.4.1.35 NMAC - Rp, 1.4.1.35 NMAC, 09-30-05]

1.4.1.36 LATE PROPOSALS, LATE WITHDRAWALS AND LATE MODIFICATIONS: Any proposal, withdrawal, or modification received after the established due date at the place designated for receipt of proposals is late. (See Section 1.4.1.35 of this rule for the definition of "established due date.") They may be considered only in accordance with Section 1.4.1.21 of this rule.

[1.4.1.36 NMAC - Rp, 1.4.1.36 NMAC, 09-30-05]

1.4.1.37 RECEIPT AND OPENING OF PROPOSALS:

A. Receipt. Proposals and modifications shall be time-stamped upon receipt and held in a secure place until the established due date. (See Section 1.4.1.35 of this rule for the definition of "established due date.")

B. Opening. Proposals shall not be opened publicly and shall not be open to public inspection until after an offeror has been selected for award of a contract. An offeror may request in writing nondisclosure of confidential data. Such data shall accompany the proposal and shall be readily separable from the proposal in order to facilitate eventual public inspection of the nonconfidential portion of the proposal.

[1.4.1.37 NMAC - Rp, 1.4.1.37 NMAC, 09-30-05]

1.4.1.38 EVALUATION OF PROPOSALS:

A. Evaluation factors: The evaluation shall be based on the evaluation factors and the relative weights set forth in the RFP. Numerical rating systems are required for procurements of information systems resources.

B. Evaluation committee. The state agency management shall appoint an evaluation committee prior to the due date for receipt of proposals. The size of the committee should be manageable and include both user and technical support representatives.

C. Classified proposals. For the purpose of conducting discussions under Section 1.4.1.39 of this rule, proposals shall be initially classified as:

(1) responsive;

(2) potentially responsive, that is, reasonably susceptible of being made responsive; or

(3) non-responsive.

D. Disqualification. Nonresponsive proposals are disqualified and eliminated from further consideration. A written determination in the form of a letter must be sent promptly to the disqualified offeror setting forth the grounds for the disqualification, and made a part of procurement file.

[1.4.1.38 NMAC - Rp, 1.4.1.38 NMAC, 09-30-05]

1.4.1.39 PROPOSAL DISCUSSIONS AND NEGOTIATIONS WITH INDIVIDUAL OFFERORS:

A. Discussions authorized.

Discussions may be conducted with responsible offerors who submit acceptable or responsive, potentially acceptable or potentially responsive proposals.

B. Purposes of discussions. Discussions are held to clarify technical or other aspects of the proposals.

C. Conduct of discussions. If during discussions there is a need for any substantial clarification or change in the request for proposals, the request for proposals shall be amended to incorporate such clarification or change. Any substantial oral clarification of a proposal shall be reduced to writing by the offeror. Proposals may be accepted and evaluated without such discussion. This is not an opportunity for the offerors to amend the substance of their proposals.

D. Short list. All responsible offerors who submit acceptable proposals are eligible for the short list. If numerous acceptable proposals have been submitted, however, the procurement officer or procurement manager may rank the proposals and select the highest ranked proposals for the short list. Those responsible offerors who are selected for the short list are the short-listed offerors" or "finalist offerors".

E. Competitive negotiations. Competitive negotiations may be held among the short-listed offerors to:

(1) promote understanding of a state agency's requirements and short-listed offerors' proposal; and

(2) facilitate arriving at a contract that will be most advantageous to a state agency taking into consideration the evaluation factors set forth in the RFP.

(3) Except for circumstances and situations otherwise approved by the state purchasing agent, negotiations of the relevant terms and conditions as well as any other important factors in an RFP and proposed contract are negotiated prior to award of a contract, not after award.

F. Conduct of competitive negotiations. Short-listed offerors shall be accorded fair and equal treatment with respect to any negotiations and revisions of proposals. The procurement officer should establish procedures and schedules for conducting negotiations. If during discussions there is a need for any substantial clarification of or change in the RFP, the RFP shall be amended to incorporate such clarification or change. Any substantial oral clarification of a proposal shall be reduced to writing by the short-listed offeror.

[1.4.1.39 NMAC - Rp, 1.4.1.39 NMAC, 09-30-05]

1.4.1.40 DISCLOSURE: The contents of any proposal shall not be disclosed so as to be available to competing offerors during the negotiation process and prior to award.

[1.4.1.40 NMAC - Rp, 1.4.1.40 NMAC, 09-30-05]

1.4.1.41 BEST AND FINAL OFFERS: The procurement officer or procurement manager may establish a common date and time for short-listed or finalist offerors to submit best and final offers. Best and final offers shall be submitted only once; provided, however, the state purchasing agent or central purchasing office may make a written determination that it is in a state agency's best interest to conduct additional discussions or change the state agency's requirements and require another submission of best and final offers. Otherwise, no discussion of or changes in the best and final offers shall be allowed prior to award. Short-listed offerors shall also be informed that if they do not submit a notice of withdrawal or another best and final offer, their immediately previous offer will be construed as their best and final offer.

[1.4.1.41 NMAC - Rp, 1.4.1.41 NMAC, 09-30-05]

1.4.1.42 MISTAKES IN PROPOSALS:

A. Modification or withdrawal of proposals. Proposals may be modified or withdrawn as provided in Section 1.4.1.35 of this rule.

B. Mistakes discovered after receipt of proposals. This subsection sets forth procedures to be applied in four situations in which mistakes in proposals are discovered after receipt of proposals.

(1) Confirmation of proposal. When the procurement officer or procurement manager knows or has reason to conclude before award that a mistake has been made, the procurement officer or procurement manager should request the offeror to confirm the proposal. If the offeror alleges mistake, the proposal may be corrected or withdrawn during any discussions that are held or if the conditions set forth in Subsection C of this section are met.

(2) During negotiations; prior to best and final offers. Once negotiations are commenced or after best and final offers are requested, any short-listed or finalist offeror may freely correct any mistake by modifying or withdrawing the proposal until the time and date set for receipt of best and final offers.

C. Technical irregularities. Technical irregularities are matters of form rather than substance evident from the proposal document, or insignificant mistakes that can be waived or corrected without prejudice to other offerors; that is, when there is no effect on price, quality or quantity. If discussions are not held or if best and final offers upon which award will be made have been received, the procurement officer or procurement manager may waive such irregularities or allow an offeror to correct them if either is in the best interest of the state. Examples include the failure of an offeror to:

(1) return the number of signed proposals required by the RFP;

(2) sign the proposal, but only if the unsigned proposal is accompanied by other material indicating the offeror's intent to be bound; or

(3) acknowledge receipt of an amendment to the RFP, but only if:

(a) it is clear from the proposal that the offeror received the amendment and intended to be bound by its terms; or

(b) the amendment involved had no effect on price, quality or quantity.

D. Correction of mistakes. If discussions are not held, or if the best and final offers upon which award will be made have been received, mistakes shall be corrected to the intended correct offer whenever the mistake and the intended correct offer are clearly evident on the face of the proposal, in which event the proposal may not be withdrawn.

E. Withdrawal of proposals. If discussions are not held, or if the best and final offers upon which award will be made have been received, an offeror alleging a material mistake of fact which makes a proposal non-responsive may be permitted to withdraw the proposal if:

(1) the mistake is clearly evident on the face of the proposal but the intended correct offer is not; or

(2) the offeror submits evidence which clearly and convincingly demonstrates that a mistake was made.

F. Determination required. When a proposal is corrected or withdrawn, or correction or withdrawal is denied under Subsections C through E of this section, the procurement officer or procurement manager shall prepare a written determination showing that the relief was granted or denied in accordance with this section.

[1.4.1.42 NMAC - Rp, 1.4.1.42 NMAC, 09-30-05]

1.4.1.43 AWARD: PROFESSIONAL SERVICES:

A. Procedure. An award shall be made to the responsible offeror whose proposal is most advantageous to a state agency, taking into consideration the evaluation factors set forth in the RFP. The procurement officer shall make a written determination showing the basis on which an award was found to be most advantageous to a state agency based on the factors set forth in the RFP.

B. Publicizing awards. After a contract is entered into, notice of award shall be publicized.

C. Publicizing awards. The procurement manager shall promptly provide all offerors who submitted proposals written notice of the award. The written notice shall be sent via certified mail, return receipt requested, and shall include the expiration date and time of the protest period, if there was a change from the date and time published in the RFP.
[1.4.1.43 NMAC - Rp, 1.4.1.43 NMAC, 09-30-05]

1.4.1.44 AWARD: ALL TANGIBLE PERSONAL PROPERTY OR SERVICES: (INCLUDES SOFTWARE, HARDWARE,NON-PROFESSIONAL SERVICES, etc)

A. Procedure The award shall be made by the state purchasing agent or designee to the responsible offeror whose proposal is most advantageous to the state agency, taking into consideration the evaluation factors set forth in the RFP. The procurement manager shall make a written determination in the form of an evaluation committee report showing the basis on which the recommended award was found to be most advantageous to the state agency based on the factors set forth in the RFP.

B. Publicizing awards. The procurement manager shall promptly provide all offerors who submitted proposals written notice of the award. The written notice shall be sent via certified mail, return receipt requested, and shall include the expiration date and time of the protest period, if there was a change from the date and time published in the RFP.
[1.4.1.44 NMAC - Rp, 1.4.1.44 NMAC, 09-30-05]

1.4.1.45 PUBLIC INSPECTION:

A. General. After award, any written determinations made pursuant to these rules, the evaluation committee report and each proposal, except those portions for which the offeror has made a written request for confidentiality, shall be open to public inspection. Confidential data is normally restricted to confidential financial information concerning the offeror's organization and data that qualifies as a trade secret in accordance with the Uniform Trade Secrets Act, Sections 57-3A-1 to 57-3A-7 NMSA 1978. The price of products offered or the cost of services proposed may not be designated as confidential information.

B. Confidential data. If a request is received for disclosure of data, for which an offeror has made a written request for confidentiality, the state purchasing agent or central purchasing office shall examine the offeror's request and make a written determination that specifies which portions of the proposal should be disclosed. Unless the offeror takes legal action to prevent the disclosure, the data will be so disclosed. After award the proposal shall be open to public inspection subject to any continuing prohibition on the disclosure of confidential data.
[1.4.1.45 NMAC - Rp, 1.4.1.45 NMAC, 09-30-05]

1.4.1.46 PAYMENTS FOR PURCHASES: Contract Clause. All contracts resulting from a request for proposals shall contain a clause allowing for late payment charges against the state agency in the amount and under the conditions set forth in Section 13-1-158 NMSA 1978.
[1.4.1.46 NMAC - Rp, 1.4.1.46 NMAC, 09-30-05]

1.4.1.47 DFA CONTRACT REVIEW: All contracts for professional services with state agencies shall be reviewed as to budget requirements by the department of finance and administration, if such review is required by DFA or subsequent DFA regulations.
[1.4.1.47 NMAC - Rp, 1.4.1.47 NMAC, 09-30-05]

1.4.1.48 APPLICATION (SMALL PURCHASES; SECTIONS 1.4.1.48 - 1.4.1.52 NMAC): The provisions of Sections 1.4.1.48 through 1.4.1.52 of this rule apply to the procurement of nonprofessional services, construction or items of tangible personal property having a value not exceeding twenty thousand dollars ($20,000) and to the procurement of professional services having a value not exceeding thirty thousand dollars ($30,000) the use of a statewide price agreement, an existing contract or the methods of procurement set forth in Sections 1.4.1.50 through 1.4.1.52 of this rule provide alternatives to the competitive sealed bid and competitive sealed proposal methods of procurement. If an existing statewide price agreement, an existing contract or, the procurement methods set forth in Sections 1.4.1.50 through 1.4.1.52 of this rule are not used, the competitive sealed bid or competitive sealed proposal methods shall apply.
[1.4.1.48 NMAC - Rp, 1.4.1.48 NMAC, 09-30-05]

1.4.1.49 DIVISION OF REQUIREMENTS: Procurement requirements shall not be artificially divided so as to constitute a small purchase under Sections 1.4.1.48 through 1.4.1.52 of this rule.
[1.4.1.49 NMAC - Rp, 1.4.1.49 NMAC, 09-30-05]

1.4.1.50 SMALL PURCHASES OF $5,000 OR LESS: A state agency may procure services, construction or items of tangible personal property having a value not exceeding five thousand dollars ($5,000)by issuing a direct purchase order to a contractor based upon the best obtainable price.
[1.4.1.50 NMAC - Rp, 1.4.1.50 NMAC, 09-30-05]

1.4.1.51 SMALL PURCHASES OF ITEMS OF TANGIBLE PERSONAL PROPERTY, CONSTRUCTION AND NONPROFESSIONAL SERVICES:

A. Quotation to be obtained. Insofar as it is practical for small purchases of nonprofessional services, construction or items of tangible personal property having a value exceeding five thousand dollars ($5,000) but not exceeding twenty thousand dollars ($20,000), no fewer than three businesses shall be solicited to submit written quotations that are recorded and placed in the procurement file. If three written quotes cannot be obtained, the agency shall document the reasons and include the document in the procurement file. Such notations as "does not carry" or "did not return my phone call" do not qualify as a valid quotation.

B. Disclosure. Prior to award, the contents of any response to a quotation shall not be disclosed to any other business from which the same request for quotation is also being solicited.

C. Award. Award shall be made to the business offering the lowest acceptable quotation.

D. Records. The names of the businesses submitting quotations and the date and the amount of each quotation shall be recorded and maintained as a public record.
[1.4.1.51 NMAC - Rp, 1.4.1.51 NMAC, 09-30-05]

1.4.1.52 SMALL PURCHASES OF PROFESSIONAL SERVICES:

A. Application. A central purchasing office may procure professional services having a value not to exceed thirty thousand dollars ($30,000) except for the services of architects, engineers, landscape architects, or surveyors for state public works projects, as that term is defined in Section 13-1-91 NMSA 1978, in accordance with Subsections B, C, and D of this section.

B. Examination of offeror list. Before contacting any business, a central purchasing office is encouraged to examine the state purchasing agent's current list of potential offerors, if any. Central purchasing offices are encouraged to contact at least three businesses for written

offers before selecting a contractor.

C. Negotiations. A central purchasing office shall negotiate a contract for the required services at a fair and reasonable price to the state agency.

D. Disclosure. If more than one business is contacted, the contents of the written or oral offer of one business shall not be disclosed to another business during the negotiation process.

[1.4.1.52 NMAC - Rp, 1.4.1.52 NMAC, 09-30-05]

1.4.1.53 APPLICATION (SOLE SOURCE PROCUREMENTS, SECTIONS 1.4.1.53 - 1.4.1.57 NMAC): The provisions of Sections 1.4.1.53 through 1.4.1.57 of this rule apply to all sole source procurements unless emergency conditions exist as defined in Section 1.4.1.59 of this rule.

[1.4.1.53 NMAC - Rp, 1.4.1.53 NMAC, 09-30-05]

1.4.1.54 SOLE SOURCE PROCUREMENT OF ITEMS OF TANGIBLE PERSONAL PROPERTY, CONSTRUCTION AND NONPROFESSIONAL SERVICES:

A. Conditions for use. A contract may be awarded without competitive sealed bids or competitive sealed proposals, regardless of the estimated cost, when the state purchasing agent makes a written determination, after conducting a good-faith review of available sources and consulting the using agency, that there is only one source for the required items of tangible personal property, construction or nonprofessional services. In cases of reasonable doubt, competition should be solicited.

B. Request by using agency.. Any request by a using agency that a procurement be restricted to one potential contractor shall be accompanied by a written explanation as to why no other will be suitable or acceptable to meet the need.

C. Negotiations. .The state purchasing agent shall conduct negotiations, as appropriate, as to price, delivery and quantity, in order to obtain the price most advantageous to the state.

[1.4.1.54 NMAC - Rp, 1.4.1.54 NMAC, 09-30-05]

1.4.1.55 [RESERVED]

1.4.1.56 [RESERVED]

1.4.1.57 RECORDS OF SOLE SOURCE PROCUREMENTS: The state purchasing agent or central purchasing office shall maintain records of sole source procurements for a minimum of three years. The record of each such procurement shall be a public record and shall contain:

A. the contractor's name and address;

B. the amount and term of the contract;

C. a listing of the services, construction, or items of tangible personal property procured under the contract; and

D. the justification for the procurement method which shall include any written determinations and written approvals required by any provision of Sections 1.4.1.53 through 1.4.1.57of this rule.

[1.4.1.57 NMAC - Rp, 1.4.1.57 NMAC, 09-30-05]

1.4.1.58 APPLICATION (EMERGENCY PROCUREMENTS, SECTIONS 1.4.1.58 - 1.4.1.64 NMAC): The provisions of Sections 1.4.1.58 through 1.4.1.64 of this rule apply to every procurement made under emergency conditions that will not permit other source selection methods to be used.

[1.4.1.58 NMAC - Rp, 1.4.1.58 NMAC, 09-30-05]

1.4.1.59 DEFINITION OF EMERGENCY CONDITIONS: An emergency condition is a situation which creates a threat to public health, welfare, safety or property such as may arise by reason of floods, epidemics, riots, equipment failures or similar events. The existence of the emergency condition creates an immediate and serious need for services, construction or items of tangible personal property that cannot be met through normal procurement methods and the lack of which would seriously threaten:

A. the functioning of government;

B. the preservation or protection of property; or

C. the health or safety of any person.

[1.4.1.59 NMAC - Rp, 1.4.1.59 NMAC, 09-30-05]

1.4.1.60 SCOPE OF EMERGENCY PROCUREMENTS: Emergency procurements shall be limited to those services, construction, or items of tangible personal property necessary to meet the emergency. Such procurement shall not include the purchase or lease-purchase of heavy road equipment.

[1.4.1.60 NMAC - Rp, 1.4.1.60 NMAC, 09-30-05]

1.4.1.61 AUTHORITY TO MAKE EMERGENCY PROCUREMENTS: The state purchasing agent, a central purchasing office, or a designee of either, may make or authorize others to make emergency procurements when an emergency condition arises; provided that emergency procurements shall be made with such competition as is practicable under the circumstances.

[1.4.1.61 NMAC - Rp, 1.4.1.61 NMAC, 09-30-05]

1.4.1.62 PROCEDURE: The procedure used shall be selected to assure that the required services, construction, or items of tangible personal property are procured in time to meet the emergency. Given this constraint, such competition as is practicable shall be obtained.

[1.4.1.62 NMAC - Rp, 1.4.1.62 NMAC, 09-30-05]

1.4.1.63 WRITTEN DETERMINATION REQUIRED: A written determination of the basis for the emergency procurement shall be included in the procurement file.

[1.4.1.63 NMAC - Rp, 1.4.1.63 NMAC, 09-30-05]

1.4.1.64 RECORDS OF EMERGENCY PROCUREMENTS: The state purchasing agent or central purchasing office shall maintain records of emergency procurements for a minimum of three years. The record of each such procurement shall be a public record and shall contain:

A. the contractor's name and address;

B. the amount and term of the contract;

C. a listing of the services, construction, or items of tangible personal property procured under the contract; and

D. the justification for the procurement method.

[1.4.1.64 NMAC - Rp, 1.4.1.64 NMAC, 09-30-05]

1.4.1.65 PROCUREMENT UNDER EXISTING CONTRACTS AUTHORIZED: The state purchasing agent or a central purchasing office may contract for services, construction, or items of tangible personal property without the use of competitive sealed bids or competitive sealed proposals as follows:

A. at a price equal to or less than the contractor's current federal supply contract (GSA), providing the contractor has indicated in writing a willingness to extend the contract's pricing, terms and conditions to the state agency and the purchase order adequately identifies the contract relied upon; or

B. with a business which has a current price agreement with the state purchasing agent or a central purchasing office for the item, services, or construction meeting the same standards and specifications as the items to be procured, if the following conditions are met:

(1) the total quantity purchased does not exceed the quantity which may be purchased under the applicable price agreement; and

(2) the purchase order adequately identifies the price agreement relied upon.

[1.4.1.65 NMAC - Rp, 1.4.1.65 NMAC, 09-30-05]

1.4.1.66 LIMITATION ON SUBSECTION A OF SECTION 1.4.1.65 OF THIS RULE RELATING TO GSA CONTRACTS: It should be understood, the state is not authorized to utilize a GSA contract per se. It is imperative, therefore, that the contractor, not a dealer or distributor, who has a current GSA contract indicate in writing a willingness to extend the contract's pricing, terms and conditions to the state of New Mexico. Therefore, a state agency shall not procure services, construction or items of tangible personal property directly under a general services administration (GSA) contract. Rather, a state agency must procure pursuant to a state purchasing agent price agreement which reflects the prices, terms and conditions of the respective GSA contract. If no such state purchasing agent price agreement exists, a state agency may make a written request to the state purchasing agent for the issuance of one. The request must be accompanied by a current copy of the applicable GSA contract, a letter from the contractor expressing a willingness to extend the contract's pricing, terms and conditions to the state of New Mexico and a letter from the state agency indicating a commitment to utilize the price agreement. The state purchasing agent will ascertain whether it is current and whether the proposed price is equal to or less than the federal supply contract price. If everything is in order, the state purchasing agent will issue a price agreement or purchase order reflecting the prices, terms and conditions of the GSA contract. A state agency shall make no procurements from the GSA contractor until a state purchasing agent price agreement has been issued.

[1.4.1.66 NMAC - Rp, 1.4.1.66 NMAC, 09-30-05]

1.4.1.67 COPIES OF CONTRACTS AND PRICE AGREEMENTS: A central purchasing office shall retain for public inspection and for the use of auditors a copy of each state purchasing agent contract or current price agreement relied upon to make purchases without seeking competitive bids.

[1.4.1.67 NMAC - Rp, 1.4.1.67 NMAC, 09-30-05]

1.4.1.68 APPLICATION (CANCELLATION OF SOLICITATIONS OR REJECTION OF BIDS OR PROPOSALS; SECTIONS 1.4.1.68 - 1.4.1.72 NMAC): The provisions of Sections 1.4.1.68 through 1.4.1.72 of this rule shall govern the cancellation of any solicitations whether issued by the state purchasing agent under competitive sealed bids, competitive sealed proposals, small purchases, or any other source selection method, and rejection of bids or proposals in whole or in part.

[1.4.1.68 NMAC - Rp, 1.4.1.68 NMAC, 09-30-05]

1.4.1.69 POLICY: Any solicitation may be canceled or any or all bids or proposals may be rejected in whole or in part when it is in the best interest of the state of New Mexico.

[1.4.1.69 NMAC - Rp, 1.4.1.69 NMAC, 09-30-05]

1.4.1.70 CANCELLATION OF SOLICITATIONS OR REJECTION OF ALL BIDS OR PROPOSALS:

A. Prior to opening:

(1) As used in this section, "opening" means the date set for opening of bids or receipt of proposals.

(2) Prior to opening, a solicitation may be canceled in whole or in part when the state purchasing agent or central purchasing office makes a written determination that such action is in the state's best interest for reasons including but not limited to:

(a) the services, construction, or items of tangible personal property are no longer required;

(b) the using agency no longer can reasonably expect to fund the procurement; or

(c) proposed amendments to the solicitation would significantly change the nature of the procurement.

(3) When a solicitation is canceled prior to opening, notice shall be sent to all businesses solicited. The notice shall:

(a) identify the solicitation;

(b) briefly explain the reason for cancellation; and

(c) where appropriate, explain that an opportunity will be given to compete on any resolicitation or any future procurements of similar services, construction, or items of tangible personal property.

B. After opening.

(1) After opening but prior to award, all bids or proposals may be rejected in whole or in part when the state purchasing agent or central purchasing office makes a written determination that such action is in the state's best interest for reasons including but not limited to:

(a) all of the bids and proposals are nonresponsive;

(b) the services, construction, or items of tangible personal property are no longer required;

(c) ambiguous or otherwise inadequate specifications were part of the solicitation;

(d) the solicitation did not provide for consideration of all factors of significance to the using agency;

(e) prices exceed available funds and it would not be appropriate to adjust quantities to come within available funds;

(f) all otherwise acceptable bids or proposals received are at clearly unreasonable prices; or

(g) there is reason to believe that the bids or proposals may not have been independently arrived at in open competition, may have been collusive, or may have been submitted in bad faith.

(2) A notice of rejection should be sent to all businesses that submitted bids or proposals, and it shall conform to Paragraph (3) of Subsection A of this section .

[1.4.1.70 NMAC - Rp, 1.4.1.70 NMAC, 09-30-05]

1.4.1.71 REJECTION OF INDIVIDUAL BIDS OR PROPOSALS:

A. Reasons for rejection.

(1) Bids. As used in this section, "bid" includes both competitive sealed bids and small purchase quotations. Reasons for rejecting a bid shall include but are not limited to:

(a) the business that submitted the bid is nonresponsible as determined under Section] 1.4.1.73 of this rule;

(b) the bid is not responsive; or

(c) the service, construction, or item of tangible personal property offered in the bid is unacceptable by reason of its failure to meet the requirements of the specifications, or permissible alternates, or other acceptability criteria set forth in the IFB.

(2) Proposals. As used in this section, "proposal" includes both competitive sealed proposals and small purchase offers. Unless the solicitation states otherwise, proposals need not be unconditionally accepted without alteration or correction and a using agency's stated requirements may be revised or clarified after proposals are submitted. This flexibility must be considered in determining whether reasons exist for rejecting all or any part of a proposal. Reasons for rejecting proposals include but are not limited to:

(a) the business that submitted the proposal is nonresponsible as determined under Sections 1.4.1.75 through 1.4.1.79 of this rule;

(b) the proposal is not responsive; or

(c) the proposed price is clearly unreasonable; or

(d) the proposal failed to ade-

quately address one or more material mandatory requirements as set forth in the request for proposals.

B. Written determination required. A written determination which contains the reasons for the rejection of an individual bid or proposal shall be prepared by the state purchasing agent or central purchasing office and made a part of the procurement file. In the case of procurements for information system resources, a written determination which contains the reasons for the rejection of an individual proposal shall be prepared by the procurement manager and shall be included as an attachment to the evaluation committee report as a part of the procurement file. Further, a copy of the determination shall also be sent to the nonresponsive offeror.

[1.4.1.71 NMAC - Rp, 1.4.1.71 NMAC, 09-30-05]

1.4.1.72 "ALL OR NONE" BIDS: When the term "all or none" is used:

A. by the purchaser in a solicitation. A solicitation may require bidders to submit bids or offers on all items listed in the solicitation, or may identify certain groups of items in which all items must be bid. If the solicitation is properly so limited, a bidder's failure to bid all items identified as "all or none" items may render the bid nonresponsive.

B. by the bidder or offeror, and not the purchaser. If the bidder restricts acceptance of the bid, or a portion thereof, by such a statement as "all or none", the bidder has "qualified" the offer which may render the bid as nonresponsive.

C. in instances as stated in both Subsections A and B of this section such a bid or offer may be accepted only if the state purchasing agent or a central purchasing office issues a determination setting forth the basis for accepting the bid or offer as being in the best interest of the state. Also in both, instances, the bid or offer is only eligible for award if it is the overall low bid for the item or items so restricted.

[1.4.1.72 NMAC - Rp, 1.4.1.72 NMAC, 09-30-05]

1.4.1.73 APPLICATION (RECEIPT; INSPECTION; ACCEPTANCE OR REJECTION OF DELIVERIES; SECTIONS 1.4.1.73 - 1.4.1.74 NMAC): The using agency is responsible for inspecting and accepting or rejecting deliveries.

A. the using agency shall determine whether the quantity is as specified in the purchase order or contract;

B. the using agency shall determine whether the quality conforms to the specifications referred to or included in the purchase order or contract;

C. if inspection reveals that the delivery does not meet or conform to the quantity or quality specified in the purchase order or contract, the using agency shall notify the vendor that the delivery has been rejected and shall order the vendor to promptly make a satisfactory replacement or supplementary delivery;

D. in case the vendor fails to comply, the using agency shall promptly file a purchasing complaint with the state purchasing agent;

E. also, in case the vendor fails to comply, the using agency shall have no obligation to pay for the nonconforming items of tangible personal property;

F. if the delivery does conform to the quantity and quality specified in the purchase order or contract, the using agency shall certify that delivery has been completed and is satisfactory.

[1.4.1.73 NMAC - Rp, 1.4.1.73 NMAC, 09-30-05]

1.4.1.74 SUMMARY: Notwithstanding the requirements of Section 1.4.1.73 NMAC, if, after delivery and acceptance of goods, the goods or a portion thereof are later found to be non-conforming to the specifications referred to or included in the purchase order or contract, such acceptance does not waive any rights or remedies which are otherwise granted to the buyer in accordance with other applicable sections of laws of New Mexico.

[1.4.1.74 NMAC - Rp, 1.4.1.74 NMAC, 09-30-05]

1.4.1.75 APPLICATION (RESPONSIBILITY OF BIDDERS AND OFFERORS; SECTIONS 1.4.1.75 - 1.4.1.79 NMAC): A determination of responsibility or non-responsibility shall be governed by Sections 1.4.1 75 through 1.4.1.79 NMAC.

[1.4.1.75 NMAC - Rp, 1.4.1.75 NMAC, 09-30-05]

1.4.1.76 STANDARDS OF RESPONSIBILITY:

A. Standards for bidders. Factors to be considered in determining whether the standard of responsibility has been met include whether a bidder has:

(1) submitted a responsive bid;

(2) adequate financial resources, production or service facilities, personnel, service reputation and experience to make satisfactory delivery of the services, construction, or items of tangible personal property described in the IFB;

(3) a satisfactory record of performance;

(4) a satisfactory record of integrity;

(5) qualified legally to contract with the state; and

(6) supplied all necessary information and data in connection with any inquiry concerning responsibility.

B. Standards for offerors. Factors to be considered in determining whether the standard of responsibility has been met include whether an offeror has:

(1) submitted a responsive proposal;

(2) adequate financial resources, production or service facilities, personnel, service reputation and experience to make satisfactory delivery of the services or items of tangible personal property described in the proposal;

(3) a satisfactory record of performance;

(4) a satisfactory record of integrity;

(5) qualified legally to contract with the state; and

(6) supplied all necessary information and data in connection with any inquiry concerning responsibility.

[1.4.1.76 NMAC -Rp, 1.4.1.76 NMAC, 09-30-05]

1.4.1.77 ABILITY TO MEET STANDARDS: A bidder or offeror may demonstrate the availability of adequate financial resources, production or service facilities, personnel and experience by submitting, upon request:

A. evidence that the bidder or offeror possesses the necessary items;

B. acceptable plans to subcontract for the necessary items; or

C. a documented commitment from, or explicit arrangement with, a satisfactory source to provide the necessary items.

[1.4.1.77 NMAC - Rp, 1.4.1.77 NMAC, 09-30-05]

1.4.1.78 INQUIRY BY PROCUREMENT OFFICER: Before awarding a contract, the procurement officer or procurement manager must be satisfied that the bidder or offeror is responsible. Therefore, a bidder or offeror shall supply information and data requested by the procurement officer concerning the responsibility of the bidder or offeror. The unreasonable failure of a bidder or offeror to promptly supply information or data in connection with such an inquiry is grounds for a determination that the bidder or offeror is not responsible.

[1.4.1.78 NMAC - Rp, 1.4.1.78 NMAC, 09-30-05]

1.4.1.79 DETERMINATION REQUIRED:

A. If a bidder or offeror who otherwise would have been awarded a contract is found to be non-responsible, a written determination, setting forth the basis of the finding, shall be prepared by the state

purchasing agent or central purchasing office. The written determination shall be made part of the procurement file, and a copy of the determination shall be sent to the non-responsible bidder or offeror.

B. In the case of procurements for information systems resources if an offeror who otherwise would have been awarded a contract is non-responsible, a written determination setting forth the basis of the finding; shall be prepared by the procurement manager and attached to the evaluation committee report. The written determination shall be made a part of the procurement file and the procurement manager shall promptly send a copy of the determination to the non-responsible offeror.

[1.4.1.79 NMAC - Rp, 1.4.1.79 NMAC, 09-30-05]

1.4.1.80 APPLICABILITY (PROTESTS; SECTIONS 1.4.1.80 - 1.4.1.93 NMAC): The provisions of Sections 1.4.1.80 through 1.4.1.93 of this rule apply to all protests filed with the state purchasing agent and all central purchasing offices that have not adopted regulations for resolving protests. Central purchasing offices with rulemaking authority, other than the state purchasing agent, may adopt regulations for resolving protests filed within their jurisdictions.

[1.4.1.80 NMAC - Rp, 1.4.1.80 NMAC, 09-30-05]

1.4.1.81 RIGHT TO PROTEST: Any bidder or offeror who is aggrieved in connection with a solicitation or award of a contract may protest to the state purchasing agent or central purchasing office.

[1.4.1.81 NMAC - Rp, 1.4.1.81 NMAC, 09-30-05]

1.4.1.82 FILING OF PROTEST:

A. Protest must be written. Protests must be in writing and addressed to the state purchasing agent or central purchasing office, whichever has control and administration over the procurement.

B. Contents. The protest shall:

(1) include the name and address of the protestant;

(2) include the solicitation number;

(3) contain a statement of the grounds for protest;

(4) include supporting exhibits, evidence or documents to substantiate any claim unless not available within the filing time in which case the expected availability date shall be indicated; and

(5) specify the ruling requested from the state purchasing agent or central purchasing office.

C. Pleadings. No formal pleading is required to initiate a protest, but protests should be concise, logically arranged, and direct.

D. Time limit. Protests shall be submitted within fifteen calendar days after knowledge of the facts or occurrences giving rise to the protest. Any person or business that has been sent written notice of any fact or occurrence is presumed to have knowledge of the fact or occurrence.

[1.4.1.82 NMAC - Rp, 1.4.1.82 NMAC, 09-30-05]

1.4.1.83 PROCUREMENTS AFTER PROTEST:

A. In the event of a timely protest, as defined in Subsection of this rule , the state purchasing agent or central purchasing office shall not proceed further with the procurement unless the state purchasing agent or central purchasing office makes a written determination that the award of the contract is necessary to protect substantial interests of a state agency or a local public body. Such written determination should set forth the basis for the determination. As used in Sections 1.4.1.80 through 1.4.1.93 of this rule, the point in time in which a contract is awarded is that point at which a legally enforceable contract is created unless the context clearly requires a different meaning.

B. A procurement shall not be halted after a contract has been awarded merely because a protest has been filed. After a contract has been awarded, the state purchasing agent or central purchasing office may, in its sole discretion, halt a procurement in exceptional circumstances or for good cause shown.

[1.4.1.83 NMAC - Rp, 1.4.1.83 NMAC, 09-30-05]

1.4.1.84 PROCEDURE:

A. Upon the filing of a timely protest, the state purchasing agent or central purchasing office shall give notice of the protest to the contractor if award has been made or, if no award has been made, to all bidders or offerors who appear to have a substantial and reasonable prospect of receiving an award if the protest is denied.

B. The protestant and every business that receives notice pursuant to Subsection A of this section will automatically be parties to any further proceedings before the state purchasing agent or central purchasing office. In addition, any other person or business may move to intervene at any time during the course of the proceedings. Intervention will be granted upon a showing of a substantial interest in the outcome of the proceedings. Interveners shall accept the status of the proceedings at the time of their intervention; in particular, they must abide by all prior rulings and accept all previously established time schedules. The state purchasing agent or central purchasing office, and all employees thereof, are not parties to the proceedings.

C. The state purchasing agent or central purchasing office may take any action reasonably necessary to resolve a protest. Such actions include, but are not limited to, the following:

(1) issue a final written determination summarily dismissing the protest;

(2) obtain information from the staff of the state purchasing agent or central purchasing office;

(3) require parties to produce for examination information or witnesses under their control;

(4) require parties to express their positions on any issues in the proceedings;

(5) require parties to submit legal briefs on any issues in the proceeding;

(6) establish procedural schedules;

(7) regulate the course of the proceedings and the conduct of any participants;

(8) receive, rule on, exclude or limit evidence;

(9) take official notice of any fact that is among the traditional matters of official or administrative notice;

(10) conduct hearings; and

(11) take any action reasonably necessary to compel discovery or control the conduct of parties or witnesses.

[1.4.1.84 NMAC - Rp, 1.4.1.84 NMAC, 09-30-05]

1.4.1.85 DISCOVERY: Upon written request of any party, or upon its own motion, the state purchasing agent or central purchasing office may require parties to comply with discovery requests.

[1.4.1.85 NMAC - Rp, 1.4.1.85 NMAC, 09-30-05]

1.4.1.86 HEARINGS:

A. Hearings will be held only when the state purchasing agent or central purchasing office determines that substantial material factual issues are present that cannot be resolved satisfactorily through an examination of written documents in the record. Any party may request a hearing, but such requests shall be deemed denied unless specifically granted.

B. Hearings, when held, should be as informal as practicable under the circumstances, but the state purchasing agent or central purchasing office has absolute discretion in establishing the degree of formality for any particular hearing. In no event is the state purchasing

agent or central purchasing office required to adhere to formal rules of evidence or procedure.
[1.4.1.86 NMAC - Rp, 1.4.1.86 NMAC, 09-30-05]

1.4.1.87 RESOLUTION:

A. The state purchasing agent or central purchasing office shall promptly issue a written determination relating to the protest. The determination shall:

(1) state the reasons for the action taken; and

(2) inform the protestant of the right to judicial review of the determination pursuant to Section 13-1-183 NMSA 1978.

B. A copy of the written determination shall be sent immediately by certified mail, return receipt requested, to each of the parties.
[1.4.1.87 NMAC - Rp, 1.4.1.87 NMAC, 09-30-05]

1.4.1.88 RELIEF:

A. Prior to award. If, prior to award, the state purchasing agent or central purchasing office makes a written determination that a solicitation or proposed award of a contract is in violation of law, then the solicitation or proposed award shall be canceled.

B. After award.

(1) No fraud or bad faith. If, after an award, the state purchasing agent or central purchasing office makes a written determination that a solicitation or award of a contract is in violation of law and that the business awarded the contract has not acted fraudulently or in bad faith:

(a) the contract may be ratified, affirmed or revised to comply with law, provided that a written determination is made that doing so is in the best interest of the state; or

(b) the contract may be terminated, and the business awarded the contract shall be compensated for the actual expenses reasonably incurred under the contract plus a reasonable profit prior to termination.

(2) Fraud or bad faith. If, after an award, the state purchasing agent or central purchasing office makes a written determination that a solicitation or award of a contract is in violation of law and that the business awarded the contract has acted fraudulently or in bad faith, the contract shall be canceled.

C. Relief not allowed. Except as provided in Subparagraph (b) of Paragraph (1) of Subsection B of this section, the state purchasing agent or central purchasing office shall not award money damages or attorneys' fees.
[1.4.1.88 NMAC - Rp, 1.4.1.88 NMAC, 09-30-05]

1.4.1.89 MOTION FOR RECONSIDERATION:

A. Motion. A motion for reconsideration of a written determination issued pursuant to Section 1.4.1.87 of this rule may be filed by any party or by any using agency involved in the procurement. The motion for reconsideration shall contain a detailed statement of the factual and legal grounds upon which reversal or modification of the determination is deemed warranted, specifying any errors of law made, or information not previously considered.

B. When to file. A motion for reconsideration shall be filed not later than seven calendar days after receipt of the written determination.

C. Response to motion. The state purchasing agent or central purchasing office shall promptly issue a written response to the motion for reconsideration. A copy of the written response shall be sent immediately by certified mail, return receipt requested, to each of the parties.
[1.4.1.89 NMAC - Rp, 1.4.1.89 NMAC, 09-30-05]

1.4.1.90 DESIGNEE:

A. Designation. At any point during a protest proceeding, the state purchasing agent or central purchasing office may appoint a designee as defined in Section 13-1-51 NMSA 1978 to preside over the proceeding. The designee will have all of the powers described in Sections 1.4.1.80 through 1.4.1.93 of this rule except the power to issue a written determination under Section 1.4.1.87 of this rule. The designee only has authority to recommend a resolution to the state purchasing agent or central purchasing office under Section 1.4.1.87 of this rule.

B. Who may be designated. Any person, other than the procurement officer, procurement manager or other person not directly involved in the procurement, may serve as a designee.

C. Recommended written determination. A designee shall present a recommended written resolution to the state purchasing agent or central purchasing office and mail a copy to each of the parties. No party may appeal from the recommended resolution of the designee.

D. Action by state purchasing agent or central purchasing office. The state purchasing agent or central purchasing office shall approve, disapprove or modify the recommended resolution of the designee in writing. Such approval, disapproval or modification shall be the written determination required by Section 1.4.1.87 of this rule. Any party may file a motion for reconsideration of the written determination pursuant to Section 1.4.1.89 of this rule.
[1.4.1.90 NMAC - Rp, 1.4.1.90 NMAC, 09-30-05]

1.4.1.91 FINAL DETERMINATION:

A. No motion for reconsideration. In those proceedings in which no motion for reconsideration is filed, the written determination issued pursuant to Section 1.4.1.87 of this rule shall be the final determination for purposes of the time limits for seeking judicial review under Section 13-1-183 NMSA 1978.

B. Motion for reconsideration. In those proceedings in which a motion for reconsideration is filed, the written response to the motion issued pursuant to Section 1.4.1.89 of this rule shall be the final determination for purposes of the time limits for seeking judicial review under Section 13-1-183 NMSA 1978.
[1.4.1.91 NMAC - Rp, 1.4.1.91 NMAC, 09-30-05]

1.4.1.92 COPIES OF COMMUNICATIONS:

A. Copies to be provided to parties. Each party to a protest proceeding shall certify that it has provided every other party with copies of all documents or correspondence addressed or delivered to the state purchasing agent or central purchasing office.

B. Ex parte communications. No party shall submit to the state purchasing agent or central purchasing office, ex parte, any material, evidence, explanation, analysis, or advice, whether written or oral, regarding any matter at issue in a protest.
[1.4.1.92 NMAC - Rp, 1.4.1.92 NMAC, 09-30-05]

1.4.1.93 COUNTING DAYS: In computing any period of time prescribed in Sections 1.4.1.80 through 1.4.1.93 of this rule, the day of the event from which the designated period of time begins to run shall not be included, but the last day of the period shall be included unless it is a Saturday, a Sunday, or a legal holiday, in which event the period shall run to the end of the next business day.
[1.4.1.93 NMAC - Rp, 1.4.1.93 NMAC, 09-30-05]

History of 1.4.1 NMAC:
Pre-NMAC History:
Laws of 1984, Chapter 65, Section 1 enacted the Procurement Code to apply to every expenditure by state agencies and local public bodies for the procurement of items of tangible personal property, services and construction. To implement the Code, and in accordance with the statutory requirements applicable at the date and time, the subject and material found in this rule was first filed with the state records center and archives in 1984 as general services department (GSD) Procurement Code

Regulations, GSD Rule No. 84-611, filed 11-21-84; superseded by Procurement Code Regulations, GSD Rule No. 87-601, filed 12-16-87; superseded by Procurement Code Regulations, GSD Rule No. 89-601, filed 12-01-89; superseded by Procurement Code Regulations, GSD Rule No. 93-601, filed 09-21-93; superseded by 1 NMAC 5.2, filed 01-15-98.

History of Repealed Material:
1.4.1 NMAC, Procurement Code Regulations (filed 11/01/2001) repealed 09-30-05.

Other History:
GSD Rule No. 93-601 (filed 09-21-93) was renumbered, reformatted and amended to 1 NMAC 5.2, Procurement Code Regulations, effective 01-15-98.
1 NMAC 5.2, Procurement Code Regulations (filed 01-02-98) was renumbered, reformatted, amended and replaced to 1.4.1 NMAC, Procurement Code Regulations, effective 11-15-01.
1.4.1 NMAC, Procurement Code Regulations (filed 11/01/2001) was replaced by 1.4.1 NMAC, Procurement Code Regulations, effective 09-30-05.

NEW MEXICO GENERAL SERVICES DEPARTMENT

STATE PURCHASING DIVISION

TITLE 1 GENERAL GOVERNMENT ADMINISTRATION
CHAPTER 4 STATE PROCUREMENT
PART 8 USE OF COMPETITIVE SEALED PROPOSALS FOR CONSTRUCTION AND FACILITY MAINTENANCE, SERVICES AND REPAIRS

1.4.8.1 ISSUING AGENCY: General Services Department State Purchasing Division.
[1.4.8.1 NMAC - N, 09-30-05]

1.4.8.2 SCOPE: All executive branch state agencies.
[1.4.8.2 NMAC - N, 09-30-05]

1.4.8.3 STATUTORY AUTHORITY: Sections 13-1-67, 13-1-111 NMSA (2003 Amendments).
[1.4.8.3 NMAC - N, 09-30-05]

1.4.8.4 DURATION: Permanent.
[1.4.8.4 NMAC - N, 09-30-05]

1.4.8.5 EFFECTIVE DATE: September 30, 2005, unless a later date is cited at the end of a section.
[1.4.8.5 NMAC - N, 09-30-05]

1.4.8.6 OBJECTIVE: The purpose of this rule is to establish uniform procedures for the use of competitive sealed proposals that will promote the delivery of high quality projects in a timely, safe and cost-effective manner.
[1.4.8.6 NMAC - N, 09-30-05]

1.4.8.7 DEFINITIONS: Most of the terms in this rule are defined in the Procurement Code and prior Procurement Code regulations. In 1.4.8 NMAC, the following definitions apply:

A. "firm" means the company or other business entity referenced under 1.4.8 NMAC for the purpose of identifying, individually or collectively: a general contractor, a prime contractor or a subcontractor, of any tier, whether basic trade subcontractor, specialty subcontractor or other;

B. "pre listed subcontractors" means the subcontractors, of any tier, that the offeror is required to list, pursuant to1.4.8.13 NMAC of 1.4.8 NMAC, at the time it submits a proposal in response to a request for proposals;

C. "reckless" shall mean the submission or omission of a false or misleading material fact in connection with a request for proposals under 1.4.8 NMAC that the submitting firm and/or person knew or should have known was false or misleading;

D. "RFP" means requests for proposals;

E. "RFP documents" means any one or combination of the following request for proposal documents: technical proposal; price proposal; contractor qualification statement; subcontractor qualification statement.
[1.4.8.7 NMAC - N, 09-30-05]

1.4.8.8 APPLICATION (COMPETITIVE SEALED PROPOSAL PROCEDURES FOR CONSTRUCTION AND FACILITY MAINTENANCE, SERVICE AND REPAIRS 1.4.8.1 -1.4.8.17 NMAC):

A. General. The provisions of 1.4.8.1 NMAC through 1.4.8.17 NMAC set forth specific procedures that shall apply to all procurements made by competitive sealed proposals for construction and facility maintenance, service and repair.

B. The regulations applicable to the use of competitive sealed proposals pursuant to 1.4.1.29 NMAC through 1.4.1.47 NMAC, as well other existing rules applicable to competitive sealed proposals and procurement generally, e.g., 1.4.1.65 NMAC through 1.4.1.92 NMAC, shall apply to procurements made by competitive sealed proposals for construction and facility maintenance, service and repair to the extent they do not conflict with the provisions of 1.4.8 NMAC.

C. A state agency with rule making authority may adopt its own regulations to supplement the provisions of 1.4.8 NMAC, provided that such regulations meet the requirements of 1.4.8 NMAC, do not otherwise conflict with 1.4.8 NMAC and the state agency receives prior written authorization from the general services department secretary.
[1.4.8.8 NMAC - N, 09-30-05]

1.4.8.9 GENERAL DISCUSSION: The RFP competitive sealed proposal process is authorized to give using agencies flexibility to achieve the best overall value from a procurement contract. This is accomplished by permitting consideration of certain contractor qualification and performance factors that add value to a procurement contract, such as contractor past performance, technical expertise and experience, management capabilities and resources, subcontractor teams and craft personnel resources. It can also be achieved by permitting consideration of other technical or non-price factors that add value to a procurement contract, including schedule or contract warranty. Due to the inherently complex nature of most construction contracts and contracts for facility maintenance, service and repairs, the procurement of these services can often be accomplished more effectively through competitive sealed proposals, rather than competitive sealed bids, since the latter process essentially makes price the sole determining factor. When the competitive sealed proposal process is used, however, it is critical that appropriate procedures, criteria and information-gathering techniques be utilized to ensure that the RFP process works efficiently and fairly and achieves optimal results. The following sections are designed to assist using agencies in meeting these goals.
[1.4.8.9 NMAC - N, 09-30-05]

1.4.8.10 RFP PLANNING PROCEDURES:

A. Information required in RFPs. In addition to the information specified in 1.4.1.29 NMAC through 1.4.1.47 NMAC, or otherwise required by 1.4.8 NMAC, an RFP issued pursuant to 1.4.8 NMAC shall include:

(1) the core evaluation factors specified in Subsection A of 1.4.8.15 NMAC;

(2) additional evaluation factors, if applicable, as provided by Subsection B. of 1.4.8.15. NMAC, and;

(3) the numerical weight or points assigned to price and each of the technical evaluation factors specified in the RFP in

accordance with the requirements of 1.4.8.14 NMAC.

B. RFP review by state purchasing agent. A using agency issuing an RFP pursuant to 1.4.8 NMAC may submit a draft RFP to the state purchasing agent for review, but must do so at least thirty (30) days prior to the proposed issue date of the RFP. The state purchasing agent shall advise the using agency of any revisions needed to comply with the requirements of 1.4.8 NMAC. If revisions are directed, they shall be made prior to the issuance of the RFP.

C. If a using agency elects to reserve its right to enter discussions or negotiations with offerors in the context of an RFP issued under 1.4.8 NMAC, it shall explicitly reserve such rights in the RFP. If a using agency elects to engage in discussions or negotiations in the context of an RFP issued under 1.4.8 NMAC, it shall comply with applicable requirements of NMAC 1.4.1.29-1.4.1.47 NMAC.

[1.4.8.10 NMAC - N, 09-30-05]

1.4.8.11 PUBLIC NOTICE: Procurements by the state purchasing agent. The state purchasing agent shall give public notice of the RFP in the same manner as provided in 1.4.1.17 NMAC.

[1.4.8.11 NMAC - N, 09-30-05]

1.4.8.12 PROPOSAL SUBMISSION REQUIREMENTS:

A. Two-part proposal submissions. In addition to any requirements imposed by 1.4.1.29 NMAC through 1.4.1.47 NMAC, or otherwise specified in the request for proposal document, RFPs issued under this rule shall instruct offers to submit two-part, two-volume written proposals. Each volume shall be submitted in a separate sealed envelope or package and offerors shall be instructed to clearly label each volume with their name, address and date of submittal and prominently identify each as: volume I: technical proposal and volume II: price proposal.

B. Restrictions regarding opening of proposals. Price proposals shall remain sealed until the using agency has completed its evaluation of the technical proposals for all offerors and has prepared final technical scores as required by this rule.

C. Representations in RFP process. All RFP documents executed in connection with an RFP issued pursuant to this rule shall contain an acknowledgement and certification section with the following provisions.

(1) All RFP documents shall be signed by a director, officer or manager of the submitting firm who has sufficient knowledge to fully address all matters and respond to all inquiries included in RFP documents.

(2) The submitting firm shall represent that the information provided in the RFP documents is truthful, accurate and complete and that the firm and individual responsible for the submission shall be fully responsible for and bound by all information, data, certifications, disclosures and attachments included in the RFP documents.

(3) The submitting firm further understands:

(a) the information and data provided in connection with the RFP documents, as well as any other relevant information obtained from any other sources regarding the firm, may be reviewed to determine whether it qualifies as a responsible contractor pursuant to 1.4.1.47 NMAC and whether its offer represents the best value to using agency;

(b) a firm's failure to meet responsibility standards or provide requested information may render it ineligible to perform work on the prospective procurement contract;

(c) the submitting firm acknowledges its obligation to carefully review and complete, and, when applicable, update the RFP documents;

(d) the omission of any material fact concerning requested or submitted information, or the submission of any material false or misleading statement, or misrepresentation of a material fact concerning any requested or submitted information, may lead to the disqualification of the proposal.

(4) The submitting firm agrees that if it is awarded the contract, the RFP documents, and all terms and conditions specified therein, and all information, data, certifications and disclosures included in the RFP documents, shall be incorporated into the contract.

(5) The submitting firm further understands that if is determined that it has intentionally or recklessly failed to disclose requested information, or has intentionally or recklessly made a false statement, misrepresentation, or omission regarding a material fact relating to the RFP documents, the firm may be declared in default of contract and any such conduct shall provide the using agency with grounds to terminate the contract and/or withhold full or partial payment and/or impose any sanctions or penalties, as deemed appropriate and available under New Mexico law.

D. Contractor/Subcontractor Qualification Statements. A general contractor or other prime contractor submitting a proposal pursuant to an RFP issued under 1.4.8 NMAC shall be required to submit as part of its technical proposal a certified contractor qualification statement and certified subcontractor qualification statements in accordance with the requirements of 1.4.8.12 NMAC.

(1) Use of Qualification Statements. Contractor and subcontractor qualification statements shall be submitted on forms prepared by the general services department or the using agency. Information provided in these statements shall be considered by the using agency for evaluating and scoring contractors and subcontractors on technical proposals required under this rule. These statements shall also be considered in determining whether a contractor or subcontractor is a responsible contractor for purposes of 1.4.1.47 NMAC. RFPs should inform contractors and subcontractors, however, that in making such evaluations and determinations, the using agency is not restricted to the minimum information required for disclosure qualification statements and that any relevant information regarding performance from reliable sources may be considered.

(2) Subcontractor Qualification Statements. Subcontractor qualification statements shall be required for all subcontractors identified in the technical proposal pursuant to the subcontractor listing requirements 1.4.8.13 NMAC, where the value of the subcontract is fifty-thousand ($50,000) or five percent, whichever is greater. A using agency may reserve the right to require subcontractor qualification statements from any other subcontractors, at whatever tier and regardless of the value of the subcontract.

(3) Minimum Information Required. Contractor and subcontractor qualification statements required pursuant to Subsection D of 1.4.8.12 NMAC shall include, at a minimum, the following information:

(a) a list of all projects the firm has performed work on in the five (5) years immediately preceding the submission of its proposal that are similar in size and scope, as specified by the using agency in the RFP, to the prospective procurement project; in the event that an offeror or a pre-listed subcontractor is a new business and does not have a performance record sufficient to evaluate the firm's past performance, the using agency may consider the past performance of the firm's officers, management and owners or partners;

(b) copies of any types of performance evaluations reports for the past five (5) years prepared in connection with the work identified in Subparagraph (a) of Paragraph (3) of Subsection D of 1.4.8.12 NMAC;

(c) the following representations, regarding the firm's present capabilities to perform the procurement contract and its prior history for the past three (3) years immediately preceding the date of this state-

ment:

(i) the firm has a current contractor registration, as required by Section 13-4-13.1 NMSA 2004;

(ii) the firm has all applicable business and/or contractor licenses required by state or local law;

(iii) the firm possesses the necessary equipment, financial resources, technical resources, management, professional and craft personnel resources and other required capabilities to successfully perform the contract, or will achieve same through its prelisted subcontractors;

(iv) the firm has not had any business, trade or contracting license suspended or revoked;

(v) the firm has not been debarred by any government agency;

(vi) the firm has not defaulted on any project;

(vii) the firm has not committed willful or repeated violations of federal or state wage laws as determined by a final non-appealable decision of a court or government agency;

(viii) the firm has not committed serious or willful violations of federal or state safety laws as determined by a final non-appealable decision of a court or government agency;

(ix) disclosure by the firm of the following most recently available safety data: experience modification ratings; total lost workday incident rates (calculated by the number of lost time injuries and illnesses x 200,000 ÷ total hours worked); and recordable incident rates (calculated by the number of injuries x 200,000 ÷ total hours worked).

(4) Additional Performance Related Information. Using agencies may also require additional relevant information relating to a firm's past performance or present capability to perform the procurement contract. The extent of detail of such information may vary with the size and complexity of the project. Using agencies may require that additional information required from contractors and subcontractors be included in contractor and subcontractor qualification statements, or in other sections of the offeror's technical proposal. Types of additional information using agencies may wish to consider include, but are not limited to:

(a) information regarding the firm's financial status and financial resources;

(b) bonding information, including affirmative letters of bonding from certified bonding companies;

(c) past incidents involving denials of pre-qualification or findings of non-responsibility;

(d) past incidents of law violations in any area relating to contracting, including violations of environmental laws, antitrust laws, licensing laws;

(e) outstanding tax delinquencies to the state of New Mexico or its political subdivisions;

(f) disclosure of the names of any corporations, partnerships or other business entities the firm or its owners or officers have owned or operated in the past five (5) years;

(g) disclosure of the following information with regard to all projects identified in response to Subsection D (3)(a) of 1.4.8.12 NMAC:

(i) the original bid or proposal price of the projects and the final price of the projects and a brief explanation of cost growth, if any, for such projects;

(ii) the originally scheduled completion date of the projects and the final completion dates of the projects and a brief explanation of schedule growth, if any, for such projects;

(iii) a list of any contract claims or cases in litigation or arbitration concerning the projects, a brief description of the reasons for such disputes and status of such cases.

[1.4.8.12 NMAC - N, 09-30-05]

1.4.8.13 PROCEDURES REGARDING SUBCONTRACTORS:

A. Evaluation of subcontractors. To ensure that an RFP secures the best value from a procurement contract, the role and impact of subcontractors proposed for a project may be evaluated in accordance with the requirements of 1.4.8.13 for any project in which subcontractors are used.

B. Objective of subcontractor evaluation. The objective of subcontractor evaluation is to identify the general/subcontractor team or prime contractor/subcontractor team that offers the most advantageous proposal and best overall value to the using agency. The qualifications and performance capabilities of subcontractors may be evaluated in conjunction with and in relation to the evaluation of the technical proposal of the offeror/general contractor, construction management firm or other prime contractor as specified in Paragraph (2) of Subsection B of 1.4.8.16 NMAC.

C. Subcontractor listing threshold. In preparing an RFP subject to this rule, the using agency shall prepare a subcontractor listing threshold, which shall establish a dollar threshold, stipulated in the RFP, above which subcontractors must be listed. All activities and issues concerning the listing of subcontractors in this regard shall be governed by the Subcontractor's Fair Practices Act NMSA 13-4-31, et. seq. and applicable regulations issued thereunder.

D. Subcontractor listing amount. The subcontractor listing threshold included in RFPs shall be five thousand dollars ($5,000) or one-half of one percent of the architect's or engineer's estimate of the total project cost, including alternatives, whichever is greater.

E. When submitting a proposal in response to an RFP issued pursuant to this rule, the offeror shall provide a list of all subcontractors that will perform work on the project above the subcontractor listing threshold. For each such prelisted contractor, the offeror shall include in its proposal the following information:

(1) the name of subcontractor that will perform work or labor or render service on the project identified in the RFP and the city or county of its principal place of business; and

(2) the category of the work that will be done by each subcontractor; only one subcontractor may be listed for each category of work as defined by the offeror in its proposal.

F. Firms identified in the subcontractor list shall not be substituted except as permitted under 13-4-36 NMAC of the Subcontractor Fair Practices Act NMSA, 14-4-36.

[1.4.8.13 NMAC - N, 09-30-05]

1.4.8.14 WEIGHT ASSIGNED TO PRICE AND RFP EVALUATION FACTORS:

A. Numerical ratings systems. Numerical ratings systems are required for procurements under 1.4.8 Use of Competitive Sealed Proposals for Construction and Facility Maintenance, Services and Repairs and shall comply with the requirements of 1.4.8.14 NMAC.

B. Total available points. The RFP shall specify the total points available for the procurement (for example, 1,000 total points for all price and non-price technical evaluation factors) and shall assign specific numerical weights or points to price and to each of the non-price evaluation factors identified in the RFP.

C. Numerical weight for price. The numerical weight assigned to price shall be no greater than seventy (70) percent of the total evaluation points available.

D. Numerical weight for core evaluation factors. The numerical weight assigned to the non-price evaluation factors shall be as follows:

(1) each of the four core evaluation factors specified in Subsection A of 1.4.8.15 NMAC shall be assigned at least twenty (20) percent of the available points

for non-price technical evaluation factors;

(2) the weight assigned to any additional evaluation factors shall be determined by the using agency in accordance with the needs of the agency and the project.
[1.4.8.14 NMAC - N, 09-30-05]

1.4.8.15 RFP EVALUATION FACTORS:

A. Core evaluation factors. Each RFP issued pursuant to 1.4.8 NMAC shall include the following core evaluation factors, for both general and subcontractors for which qualification statements are required, with the sub-factors and criteria specified herein:

(1) Past performance:

(a) budget and schedule data;

(b) if available, performance quality and overall customer satisfaction;

(c) compliance with applicable laws and regulations;

(d) safety performance record.

(2) Management plan:

(a) management team;

(b) technical approach to project;

(c) safety plan/programs;

(d) project schedule.

(3) Project staffing/craft labor capabilities:

(a) participation in skill training;

(b) reliable staffing sources/project staffing.

(4) Health & Safety.

B. Additional evaluation factors:

(1) a using agency may include additional evaluation factors in an RFP issued pursuant to 1.4.8.15 of this NMAC 1.4.8 provided that any such factor is relevant to the successful completion of the contract or otherwise in the best interest of the state or using agency;

(2) examples of such additional factors may include, but are not limited to financial capabilities, project schedule, contract warranty or hiring of local construction or maintenance craft labor.
[1.4.8.15 NMAC - N, 09-30-05]

1.4.8.16 EVALUATION OF PROPOSALS:

A. Evaluation Committee ("EC"). Proposals submitted in response to RFPs issued under this regulation shall be evaluated by an evaluation committee ("EC") of at least three persons appointed by the procuring agency's management. The team should collectively possess expertise in the technical requirements of the project, construction design and contracting. A using agency may use independent consultants or agents to support source selection teams, provided appropriate precautions are taken to avoid potential conflicts of interest.

B. Scoring technical proposals. General procedures regarding technical proposal evaluation.

(1) When rating the technical proposals, the EC shall consider only the evaluation factors stated in the RFP.

(2) The EC may consider any relevant information or data, from any reliable source, relating to the RFP evaluation factors and the firm's ability to successfully perform the project. Such information may be obtained from the firm itself, prior customers of the firm, commercial and public databases and other reliable sources.

C. Scoring price proposals. Procedures for scoring price proposals under this rule shall be as follows:

(1) price proposals shall be initially evaluated to ensure that the price(s) offered is responsive to the RFP requirements and instructions and is realistic in respect to the project plans and specifications;

(2) price proposals shall be evaluated on the basis of the numerical weight assigned to price in the RFP and scored in accordance with the following process to permit the scoring of competing offerors' price proposals in relation to one another: the offeror with the lowest price shall receive the maximum price score, i.e., the maximum numerical weight assigned to price in the RFP (for example, 500 points out of a total 1,000 points);

(3) the price score of each other offeror shall be determined by applying the following mathematical formula: price of lowest offeror divided by the price for this offeror multiplied by the maximum price score, i.e.,

$$\frac{\text{price of lowest offeror}}{\text{price of this offeror}} \times \text{maximum price score} = \text{price score of this offeror}$$

[1.4.8.16 NMAC - N, 09-30-05]

1.4.8.17 RESIDENT PREFERENCE: To effectuate the requirements of the state's resident contractor preference laws, 13-4-1 NMSA, et. seq., final cost scores of proposals under 1.4.8 NMAC shall be modified.

HISTORY OF 1.4.8 NMAC: [RESERVED].

NEW MEXICO HUMAN SERVICES DEPARTMENT

INCOME SUPPORT DIVISION

This is an emergency amendment to 8.102.500 NMAC, Section 8, effective October 1, 2005.

8.102.500.8 G E N E R A L REQUIREMENTS

A. Need determination process: Eligibility for NMW or refugee cash assistance based on need requires a finding that:

(1) the benefit group's countable gross monthly income does not exceed the gross income limit for the size of the benefit group;

(2) the benefit group's countable net income after all allowable deductions does not equal or exceed the standard of need for the size of the benefit group;

(3) the countable resources owned by and available to the benefit group do not exceed the $1500 liquid and $2000 non-liquid resource limits;

(4) the benefit group is eligible for a cash assistance payment after subtracting from the standard of need the benefit group's countable income, and any payment sanctions or recoupments.

B. GA program need determination: Eligibility for the GA program requires a finding that the benefit group's countable gross earned and unearned income does not equal or exceed the standard of need for the size of the benefit group.

C. Gross income limits: The total countable gross earned and unearned income of the benefit group cannot exceed eighty-five percent of the federal poverty guidelines for the size of the benefit group.

(1) Income eligibility limits are revised and adjusted each year in October.

(2) The gross income limit for the size of the benefit group is as follows:

(a) one person . . . . . [~~$ 659~~] $ 679

(b) two persons . . . . . [~~$ 884~~] $ 910

(c) three persons . . . . . [~~$1,110~~] $1,140

(d) four persons . . . . . .[~~$1,335~~] $1,372

(e) five persons . . . . . [~~$1,560~~] $1,603

(f) six persons . . . . . [~~$1,785~~] $1,833

(g) seven persons .. . .[~~$2,011~~] $2,064

(h) eight persons .. . . . . [~~$2,236~~] $2,295

(i) nine persons . . . . . [~~$2,461~~] $2,527

(j) ten persons . . . .[~~$2,686~~] $2,759

(k) for more than ten persons, add [~~$225~~] $232 for each additional person.

D. Eligibility for support services only: Subject to the availability of state and federal funds, a benefit group that is not receiving cash assistance but has countable gross income that is less than 100% of the federal poverty guidelines applicable to the size of the benefit group may be eligible to receive services. The

gross income guidelines for the size of the benefit group are as follows:

(1) one person [~~$ 776~~] $ 798

(2) two persons [~~$1,041~~] $1,070

(3) three persons [~~$1,306~~] $1,341

(4) four persons [~~$1,571~~] $1,613

(5) five persons [~~$1,836~~] $1,885

(6) six persons [~~$2,101~~] $2,156

(7) seven persons [~~$2,366~~] $2,428

(8) eight persons [~~$2,631~~] $2,700

(9) nine persons [~~$2,896~~] $2,972

(10) ten persons [~~$3,161~~] $3,244

(11) for more than ten persons, add [~~$265~~] $272 for each additional person.

E. Standard of need:

(1) The standard of need is based on the number of individuals included in the benefit group and allows for a financial standard and basic needs.

(2) Basic needs include food, clothing, shelter, utilities, personal requirements and the individual's share of benefit group supplies.

(3) The financial standard includes approximately $79 per month for each individual in the benefit group.

(4) The standard of need for the NMW, GA, and refugee cash assistance benefit group is:

(a) one person $231
(b) two persons $310
(c) three persons $389
(d) four persons $469
(e) five persons $548
(f) six persons $627
(g) seven persons $706
(h) eight persons $802
(i) nine persons $881
(j) ten persons $960

(k) for more than 10 persons, add $79 for each additional person.

F. Special needs:

(1) Special clothing allowance: In order to assist in preparing a child for school, a special clothing allowance is made each year in the amount of $44 for the month of August only.

(a) For purposes of determining eligibility for the clothing allowance, a child is considered to be of school age if the child is six years of age or older and less than age 19 by the end of August.

(b) The clothing allowance shall be allowed for each school-age child who is included in the NMW, GA, or Refugee cash assistance benefit group for the month of August.

(c) The clothing allowance is not allowed in determining eligibility for NMW, GA, or refugee cash assistance.

(2) Layette: A one-time layette allowance of $25 is allowed upon the birth of a child who is or will be included in the benefit group. The allowance shall be authorized by no later than the end of the month following the month in which the child is born.

G. Shelter home care: A cash payment may be made to a GA or an SSI recipient when the recipient resides in a licensed shelter care home because the recipient needs help with personal care, such as bathing, dressing, eating or taking prescribed medication.

(1) The payment shall be allowed only if the GA or SSI recipient is living in a residential shelter care facility that is licensed by the New Mexico department of health.

(2) Eligibility and payment standard for GA recipients: The payment for a GA recipient living in a licensed residential shelter care facility is equal to the cash assistance payment plus $100.

(3) Payment to an SSI recipient: The payment made to an SSI recipient living in a licensed residential shelter care facility is $100 per month.

[8.102.500.8 NMAC - Rp 8.102.500.8 NMAC, 07/01/2001; A, 10/01/2001; A, 10/01/2002; A, 10/01/2003; A/E, 10/01/2004; A/E, 10/01/2005]

NEW MEXICO HUMAN SERVICES DEPARTMENT

INCOME SUPPORT DIVISION

This is an emergency amendment to 8.106.500 NMAC, Section 8, effective 10/01/2005.

8.106.500.8 GA - GENERAL REQUIREMENTS:

A. Need determination process: Eligibility for the GA program based on need requires a finding that the:

(1) countable resources owned by and available to the benefit group do not exceed either the $1500 liquid or $2000 non-liquid resource limit;

(2) benefit group's countable gross earned and unearned income does not equal or exceed eighty-five percent (85%) of the federal poverty guideline for the size of the benefit group; and

(3) benefit group's countable net income does not equal or exceed the standard of need for the size of the benefit group.

B. GA payment determination: The benefit group's cash assistance payment is determined after subtracting from the standard of need the benefit group's countable income and any payment sanctions or recoupments.

C. Gross income test: The total countable gross earned and unearned income of the benefit group cannot exceed eighty-five percent (85%) of the federal poverty guidelines for the size of the benefit group.

(1) Income eligibility limits are revised and adjusted each year in October.

(2) The gross income limit for the size of the benefit group is as follows:

(a) one person [~~$ 659~~] $679

(b) two persons [~~$ 884~~] $910

(c) three persons [~~$1,110~~] $1,140

(d) four persons [~~$1,335~~] $1,372

(e) five persons [~~$1,571~~] $1,603

(f) six persons [~~$1,785~~] $1,833

(g) seven persons [~~$2,011~~] $2,064

(h) eight persons [~~$2,236~~] $2,295

(i) nine persons [~~$2,461~~] $2,527

(j) ten persons [~~$2,686~~] $2,759

(k) for more than ten persons, add [~~$225~~] $232 for each additional person.

D. Standard of need:

(1) The standard of need is based on the number of individuals included in the benefit group and allows for a financial standard and basic needs.

(2) Basic needs include food, clothing, shelter, utilities, personal requirements and an individual benefit group member's share of supplies.

(3) The financial standard includes approximately $79 per month for each individual in the benefit group.

(4) The standard of need for the GA cash assistance benefit group is:

(a) one person $ 231
(b) two persons 310
(c) three persons 389
(d) four persons 469
(e) five persons 548
(f) six persons 627
(g) seven persons 706
(h) eight persons 802
(i) nine persons 881
(j) ten persons 960

(k) for more than 10 persons, add $79 for each additional person.

E. Net income test: The total countable earned and unearned income of the benefit group after all allowable deductions cannot equal or exceed the stan-

dard of need for the size of the GA benefit group.

F. Special clothing allowance for school-age dependent children: In order to assist in preparing a child for school, a special clothing allowance is made each year in the amount of $44 for the month of August only.

(1) For purposes of determining eligibility for the clothing allowance, a child is considered to be of school age if the child is six years of age or older and less than age nineteen (19) by the end of August.

(2) The clothing allowance shall be allowed for each school-age child who is included in the GA cash assistance benefit group for the month of August.

(3) The clothing allowance is not counted in determining eligibility for GA cash assistance.

[8.106.500.8 NMAC - N, 07/01/2004; A/E, 10/01/2004; A/E, 10/01/2005]

NEW MEXICO HUMAN SERVICES DEPARTMENT

INCOME SUPPORT DIVISION

This is an emergency amendment to 8.139.500 NMAC, Section 8, effective 10/01/2005.

8.139.500.8 BASIS OF ISSUANCE

A. Income standards: Determination of need in the Food Stamp Program is based on federal guidelines. Participation in the program is limited to households whose income is determined to be a substantial limiting factor in permitting them to obtain a nutritious diet. The net and gross income eligibility standards are based on the federal income poverty levels established in the Community Services Block Grant Act [42 USC 9902(2)].

B. Gross income standards: The gross income eligibility standards for the 48 contiguous states, District of Columbia, Guam and the Virgin Islands is 130 percent (130%) of the federal income poverty levels for the 48 states and the District of Columbia. One hundred thirty percent (130%) of the annual income poverty guidelines is divided by 12 to determine monthly gross income standards, rounding the results upward as necessary. For households larger than eight, the increment in the federal income poverty guidelines is multiplied by 130%, divided by 12, and the results rounded upward if necessary.

C. Net income standards: The net income eligibility standards for the 48 contiguous states, District of Columbia, Guam and the Virgin Islands are the federal income poverty levels for the 48 contiguous states and the District of Columbia. The annual income poverty guidelines are divided by 12 to determine monthly net income eligibility standards, (results rounded upward if necessary). For households larger than eight, the increment in the federal income poverty guidelines is divided by 12, and the results rounded upward if necessary.

D. Yearly adjustment: Income eligibility limits are revised each October 1st to reflect the annual adjustment to the federal income poverty guidelines for the 48 states and the District of Columbia.

E. Issuance table: The issuance table lists applicable income guidelines used to determine food stamp (FS) eligibility based on household size. Some amounts are increased to meet the needs of certain categorically eligible households. Some of the net income amounts listed are higher than the income limits for some household sizes. Households not categorically eligible for FS benefits must have income below the appropriate gross income limit for household size.

Household Size

Household Size	Maximum Gross Monthly Income Elderly/Disabled Separate Status at 165% of Poverty	Maximum Gross Monthly Income At 130% of Poverty	Maximum Net Monthly Income At 100% of Poverty	Maximum Allotment (benefit amount)
1	[~~$1,281~~] $1,316	[~~$1,009~~] $1,037	[~~$ 776~~] $ 798	[~~$149~~] $152
2	[~~$1,718~~] $1,765	[~~$1,354~~] $1,390	[~~$1,041~~] $1,070	[~~$274~~] $278
3	[~~$2,155~~] $2,213	[~~$1,698~~] $1,744	[~~$1,306~~] $1,341	[~~$393~~] $399
4	[~~$2,592~~] $2,661	[~~$2,043~~] $2,097	[~~$1,571~~] $1,613	[~~$499~~] $506
5	[~~$3,030~~] $3,109	[~~$2,387~~] $2,450	[~~$1,836~~] $1,885	[~~$592~~] $601
6	[~~$3,467~~] $3,558	[~~$2,732~~] $2,803	[~~$2,101~~] $2,156	[~~$711~~] $722
7	[~~$3,904~~] $4,006	[~~$3,076~~] $3,156	[~~$2,366~~] $2,428	[~~$786~~] $798
8	[~~$4,341~~] $4,454	[~~$3,421~~] $3,509	[~~$2,631~~] $2,700	[~~$898~~] $912
Each Additional Member	[~~+ $438~~] + $449	[~~+ $345~~] + $354	[~~+ $265~~] + $ 272	[~~+ $112~~] + $114

F. Deductions and standards:

(1) Determination: Expense and standard deduction amounts are determined by federal guidelines and may be adjusted each year. Households eligible based on income and resource guidelines, and other relevant eligibility factors, are allowed certain deductions to determine countable income.

(2) Yearly adjustment: The expense and standard deductions may change each year. If federal guidelines mandate a change, it is effective each October 1st.

(3) Expense deductions and standards table:

Standard Deduction fo r Household Size of 1 through 4	$134.00
Standard De duction for Household Size of 5	[~~$153.00~~] $157.00
Standard Deduction for Household Size of 6 or more	[~~$175.00~~] $179.00
Earned Income Deduction (EID)	20%
Dependent Care Deduction Limit (per dependent)	
Under age 2	$200.00
All others including elderly dependent	$175.00
Heating/Cooling Standard Utility Allowance (HCSUA)	[~~$211.00~~] $231.00
Limited Utility Allowance (LUA)	[~~$ 91.00~~] $ 93.00
Telephone Standard (TS)	$ 29.00
Excess Shelter Cost Deduction Limit for Non -Elderly/Disabled Households	[~~$388.00~~] $400.00
Homeless Household Shelter Standard	$143.00
Prescription Drug Card Deduction (valid until June 2006)	$ 23.00
Minimum Allotment for Eligible One -and Two-Person Households	$ 10.00

[02/1/95, 10/01/95, 02/29/96, 10/01/96, 3/15/97, 01/15/98, 11/15/98, 12/15/99, 01/01/01, 03/01/01; 8.139.500.8 NMAC - Rn, 8 NMAC 3.FSP.501, 05/15/2001; A, 10/01/2001; A, 10/01/2002; A, 09/01/2003; A, 10/01/2003; A/E, 10/01/2004; A/E, 10/01/2005]

NEW MEXICO HUMAN SERVICES DEPARTMENT
INCOME SUPPORT DIVISION

This is an amendment to 8.150.101 NMAC, sections 8 and 9, effective October 1, 2005.

8.150.101.8 BUREAU RESPONSIBILITIES: The [~~Community Development & Commodities Bureau~~] food and nutrition services bureau [~~(CDCB)~~] (FANS) of the income support division (ISD) of the New Mexico human services department (HSD) is responsible for administering the LIHEAP grant award received from the U.S. department of health and human services (DHHS).
[11-15-96, 10-1-00; 8.150.101.8 NMAC - Rn, 8 NMAC 22.LHP.022, 10-1-01; A, 10-1-05]

8.150.101.9 [~~CDCB~~] FANS RESPONSIBILITIES:

A. State LIHEAP plan: Every year, the [~~CDCB~~] FANS submits a state plan for New Mexico's administration of LIHEAP to DHHS. The proposed state plan and the proposed LIHEAP policy manual are made available for public comment and a public hearing is held.

B. LIHEAP administration: The [~~CDCB~~] FANS is responsible for overseeing the administration of the program, including such matters as:

(1) formulating and interpreting LIHEAP policy;

(2) coordinating with other divisions within HSD for data processing of LIHEAP eligibility and payment;

(3) allocating and distributing LIHEAP monies;

(4) data entry of client information not available on ISD-2; and

(5) oversight responsibility for LIHEAP policy and procedures training and for the review of all LIHEAP training materials.

[7-1-95, 11-1-95, 11-15-96, 10-1-00; 8.150.101.9 NMAC - Rn, 8 NMAC 22.LHP.022, 10-1-01; A, 10-1-05]

NEW MEXICO HUMAN SERVICES DEPARTMENT
INCOME SUPPORT DIVISION

This is an amendment to 8.150.102 NMAC, section 8, effective October 1, 2005.

8.150.102.8 ISD FIELD OFFICE RESPONSIBILITIES: Each of the field offices of the income support division in the state is responsible for:

A. providing outreach and referral for low-income clients, particularly disabled and elderly clients, regarding the LIHEAP program;

B. informing low-income clients, particularly disabled and elderly clients, about the eligibility determination process and application procedures for the LIHEAP program;

C. providing documentation to households requesting verification of cash benefits received from the human services department or other documentation available to the department or in the case file;

D. complying with other LIHEAP program directives as may be issued by [~~CDCB~~] FANS;

E. assisting all applicant households to complete the LIHEAP application and interviewing the household when LIHEAP benefits have been requested;

F. entering the completed LIHEAP application into HLEA, the LIHEAP computer system;

G. responding to inquires about the status of a LIHEAP application; and

H. processing payment errors when identified; the ISD office must issue a supplement in cases of benefit under-issuances or complete and submit paperwork to restitution for over-issuances.

[7-1-95, 11-1-95, 11-15-96, 10-01-97, 10-1-00; 8.150.102.8 NMAC - Rn, 8 NMAC 22.LHP.023, 10-1-01; A, 10-1-05]

NEW MEXICO HUMAN SERVICES DEPARTMENT
INCOME SUPPORT DIVISION

This is an amendment to 8.150.410 NMAC, section 12, effective October 1, 2005.

8.150.410.12 INDIAN TRIBAL ELIGIBILITY: In New Mexico, an Indian tribe may choose to administer its own LIHEAP program for tribal members and request from DHHS an allocation of the state's share of the LIHEAP grant award for this purpose. An Indian tribe is defined as a legal entity of a group of Native Americans living on tribal lands with a distinct and separate government. Residents of tribal land may be eligible for tribal administered LIHEAP or HSD-administered LIHEAP under the following circumstances.

A. Tribes that administer LIHEAP: Indian tribal members living on their tribe's tribal lands, whose tribe administers their own LIHEAP program, are not eligible for HSD-administered LIHEAP benefits.

B. Tribes not administering LIHEAP: Indian tribal members living on the tribal lands of tribes not administering their own LIHEAP program may be considered for HSD-administered LIHEAP benefits providing they meet categorical or

income eligibility and heating/cooling responsibility requirements as specified in this policy.

C. Indians on other tribes' land: Indians who are members of Indian tribes administering their own LIHEAP program but not living on their tribe's tribal lands may be considered for HSD-administered LIHEAP benefits providing they meet categorical or income eligibility and heating responsibility requirements as specified in this policy.

D. Non-Indians and non-tribal members on tribal land: Non-Indians living on tribal lands and Indians living on tribal lands who are excluded from eligibility for LIHEAP by the Indian tribe administering their own LIHEAP program may be considered for HSD-administered LIHEAP benefits providing they meet categorical or income eligibility and heating/cooling responsibility requirements as specified in this policy.

E. At the direction of the HSD secretary, HSD may serve tribal members normally excluded due to Subsection A of 8.150.410.12 NMAC if they have not been or do not expect to be served by the tribal LIHEAP program.

[7-1-95, 11-1-95, 11-15-96; 8.150.410.12 NMAC - Rn, 8 NMAC 22.LHP.410 & A, 10-10-01; A, 10-1-05]

NEW MEXICO HUMAN SERVICES DEPARTMENT
INCOME SUPPORT DIVISION

This is an amendment to 8.150.500 NMAC, section 10, effective October 1, 2005.

8.150.500.10 GROSS INCOME DETERMINATION: Gross income is defined as all income received prior to deductions, including taxes, and garnishments, whether voluntary or involuntary.

A. Income sources: Gross income includes income from both earned and unearned sources.

B. Countable income: The gross unearned income of all household members is counted in its entirety, and the gross earned income of all household members over the age of 18 is counted in its entirety, unless:

(1) the income is specifically exempted; or

(2) the income is self-employment (see LIHEAP 8.150.520.9 NMAC); or

(3) the income is that of an ineligible alien, in which case the income is prorated (see LIHEAP policy 8.150.520.10 NMAC);

(4) the income is a full month's income and is anticipated to be received on a weekly or biweekly basis; in these circumstances, the income shall be converted to a monthly amount as follows:

(a) income received on a weekly basis is multiplied by 4.3;

(b) income received on a biweekly basis is multiplied by 2.15;

(c) using the conversion factors accounts for those months in which an extra paycheck is received;

(d) averaged income shall be rounded to the nearest whole dollar prior to application of the conversion factor; amounts resulting in $.50 or more are rounded up; amounts resulting in $.49 or lower are rounded down.

C. Gross income receipt period: Gross [~~averaged~~] income received or anticipated to be received by the household in the month of application is [~~the amount~~] used to establish income eligibility for [~~regular~~] LIHEAP applications.

[7-1-95, 11-1-95, 11-15-96, 10-15-98, 10-1-00; 8.150.500.10 NMAC - Rn, 8 NMAC 22.LHP.501.2 & A, 10-1-01; A, 10-1-05]

NEW MEXICO HUMAN SERVICES DEPARTMENT
INCOME SUPPORT DIVISION

This is an amendment to 8.150.600 NMAC, section 8, effective October 1, 2005.

8.150.600.8 BENEFITS - ISSUANCE AND USE:

A. Issuance of benefits: Benefits are issued in one of the three following methods:

(1) client warrants: HSD issues benefits directly to clients through client warrants when authorized by the LIHEAP director; or

(2) vendor payments:

(a) HSD will provide the name and, when applicable, customer account number for the LIHEAP-eligible household to the vendor specified by the household. The vendor will notify HSD of mismatches within a specified time frame.

(b) Vendors who carry customer accounts will credit eligible households with the amount of the LIHEAP regular benefit no more than 30 days from the time of the payment. Vendors who provide fuel on demand will provide fuel to eligible households equal to the amount of the LIHEAP regular benefit no more than 30 days from the date of the eligible household's contact with the vendor to make arrangements for the provision of such fuel.

(c) Vendors may transfer excess LIHEAP benefits from the account originally credited to another account they have for the household. The vendor must document the transfer in a manner that meets generally accepted audit standards. In order to transfer LIHEAP funds, the following conditions must be met:

(i) the vendor must provide multiple utility services and/or bulk fuel; and

(ii) a credit remains on the originally credited account after current and delinquent charges are satisfied; and

(iii) the household approves the transfer; and

(iv) the utility or bulk fuel account that is credited is used by the household for their heating or cooling needs; or

(3) electronic benefit transfer account: LIHEAP benefits are deposited directly into the household's special account that may be:

(a) a cash account available to the household at ATM's and retail stores; or

(b) a special account for LIHEAP payments accessed at authorized utility vendors to pay for heating or cooling costs; the EBT card is used at a point of sale (POS) terminal at the utility company office or other retailers authorized to accept utility company payments.

B. Benefit use: The recipient household is responsible for using the benefit for the purpose intended:

(1) to purchase fuel, such as propane, wood, coal, kerosene, fuel oil or other unregulated fuels; [~~or~~]

(2) to pay the household's utility charges, such as those for electric or natural gas services; [~~or~~]

(3) to purchase gasoline and/or tools needed when a household gathers/cuts it's own firewood; [~~or~~]

(4) to pay a landlord for the utility costs that are included in the rent payment;

(5) to pay for a deposit obligation needed to initiate or continue service.

[7-1-95, 11-1-95, 11-15-96, 10-01-97; 8.150.600.8 NMAC - Rn, 8 NMAC 22.LHP.601 & A, 10-1-01; A, 10-1-05]

NEW MEXICO HUMAN SERVICES DEPARTMENT
INCOME SUPPORT DIVISION

This is an amendment to 8.150.620 NMAC, sections 9 and 10, effective October 1, 2005.

8.150.620.9 CALCULATING THE BENEFIT/ASSIGNMENT OF POINTS: To determine the amount of the regular benefit for households with an energy cost, HSD assigns points for each following factors.

A. Energy costs points: Points are assigned based on the cost of heating and cooling for a household at their current residence.

(1) Energy burden: Energy bur-

den is "the expenditures of the household for home energy divided by the income of the household." Points are assigned to the household by determining the households' percentage of energy burden. The point allocation for energy burden is:

(a) 0 points for 0 - 5% energy burden;

(b) 1 point for 6 - 10% energy burden;

(c) 2 points for 11 - 15% energy burden;

(d) 3 points for 16% or more energy burden; or

(2) Energy matrix: When there is insufficient information to calculate energy burden, the energy matrix will be used to determine energy cost points. Households that have never had utility service or bulk fuel usage at their current residence will have their energy cost points determined by using the energy matrix. The matrix will be used for households who have moved into a new residence or when new heating or cooling appliances have been installed. The matrix is calculated using prior year recipient data to determine average energy cost points based on housing type, utility type and zip code. When no data is available for the housing type, utility type and zip code, the average for the zip code will be used.

B. Income points: HSD assigns income points using the household's monthly total countable gross income and the household size. The number of points is determined by identifying what percentage that the household's income is, of the federal poverty guidelines (FPG) for the LIHEAP FFY. For example, if the total monthly income is 60% of the FPG, the household will receive [~~two~~] four income points. (See below.)

(1) [~~3~~] 4 points - income is 0 - [~~50%~~] 75% of the FPG

(2) [~~2~~] 3 points - income is [~~51~~] 76 - 100% of the FPG

(3) [~~1 point~~] 2 points - income is 101 - [~~150%~~] 125% of the FPG

(4) 1 point - income is 126 - 150% of the FPG

[~~C. Household Size Points: Household Size Points are assigned to the household based on the number of household members. The point allocation by household size is:~~

~~(1) 1 point for 1 - 2 members~~

~~(2) 2 points for 3 - 5 members~~

~~(3) 3 points for 6 or more members~~]

[~~D.~~] C. Vulnerable population points: HSD assigns additional points for any household members in the following vulnerable groups.

(1) Age 60 and over: [~~One (1) point is~~] Two (2) points are assigned to eligible households based on the inclusion of one or more household members age 60 or over as determined by birthdate data.

(2) Age 6 and under: [~~One (1) point is~~] Two (2) points are assigned to eligible households based on the inclusion of one or more household members age 6 and under as determined by birthdate data.

(3) Disability: [~~One (1) point is~~] Two (2) points are assigned to eligible households having one or more members with a disability. Disability is defined as physical or mental impairment resulting in substantial reduction in the ability of an individual to care for him/herself or carry out normal activities. When one or more members receive disability based income, the household is entitled to the point. A doctor's statement of current disability will be required for assignment of the point for this factor if the disabled member does not receive disability-based income.

[7-1-95, 11-1-95, 11-15-96, 10-1-97, 12-1-97, 10-1-00; 8.150.620.9 NMAC - Rn, 8 NMAC 22.LHP.621.1 & A, 10-1-01; A, 10-1-05]

8.150.620.10 CALCULATION OF BENEFIT AMOUNT:

A. Prior to the start of the application period projections will be made to determine point value. Anticipated grant of award, potential applicants and the current economy of the state of New Mexico will be used to determine the point value. Households eligible for a LIHEAP benefit will have their point total multiplied times the point value. The product is the amount of payment that is issued to the utility vendor for credit on the household's account.

B. [~~Regular~~] Benefits are issued for eligible applications received through August 31 or as long as grant of award funds are available, whichever is earlier. The application period ends when funds are exhausted.

C. At the direction of the HSD secretary the point value for energy cost points, income points, and/or vulnerable population points or any of their parts may be higher or lower than the value determined under Subsection A of 8.150.620.10 NMAC.

[7-1-95, 11-1-95, 11-15-96, 10-1-97, 10-15-98, 10-1-00; 8.150.620.10 NMAC - Rn, 8 NMAC 22.LHP.621.2, 10-1-01; A, 10-01-05]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 315 OTHER LONG TERM CARE SERVICES
PART 5 ASSERTIVE COMMUNITY TREATMENT SERVICES

8.315.5.1 ISSUING AGENCY: New Mexico Human Services Department.
[8.315.5.1 NMAC - N, 10-1-05]

8.315.5.2 SCOPE: The rule applies to the general public.
[8.315.5.2 NMAC - N, 10-1-05]

8.315.5.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state human services department pursuant to state statute. See NMSA 1978, section 27-2-12 et. seq. (Repl. Pamp. 1991).
[8.315.5.3 NMAC - N, 10-1-05]

8.315.5.4 DURATION: Permanent
[8.315.5.4 NMAC - N, 10-1-05]

8.315.5.5 EFFECTIVE DATE: October 1, 2005, unless a later date is cited at the end of a section.
[8.315.5.5 NMAC - N, 10-1-05]

8.315.5.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid program. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.
[8.315.5.6 NMAC - N, 10-1-05]

8.315.5.7 DEFINITIONS: [RESERVED]

8.315.5.8 MISSION STATEMENT: The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of medicaid-eligible individuals by furnishing payment for quality health services.
[8.315.5.8 NMAC - N, 10-1-05]

8.315.5.9 ASSERTIVE COMMUNITY TREATMENT (ACT) SERVICES: The New Mexico medicaid program (medicaid) pays for medically necessary health services furnished to eligible recipients. To help New Mexico recipients receive necessary services, the New Mexico medical assistance division (MAD) pays for covered professional and peer mental health services [42 CFR SS 440.40, 440.60(a) and 441.57]. This part describes eligible providers, covered services, service limitations and general reimbursement methodology.
[8.315.5.9 NMAC - N, 10-1-05]

8.315.5.10 ELIGIBLE

PROVIDERS: Upon approval of New Mexico medical assistance program provider participation agreements by MAD, the following providers are eligible to be reimbursed for providing mental health peer and professional services.

A. Political subdivisions of the state of New Mexico who have a contract with the medical assistance division to perform ACT. The provider must be able to contract with or employ qualified personnel to provide the service. The provider or the contractor must demonstrate compliance with administrative, financial, clinical, quality improvement and information services infrastructure standards established by the medical assistance division or be accredited by a national accrediting body for medical or behavioral health services providers.

B. Once enrolled, providers are advised as to where a packet of information, including medicaid program policies, billing instructions, utilization review instructions, and other pertinent material from MAD can be obtained through internet access. Providers who do not have internet access are advised to contact MAD or its designee to receive this information. Providers are responsible for ensuring that they have received these materials and for updating them as new materials are received from MAD.

C. ACT services must be provided by a team of ten to twelve individuals. Each team must have a designated team leader. Individuals on this team shall have sufficient individual competence, professional qualifications and experience to provide service coordination; crisis assessment and intervention; symptom assessment and management; individual counseling and psychotherapy; prescription, administration, monitoring and documentation of medications; substance abuse treatment; work-related services; activities of daily living services; support services or direct assistance to ensure that individuals obtain the basic necessities of daily life; and education, support, and consultation to individuals' families and other major supports.

D. Each team staff member must successfully be certified as trained according to standards for ACT as developed by the behavioral health services division of the New Mexico department of health. The approved training will focus on developing staff's competencies for delivering assertive community treatment services according to the most recent evidenced-based practices. Each assertive community treatment team shall have sufficient numbers of staff to provide treatment, rehabilitation, crisis and support services 24 hours a day, seven days per week.

E. Each assertive community treatment team shall have a staff-to-individual ratio in keeping with ACT evidence-based practice standards as approved by the behavioral health services division of the New Mexico department of health.

F. Each assertive community treatment team shall include at least one psychiatrist; two nurses, one of whom shall be a registered nurse; one other mental health professional; one substance abuse professional; one employment specialist; at least one peer provider; and one administrative staff person. The service recipient shall be considered a part of the team for decisions impacting his services.

[8.315.5.10 NMAC - N, 10-1-05]

8.315.5.11 PROVIDER RESPONSIBILITIES:

A. Providers who furnish services to medicaid recipients must comply with all specified medicaid participation requirements. See 8.302.1 NMAC, *General Provider Policies*.

B. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance. See 8.302.1.12 NMAC for recipients whose medicaid coverage is restricted and 8.302.2.12 NMAC for dual eligible medicaid recipients.

C. Providers must maintain records that are sufficient to fully disclose the extent and medically necessary nature of the services provided to recipients. See 8.302.1 NMAC, *General Provider Policies*.

[8.315.5.11 NMAC - N, 10-1-05]

8.315.5.12 ELIGIBLE RECIPIENTS: Assertive community treatment services are provided to individuals aged eighteen (18) and older who have a diagnosis of severe mental illness (including schizophrenia, schizoaffective disorder, bipolar disorder or psychotic depression) who have severe problems completing activities of daily living, who have a significant history of involvement in behavioral health services, and who have experienced repeated hospitalizations and/or incarcerations due to mental illness. A co-occurring diagnosis of substance abuse shall not exclude an individual from eligibility for the program.

[8.315.5.12 NMAC - N, 10-1-05]

8.315.5.13 COVERAGE CRITERIA:

A. Medicaid covers medically necessary assertive community treatment services required by the condition of the recipient.

B. This culturally sensitive service, delivered by an appropriately constituted team, provides therapeutic interventions that address the functional problems associated with the most complex and/or pervasive conditions of the identified population. These interventions are strength-based and focused on promoting symptom stability; increasing the recipient's ability to cope and relate to others; and enhancing the highest level of functioning in the community, including learning, working and recreation, and making informed choices.

C. Interventions may address adaptive skill areas such as: housing; school, work and training opportunities; daily activities; health and safety; medication support; harm reduction; money management and entitlements; promotion of individual recovery processes; relapse prevention; and service planning and coordination.

D. All services must be furnished within the limits of medicaid benefits, within the scope and practice of the eligible provider's respective profession as defined by state law, and in accordance with applicable federal, state, and local laws and regulations.

E. **Medical necessity:** All services must be provided in compliance with the medicaid definition of medical necessity as found in current medicaid regulations.

[8.315.5.13 NMAC - N, 10-1-05]

8.315.5.14 COVERED SERVICES:

A. Assertive community treatment is a voluntary medical, comprehensive case management and psychosocial intervention program provided on the basis of the following principles:

(1) the service is available twenty-four hours a day, seven days a week;

(2) the service is provided by an interdisciplinary team which may include trained personnel such as psychiatrists, nurses, nurse practitioners, case managers, master's level behavioral health professionals, qualified peer providers and clerical support staff;

(3) an individualized treatment plan and supports are developed;

(4) at least 90% of services are delivered as community-based, non-office-based outreach services;

(5) an array of services are provided based on individual patient medical need;

(6) the service is consumer-directed;

(7) the service is recovery-oriented;

(8) the team maintains a low staff-to-patient ratio;

(9) mobilized crisis intervention is provided in various environments such as homes, schools, jails, homeless shelters, streets and other locations; and

(10) the team is not just a consortium of mental health specialists, but

includes collaborative assessment and treatment planning for each service recipient; cross-training of team members; daily team meetings; use of an open office format to promote team communication; and a team approach to each service recipient's care and services; the team will assist the individual to access other appropriate services in the community that are not funded by medicaid.

B. **Quality measurement:** Program success is evaluated based on outcomes which may include but are not limited to: improved engagement by patients in medical and social services; decreased rates of incarceration; decreased rates of hospitalization; decreased use of alcohol or illegal drugs; increased housing stability; increased relationships of patients with families; and increased employment; and increased attainment of goals self-identified by the service recipient for his own life. Fidelity to the specific evidence-based ACT service will also be measured to assure that ACT rather than some other form of intensive case management is being provided.
[8.315.5.14 NMAC - N, 10-1-05]

8.315.5.15 NONCOVERED SERVICES: ACT services are subject to the limitations and coverage restrictions that exist for other medicaid services. See 8.301.3 NMAC, *General Noncovered Services* [MAD-602]. No other psychiatric, mental health nursing, therapeutic, substance abuse or crisis services will be concurrently reimbursed for the ACT service recipient except medically necessary medications and hospitalizations.
[8.315.5.15 NMAC - N, 10-1-05]

8.315.5.16 PRIOR AUTHORIZATION AND UTILIZATION REVIEW: All medicaid services are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. See 8.302.5 NMAC, *Prior Authorization And Utilization Review*. Once enrolled, providers receive instructions and documentation forms necessary for prior approval and claims processing.

A. **Prior authorization:** Services or procedures require prior authorization from MAD or its designee. Services may be reviewed retrospectively. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process. See Subsection A of 8.311.2.16 NMAC, *Covered Emergency Services* [MAD-721.71].

B. **Eligibility determination:** Prior authorization of services does not guarantee that individuals are eligible for medicaid. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance.

C. **Reconsideration:** Providers who disagree with prior authorization request denials or other review decisions can request a re-review and a reconsideration. See 8.350.2 NMAC, *Reconsideration Of Utilization Review Decisions* [MAD-953].
[8.315.5.16 NMAC - N, 10-1-05]

8.315.5.17 REIMBURSEMENT:

A. ACT service providers must submit claims for reimbursement on the HCFA-1500 claim form or its successor. See 8.302.2 NMAC, *Billing For Medicaid Services*. Once enrolled, providers receive instructions on documentation, billing, and claims processing.

B. Reimbursement to providers for covered services is made at the lesser of the following:

(1) the provider's billed charge; or

(2) the MAD fee schedule for the specific service or procedure for the provider, as established after considering cost data.

(a) The provider's billed charge must be their usual and customary charge for services.

(b) "Usual and customary charge" refers to the amount that the individual provider charges the general public in the majority of cases for a specific procedure or service.

C. ACT services must be provided directly to the recipient by the treatment team members.
[8.315.5.17 NMAC - N, 10-1-05]

HISTORY OF 8.315.5 NMAC: [RESERVED]

NEW MEXICO INFORMATION TECHNOLOGY COMMISSION

1.12.5 NMAC named "Oversight of Project and Program Management and Certification" (filed 8/30/2000) and amendment (filed 4/30/2004) is repealed and replaced with 1.12.5 NMAC named "Oversight of Information Technology Projects". The repeal and replace will become effective 9/30/2005.

NEW MEXICO INFORMATION TECHNOLOGY COMMISSION

TITLE 1 GENERAL GOVERNMENT ADMINISTRATION
CHAPTER 12 INFORMATION TECHNOLOGY
PART 5 OVERSIGHT OF INFORMATION TECHNOLOGY PROJECTS

1.12.5.1 ISSUING AGENCY. Information Technology Commission.
[1.12.5.1 NMAC - Rp 1.12.5.1 NMAC, 9/30/2005]

1.12.5.2 SCOPE. This rule applies to the oversight of all information technology projects undertaken by executive agencies.
[1.12.5.2 NMAC - Rp 1.12.5.2 NMAC, 9/30/2005]

1.12.5.3 STATUTORY AUTHORITY. Sections 15-1C-5 and 15-1C-8 NMSA 1978.
[1.12.5.3 NMAC - Rp 1.12.5.3 NMAC, 9/30/2005]

1.12.5.4 DURATION. Permanent.
[1.12.5.4 NMAC - Rp 1.12.5.4 NMAC, 9/30/2005]

1.12.5.5 EFFECTIVE DATE. September 30, 2005, unless a later date is cited at the end of a section.
[1.12.5.5 NMAC - Rp 1.12.5.5 NMAC, 9/30/2005]

1.12.5.6 OBJECTIVE. The purpose of this rule is to set forth agency and office IT project management oversight responsibilities.
[1.12.5.6 NMAC - Rp 1.12.5.6 NMAC, 9/30/2005]

1.12.5.7 DEFINITIONS.

A. "Agency" means a state organizational entity of the executive branch, used interchangeably with department.

B. "Independent" is used to describe the autonomous and impartial verification and validation assessment of compliance to a project and the project's products requirements. These independent assessments are performed by a contractor that is not responsible for developing the product or performing the activity being evaluated.

C. "Independent verification and validation (IV&V)" means the

process of evaluating a project and the project's product to determine compliance with specified requirements and the process of determining whether the products of a given development phase fulfill the requirements established during the previous stage, both of which are performed by an organization independent of the lead agency.

D. "Executive sponsor" is the person or group that provides the financial resources, in cash or kind, for the project.

E. "Lead agency" of a multi-agency project is the agency that is indicated as lead agency in the General Appropriations Act or as designated by the office. In the case that a single agency sponsors a project then that agency shall be known as the lead agency.

F. "Office" means the office of the chief information officer.

G. "Oversight" means a continuous process of project review and evaluation to ensure that project objectives are achieved in accordance with an approved project plan and project schedule and that IT projects are in scope, on time and within budget.

H. "Product development life cycle" is a series of sequential , non-overlapping phases comprised of iterative disciplines such as requirements, analysis and design, implementation, test, and deployment implemented to build a product or develop a service.

I. "Project" means a temporary process undertaken to solve a well-defined goal or objective with clearly defined start and end times, a set of clearly defined tasks, and a budget. The project terminates once the project scope is achieved and project approval is given by the project executive sponsor and verified by the office.

J. "Project director" means a qualified person from the lead agency whose responsibility is to manage a series of related projects.

K. "Project manager" means a qualified person from the lead agency responsible for all aspects of the project over the entire project management lifecycle (initiate, plan, execute, control, close). Must be familiar with project scope and objectives, as well as effectively coordinate the activities of the team. In addition, responsible for developing the project plan and project schedule with the project team to ensure timely completion of the project. Interfaces with all areas affected by the project including end users, distributors, and vendors. Ensures adherence to the best practices and standards of the office.

L. "Project management plan" is a formal document approved by the executive sponsor and the office and developed in the plan phase used to manage both project execution, control, and project close. The primary uses of the project plan are to document planning assumptions and decisions, facilitate communication among stakeholders, and documents approved scope, cost, and schedule baselines. A project plan includes at least other plans for issue escalation, change control, communications, deliverable review and acceptance, staff acquisition, and risk management.

M. "Project product" means the final project deliverable as defined in the project plan meeting all agreed and approved acceptance criteria.

N. "Project schedule" is a tool used to indicate the planned dates, dependencies, and assigned resources for performing activities and for meeting milestones.

O. "Qualified" means demonstrated experience managing IT projects. Demonstrated experience includes exhibiting the ability to apply project management methodology to maintain projects on time, on budget, and on schedule. Qualified also includes those employees who have the demonstrated ability to manage resources, lead people to accomplishing project objectives and who possess a working knowledge of the project scope.

P. "Quality" means the degree to which a system, system component, or process meets specified requirements, customer needs, and user expectations.

Q. "Quality assurance" means a planned and systematic pattern of all actions necessary to provide adequate confidence that a product or system component conforms to established requirements.

R. "Validation" means ensuring a system meets documented performance outcomes and requirements of the project.

S. "Verification" means application of an appropriate test yielding documentable, measurable evidence that ensures a process executed or the technical system developed produces required performance outcomes.

[1.12.5.7 NMAC - Rp 1.12.5.7 NMAC, 9/30/2005]

1.12.5.8 PROJECT MANAGEMENT METHODOLOGY.

A. All IT projects shall be managed:

(1) using a qualified project manager;

(2) using a formal project management methodology, processes, and techniques approved by the office; and

(3) by analyzing and monitoring risk at periodic intervals during the project management lifecycle, and mitigating risks before they negatively impact the IT project schedule, scope, or budget.

B. During the project management lifecycle, agencies shall select and implement a phase product development lifecycle methodology approved by the office.

C. The project budget must be documented in the project management plan by the phases and by deliverable.

[1.12.5.8 NMAC - Rp 1.12.5.8 NMAC, 9/30/2005]

1.12.5.9 LEAD AGENCY RESPONSIBILITIES.

A. A lead agency shall perform the following functions.

(1) Manage its own information technology (IT) projects and project resources and use the state project management methodology for planning, executing, and controlling the project.

(2) Appoint a qualified state employee as the lead project manager and if applicable a project director. If the agency hires a contract project manager, the lead project manager/director shall be responsible for ensuring that the consulting firm and/ or contract project manager is managed to the best interests of the state.

(3) Provide to the office all project management and product deliverables. Deliverables shall include but not limited to the project plan, project schedule, initial and periodic risk assessments, quality strategies and plan, periodic project status reports, requirement and design documents for all projects. The lead agency must make available all deliverables in a repository with open access for the Information Technology Commission (ITC) and office review.

(4) Prepare and submit a written project status report at least monthly to the office, and more frequently at the request of the ITC or the office.

(5) Prepare a written risk assessment report at the inception of a project and at the end of each product development lifecycle phase or more frequently for large and high-risk projects. Each risk assessment shall be included as a project activity in the project schedule.

(6) Develop and provide quality strategies, including Independent Verification and Validation, in compliance with the office best practices and standards.

B. The lead agency shall fully cooperate and seek the assistance of the office regarding the planning and execution of IT projects.

[1.12.5.9 NMAC - Rp 1.12.5.9 NMAC, 9/30/2005]

1.12.5.10 RESPONSIBILITIES OF THE OFFICE. The office shall:

A. provide oversight of all IT projects;

B. review agency IT plans;

C. make recommendations

to the ITC regarding prudent allocation of IT resources, reduction of redundant data, hardware, and software, and improve interoperability and data accessibility between agencies;

D. approve agency RFPs, contract vendor requests and IT contracts including amendments, emergency procurements, sole source contracts and price agreements;

E. recommend procedure and rules to the ITC to improve oversight of IT procurement;

F. monitor agency compliance and report to the Governor, ITC and agency management on noncompliance;

G. review IT cost recovery mechanisms and rate structures and make recommendations to the ITC;

H. provide technical support to agencies for IT plan development;

I. review appropriation requests to ensure compliance with agency plans and the strategic plan;

J. monitor the progress of agency IT projects, including ensuring adequate project management, risk management and disaster recovery practices;

K. submit project portfolio status reports to the ITC; and

L. recommend IT project funding as required by law.

[1.12.5.10 NMAC - Rp 1.12.5.10 NMAC, 9/30/2005]

1.12.5.11 REPORTING REQUIREMENTS.

A. Project status reports. For all projects that require office oversight, the lead agency project manager shall submit an agency approved project status report on a monthly basis to the office.

B. Independent verification and validation assessment reporting. The office requires all projects subject to oversight to engage an independent verification and validation contractor unless waived by the office. The IV&V contractor shall perform the following activities.

(1) Prepare an initial risk assessment report at project inception. This assessment will include recommended mitigation activity to reduce the impact and probability of the identified risk.

(2) Prepare initial status report at project inception to disclose the effectiveness of project management and whether the documented project activities are meeting the objectives set forth by project.

(3) Prepare interim reports based on the phases as indicated within the project schedule. Included in the report will be an evaluation on whether product development requirements are being met, project management is effective, continuing risk analysis, and how the project is implementing previous recommended risk mitigation strategies.

(4) Prepare a post implementation assessment at project close to indicate whether project objectives were met based on the project's scope and acceptance criteria.

(5) Submit each risk assessment report, status report, interim report, and post-implementation assessment report to the office within five (5) business days of each deliverable due date as indicated on the project schedule. All reports must be submitted to the agency heads and the office.

[1.12.5.11 NMAC - Rp 1.12.5.11 NMAC, 9/30/2005]

HISTORY OF 1.12.5 NMAC:

History of Repealed Material:
1.12.5 NMAC, Oversight of Project and Program Management and Certification (filed 8/30/2000) and amendment (filed 4/30/2004) is repealed effective 9/30/2005.

NMAC History:
1.12.5 NMAC, Oversight of Project and Program Management and Certification (filed 8/30/2000) and amendment (filed 4/30/2004) is replaced with 1.12.5 NMAC, Oversight of Information Technology Projects, effective 9/30/2005.

NEW MEXICO MEDICAL BOARD

This is an amendment to 16.10.2 NMAC, Sections 7, 9, 10, 12, 14 and 15, Effective October 7, 2005.

16.10.2.7 DEFINITIONS.

A. "Board approved school" means a medical [~~college or~~] school that has been approved by the liaison committee on medical education, composed of the American medical association and the association of American medical colleges, has a liaison council on medical education (LCME)-approved curriculum or equivalent for graduates of Canadian schools, is on the approved list of the California state medical board, or has been approved by the board.

B. "Board approved training program" means a program approved by the accrediting council on graduate medical education of the American medical association (ACGME), the royal collage of physicians and surgeons of Canada (RCPSC), or a residency program located within an ACGME approved institution that has been approved by the board.

C. "HSC" means the hospital services corporation, a New Mexico corporation, and a credential verification organization certified by the national commission on quality assurance (NCQA).

D. "FCVS" means the federation credential verification service of the federation of state medical boards.

E. "Telemedicine" means the practice of medicine across state lines as defined in the Medical Practice Act, Section 61-6-6,K NMSA 1978.

[16.10.2.7 NMAC - Rp 16 NMAC 10.2.7, 4/18/02; A, 1/20/03, A, 10/7/05]

16.10.2.9 MEDICAL LICENSE BY EXAMINATION.

A. Prerequisites for licensure. Each applicant for a license to practice as a medical doctor in New Mexico must possess the following qualifications:

(1) graduated and received a diploma from a board approved school, [~~or~~] completed a program determined by the board to be substantially equivalent to a U.S. medical school, based on board review of an evaluation by a board approved credential evaluation service, or is a graduate of a medical school located outside the United States who successfully completes two years or more of an approved postgraduate training program at an institution located in New Mexico prior to December 30, 2007;

(2) successfully passed one of the examinations or combinations of examinations defined in 16.10.3 NMAC; and

(3) completed two years of postgraduate training or been approved by the board in accordance with the provisions of Section 61-6-11, B NMSA 1978;

(4) when the board has reason to believe that an applicant for licensure is not competent to practice medicine it may require the applicant to complete a special competency examination or to be evaluated for competence by other means that have been approved by the board; and

(5) a qualified applicant who has not been actively and continuously in practice for more than 2 years prior to application may be required to successfully complete a special examination or evaluation such as, but not limited to, the SPEX (special purpose examination), the PLAS (postlicensure assessment system of the federation of state medical boards), or specialty re-certification.

B. Required documentation for all applicants. Each applicant for a license must submit the required fees as specified in 16.10.9.8 NMAC and the following documentation:

(1) a completed application signed and notarized with a passport-quality photo taken within the previous 6 months; applications are valid for 1 year from the date of receipt by the board;

(2) verification of licensure in all

states or territories where the applicant holds or has held a license to practice medicine, or other health care profession; verification must be received directly from the other state board(s), and must attest to the status, issue date, license number, and other information requested and contained on the form; this information will be provided by HSC for applicants using that service, or directly to the New Mexico medical board for applicants using FCVS or applying directly to the board;

(3) two recommendation forms from physicians, chiefs of staff or department chairs or equivalent with whom the applicant has worked and who have personal knowledge of the applicant's character and competence to practice medicine; the recommending physicians must have personally known the applicant and have had the opportunity to personally observe the applicant's ability and performance; forms must be sent directly to the board from the recommending physician; this information will be provided by HSC for applicants using that service, or directly to the New Mexico medical board for applicants using FCVS or applying directly to the board;

(4) verification of all work experience and hospital affiliations in the last five years, if applicable, not to include postgraduate training; this information will be provided by HSC for applicants using that service, or directly to the New Mexico medical board for applicants using FCVS or applying directly to the board;

(5) a copy of all ABMS specialty board certifications, if applicable; this information will be provided by HSC for applicants using that service, or directly to the New Mexico medical board for applicants using FCVS or applying directly to the board; and

(6) the board may request that applicants be investigated by the biographical section of the American medical association, the drug enforcement administration, the federation of state medical boards, the national practitioner data bank, and other sources as may be deemed appropriate by the board;

(7) applicants who are not United States citizens must provide proof that they are in compliance with the immigration laws of the United States.

C. Additional documentation for applicants using the FCVS. Applicants are encouraged to use the FCVS as once a credential file is created future applications for medical licensure will be streamlined. However, application through FCVS is not required. Applicants using the FCVS must submit a completed application to the FCVS, who will provide primary source documentation to the board. Only the documents required in Subsection B of 16.10.2.9 are required in addition to the FCVS report.

D. Additional documentation for applicants using HSC.

(1) status report of ECFMG certification sent directly to the board from ECFMG, if applicable;

(2) copy of ECFMG interim letter documenting additional postgraduate training for international medical graduates applying through the fifth pathway process, if applicable;

(3) certified transcripts of exam scores as required in 16.10.3 NMAC sent directly to the board from the testing agency;

(4) proof of identity may be required; acceptable documents include birth certificate, passport, naturalization documents, and visas.

E. Additional documentation for applicants applying directly to New Mexico and not using FCVS or HSC.

(1) verification of medical education form with school seal or notarized, sent directly to the board from the school;

(2) transcripts sent directly to the board from the medical school;

(3) status report of ECFMG certification sent directly to the board from ECFMG, if applicable;

(4) copy of ECFMG interim letter documenting additional postgraduate training for international medical graduates applying through the fifth pathway process, if applicable;

(5) postgraduate training form sent to the board directly from the training program;

(6) certified transcripts of exam scores as required in 16.10.3 NMAC sent directly to the board from the testing agency; and

(7) proof of identity may be required; acceptable documents include birth certificate, passport, naturalization documents, and visas;

(8) certified copies of source documents obtained directly from another state licensing jurisdiction who has the original document on file will be accepted in lieu of original documents when the originals cannot be obtained for a valid cause.

F. Licensure process. Upon receipt of a completed application, including all required documentation and fees, the applicant may be scheduled for a personal interview before the board, a board member designated by the board, or an agent of the board and must present original documents as requested by the board. The initial license will be issued following completion of any required interview, and/or approval by a member or agent of the board.

G. Initial license expiration. Medical licenses shall be renewed on July 1 following the date of issue. Initial licenses are valid for a period of not more than thirteen months or less than one month. [16.10.2.9 NMAC - N, 5/1/02; A, 1/20/03; A, 7/1/03; A, 4/3/05; A, 10/7/05]

16.10.2.10 MEDICAL LICENSE BY ENDORSEMENT.

A. Prerequisites for licensure. Each applicant for a license to practice as a medical doctor in New Mexico by endorsement must be of good moral character, hold a full and unrestricted license to practice medicine in another state, and possess the following qualifications:

(1) have practiced medicine in the United States or Canada immediately preceding the application for at least three years;

(2) be free of disciplinary history, license restrictions, or pending investigations in all jurisdictions where a medical license is or has been held;

(3) graduated from [~~an~~] a board approved [~~medical~~] school or hold current educational commission for foreign medical graduates (ECFMG) certification; and

(4) current certification from a medical specialty board recognized by the American board of medical specialties (ABMS).

B. Required documentation for all applicants. Each applicant for a license must submit the required fees as specified in 16.10.9.8 NMAC and the following documentation:

(1) a completed application signed and notarized with a passport-quality photo taken within the previous 6 months; applications are valid for 1 year from the date of receipt by the board;

(2) verification of licensure in all states or territories where the applicant holds or has held a license to practice medicine, or other health care profession; verification must be received directly from the other state board(s), and must attest to the status, issue date, license number, and other information requested and contained on the form;

(3) two recommendation forms from physicians, chiefs of staff or department chairs or equivalent with whom the applicant has worked and who have personal knowledge of the applicant's character and competence to practice medicine; the recommending physicians must have personally known the applicant and have had the opportunity to personally observe the applicant's ability and performance; forms must be sent directly to the board from the recommending physician; this information will be provided by HSC for applicants using that service, or directly to the New Mexico medical board;

(4) verification of all work experience and hospital affiliations in the last five years, if applicable, not to include postgraduate training; this information will be

provided by HSC for applicants using that service, or directly to the New Mexico medical board;

(5) a copy of all ABMS specialty board certifications, if applicable; this information will be provided by HSC for applicants using that service, or directly to the New Mexico medical board; and

(6) the board may request that applicants be investigated by the biographical section of the American medical association, the drug enforcement administration, the federation of state medical boards, the national practitioner data bank, and other sources as may be deemed appropriate by the board;

(7) applicants who are not U.S. citizens must provide proof that they are in compliance with the immigration laws of the United States.

C. Licensure process. Upon receipt of a completed application, including all required documentation and fees, the applicant may be scheduled for a personal interview before the board, a board member designated by the board, or an agent of the board and must present original documents as requested by the board. The initial license will be issued following completion of any required interview, and/or approval by a member or agent of the board.

D. Initial license expiration. Medical licenses shall be renewed on July 1 following the date of issue. Initial licenses are valid for a period of not more than thirteen months or less than one month.
[16.10.2.10 NMAC - N, 1/20/03; A, 7/1/03; A, 4/3/05; A, 10/7/05]

16.10.2.12 POSTGRADUATE TRAINING LICENSE. A postgraduate training license is required for all interns, residents, and fellows enrolled in board approved training programs within the state. Individuals enrolled in board approved training programs outside of New Mexico may apply for a postgraduate training license as a pre-requisite to obtaining a New Mexico public service license.

A. Prerequisites for licensure. Each applicant for a postgraduate training license must possess the following qualifications:

(1) graduated from a board approved school or completed a program determined by the board to be substantially equivalent to a U.S. medical school, based on board review of an evaluation by a board approved credential evaluation service;

(2) passed part I of the USMLE; and

(3) be of good moral character.

[~~**A.**~~] **B. Required documentation.** Each applicant shall submit the required fee as specified in 16.10.9.8 NMAC and complete the board-approved application.

(1) Applicants enrolled at the university of New Mexico health science center must submit an application through the office of graduate medical education for review before it is forwarded to the board for review and approval.

(2) Applicants enrolled at a board approved training program outside New Mexico must submit the postgraduate training license application directly to the board.

(3) A copy of the official examination results must be attached to each application.

[~~**B.**~~] **C. Licensure process.** Upon receipt of a completed application and fee, the secretary-treasurer or board designee will review the application and may approve the license. The applicant may be scheduled for a personal interview before the board, a board member designated by the board, or an agent of the board.

[~~**C.**~~] **D. License expiration:** Postgraduate training licenses are valid for no longer than one year, but may be renewed for a period not to exceed eight years or completion of the residency, whichever is shorter, and as long as the license holder is enrolled in a board approved training program. Postgraduate training licenses may be renewed prior to expiration.
[16.10.2.12 NMAC - Rp, 16 NMAC 10.2.14, 4/18/02; 16.10.2.12 NMAC - Rn, 16.10.2.11 NMAC, 1/20/03; A, 10/7/05]

16.10.2.14 TEMPORARY TEACHING, RESEARCH, AND SPECIALIZED DIAGNOSTIC AND TREATMENT LICENSES. The secretary-treasurer or board designee may issue [~~temporary licenses~~] a temporary license to physicians licensed in other states or jurisdictions [~~who wish to teach, conduct research, or perform specialized diagnostic and treatment procedures~~] for the purpose of teaching, conducting research, performing specialized diagnostic and treatment procedures, implementing new technology, or for physician educational purposes in New Mexico on a temporary basis under the supervision of a New Mexico licensed physician. The following provisions apply:

A. Prerequisites for licensure. The applicant must:

(1) be otherwise qualified to practice medicine in New Mexico;

(2) hold an unrestricted license in another state or country;

(3) submit the name of the sponsoring or associating physician(s), who must be actively licensed in New Mexico.

B. Required documentation:

(1) specific program or protocol of work planned;

(2) address of sponsoring institution or organization where the work will be performed;

(3) an affidavit from the sponsoring physician attesting to the qualifications of the applicant and the purpose of the functions or medical procedures the applicant will perform;

(4) verification of licensure in state or jurisdiction where physician is practicing; and

(5) a license fee as set forth in 16.10.9 NMAC.

C. Licensure process. Upon receipt of a completed application, including all required documentation and fees, board staff will request and review an AMA physician profile and federation of state medical boards board action databank search. When the application is complete the secretary-treasurer or board designee will review and may approve the application. A personal interview is not required unless there is a discrepancy in the application that cannot be resolved or if there are any actions or restrictions on any license held in another state or jurisdiction.

D. The applicant may perform only those functions listed in the application. The supervising physician must notify the board and obtain approval prior to any change in the activities of the temporary license holder.

E. The duration of a temporary teaching, research, or specialized diagnostic and treatment license shall not exceed three months, provided however that the license may be renewed up to three times upon payment of appropriate fees and written justification for the plan remaining in effect. [~~If the plan changes, an updated plan must be submitted by the sponsoring physician to the board for review and approval.~~] After the third renewal of a temporary license the physician shall re-apply under the provisions of this rule.
[16.10.2.14 NMAC - Rp, 16 NMAC 10.3.8, 4/18/02; 16.10.2.14 NMAC - Rn, 16.10.2.13 NMAC, 1/20/03; A, 10/7/05]

16.10.2.15 YOUTH CAMP OR SCHOOL LICENSES. The secretary-treasurer or board designee may [~~issue temporary licenses to~~] approve a temporary license for physicians to provide temporary medical services to organized youth camps or schools. Youth camp or school licenses are issued for a period not to exceed three months. Practice under the temporary license shall be limited to enrollees, leaders and employees of the camp or school. Applicants must be qualified for licensure in New Mexico and shall submit the following documentation:

A. completed application with a passport-quality photograph, taken

within the previous 6 months, attached;

B. verification of current unrestricted license from state or jurisdiction where applicant is currently practicing or licensed;

C. verification of D.E.A. permit; and,

D. a temporary license fee as set forth in 16.10.9.8 NMAC.

E. Licensure process. Upon receipt of a completed application, including all required documentation and fees, board staff will request and review an AMA physician profile and federation of state medical boards board action databank search. When the application is complete the secretary-treasurer or board designee will review and may approve the application. A personal interview is not required unless there is a discrepancy in the application that cannot be resolved or if there are any actions or restrictions on any license held in another state or jurisdiction.

[16.10.2.15 NMAC - Rn, 16.10.2.14 NMAC, 1/20/03; A, 10/7/05]

NEW MEXICO MEDICAL BOARD

This is an amendment to 16.10.3 NMAC, Section 10, Effective October 7, 2005.

16.10.3.10 Successful Completion of Examinations

A. An applicant must score a minimum of 75 on each component part of a board-approved examination as described in Subsection C of 16.10.3.8 NMAC. The minimum score of 75 may not be achieved for any component part of an examination by averaging that component's scores with scores of other component part(s).

B. A FLEX weighted average score of 75 or higher will be considered passing if obtained by testing prior to June 1984.

C. An applicant who has taken the Canadian medical licensing examination (LMCC) must achieve the minimum passing score established for the exam as documented by LMCC certification.

D. Except as set forth in below, an applicant may attempt six times to successfully complete any part of a board-approved examination, as long as the entire examination is successfully completed within seven years from the date the first step of the examination is passed.

E. An applicant taking a combination examination set forth above in 16.10.3.8 must successfully complete the combination examination by January 1 of the year 2000. If not, the applicant must successfully complete the USMLE (steps 1, 2, and 3). Either the combination examination or the USMLE must be successfully completed in a total of six attempts maximum for each part. The applicant must successfully complete a combination examination or the USMLE within seven years from the date any part of the combination examination was first passed. The board may grant exceptions to the seven-year requirement, when:

(1) the combination examination is successfully completed within ten years from the date the first step of the examination is passed; and

(2) the applicant has:

(a) been continuously enrolled in postgraduate medical training;

(b) been continuously practicing in another country; or

(c) passed each part of the required examination within 2 attempts.

F. Applicants who are MD/PhD candidates must successfully complete the entire examination within ten years from the date the first step of the examination is passed.

G. [~~Candidates~~] Applicants may repeat a previously passed step if they need to retake the exam in order to bring an entire sequence within the mandated time frame.

H. The board may allow exceptions to the time limits established by this rule for qualified applicants with bona fide disabilities, on a case by case basis.

[16.10.3.10 NMAC - Rp 16 NMAC 10.9.2, 4/18/02; A, 10/5/03; A, 10/7/05]

NEW MEXICO MEDICAL BOARD

This is an amendment to 16.10.15 NMAC, Sections 7, 9, 11, 12, 13 and 14, Effective October 7, 2005.

16.10.15.7 DEFINITIONS:

A. "**AAPA"** means American academy of physician assistants.

B. "**Alternate supervising physician"** means a physician who holds a current unrestricted license, is a cosignatory on the notification of supervision, agrees to act as the supervising physician in the supervising physician's absence and is approved by the board.

C. "**Interim permit"** means a document issued by the board that allows a physician assistant to practice pending completion of all licensing requirements.

D. "**NCCPA"** means national commission of certification of physician assistants.

E. "Oral communication" means in person, telephonically, by two-way radio, by email or other electronic means.

[~~**F. "Reasonable proximity"** means a location not more than one hundred and twenty miles or two hours, by automobile, from the supervising physician and alternate supervising physician(s).~~

~~**G.**~~] **F.** "**Scope of practice"** means duties and limitations of duties placed upon a physician assistant by their supervising physician and the board; includes the limitations implied by the field of practice of the supervising physician.

[~~**H.**~~] **G.** "**Supervising physician"** means a physician who holds a current unrestricted license, provides a notification of supervision, assumes legal responsibility for health care tasks performed by the physician assistant and is approved by the board.

[~~**I. "Written utilization plan"** means written guidelines developed by the supervising physician in conjunction with the physician assistant that define standard protocols of care.~~]

[16.10.15.7 NMAC - Rp 16 NMAC 10.15.7, 7/15/01; A, 10/7/05]

16.10.15.9 LICENSURE PROCESS. Each applicant for a license as a physician assistant shall submit the required fees and following documentation:

A. A completed application for which the applicant has supplied all information and correspondence requested by the board on forms and in a manner acceptable to the board. Applications are valid for 1 year from the date of receipt.

B. Two letters of recommendation from physicians licensed to practice medicine in the United States or physician assistant program directors, or the director's designee, who have personal knowledge of the applicant's moral character and competence to practice. Letters of recommendation must be sent directly to the board from the individual recommending the applicant.

C. Verification of licensure in all states where the applicant holds or has held a license to practice as a physician assistant, or other health care profession. Verification must be sent directly to the board from the other state board(s). Verification must include a raised seal; attest to current status, issue date, license number, and all other related information.

D. All applicants may be required to personally appear before the board or the board's designee for an interview and must present original documents, as the board requires. The initial license will be issued following completion of any required interview, and/or approval by a member or agent of the board.

E. The initial license is valid until March 1 of the year following NCCPA expiration.

F. [~~The board will develop~~

~~a process to transition from the current renewal cycle of August 31 of each even-numbered year so licensees with NCCPA certifications that expire on December 31, 2004 will renew their license on March 1, 2005 and that licensees with NCCPA certifications that expire on December 31, 2005 will renew their license on March 1, 2006. The process may include prorating of those fees defined in 16.10.9.9 NMAC.~~] License by endorsement from New Mexico board of osteopathic examiners. Applicants who are currently licensed in good standing by the New Mexico board of osteopathic examiners may be licensed by endorsement upon receipt of a verification of licensure directly from the New Mexico board of osteopathic examiners, a supervising physician form signed by the M.D. who will serve as supervising or alternate supervising physician, and a fee of $25.00.

[16.10.15.9 NMAC - N, 7/15/01; A, 10/5/03; A, 8/6/04; A, 10/7/05]

16.10.15.11 APPROVAL OF SUPERVISING PHYSICIANS.

A. Pursuant to Section 61-6-10 NMSA 1978, a physician may not supervise more than two (2) physician assistants, without prior written board approval. Section 61-6-10(C) NMSA 1978 provides certain exceptions to this limit which may be considered by the board. A committee composed of the board chair, board secretary and one other member or the medical director may grant approval for the supervision of more than two physician assistants.

B. All supervising physicians shall submit written notice of intent to supervise a physician assistant on forms prescribed by the board. These forms must be submitted and approved before the physician assistant begins work. Failure of the supervising physician to comply with the Medical Practice Act and the rules may result in denial of approval for current or future physician assistant supervision.

C. Within thirty days after an employer terminates the employment of a physician assistant, the supervising physician and/or the physician assistant shall submit a written notice to the board providing the date of termination and reason for termination. The physician assistant shall not work as a physician assistant until the board approves another supervising physician.

D. A physician assistant who is employed by the United States government and who works on land or in facilities owned or operated by the United States government or a physician assistant who is a member of the reserve components of the United States and on official orders or performing official duties as outlined in the appropriate regulation of that branch may be licensed in New Mexico with proof that their supervising physician holds an active medical license in another state.

[16.10.15.11 NMAC - Rp 16 NMAC 10.15.11, 7/15/01; A, 10/7/05]

16.10.15.12 SUPERVISION OF PHYSICIAN ASSISTANT. Supervision of a physician assistant must be rendered by a supervising physician or alternate supervising physician and not through a third party.

A. Responsibility of supervising physician.

(1) Provide direction to the physician assistant to specify what medical services should be provided under the circumstances of each case. This may be done through a written utilization plan or by oral communications.

(2) Provide a means for immediate communication between the physician assistant and the supervising physician or alternate supervising physician.

[~~**(3)** Complete and keep on file a written utilization plan for each physician assistant. This plan may include, but not be limited to: taking medical history; performing or assisting in routine office laboratory procedures; specific therapeutic procedures; recognizing and evaluating situations that require immediate attention of a physician and instituting treatment procedures when necessary; instructing/counseling patients; etc.~~

~~**(4)**~~] **(3)** Comply with the quality assurance requirements specified in Subsection B of 16.10.15.12 NMAC.

[~~**(5)** When the physician assistant is located away from the supervising physician, the supervising physician must visit the premises where the physician assistant(s) is performing their delegated duties at least once every two weeks.~~

~~**(6)**~~] **(4)** Designate an alternate supervising physician and notify the board in writing by letter, fax or email of any change from forms previously submitted.

[~~**(7)** Waiver of requirements: If the supervising physician(s) believes that special circumstances warrant exceptions to the requirement for on-site visits they must specify the circumstances in writing. The board designee will review, grant or deny requests for exceptions or waivers.~~]

B. Quality assurance requirements.

[~~**(1)**~~] A quality assurance program for review of medical services provided by the physician assistant must be in place [~~and reviewed at least quarterly.~~

~~**(2)** The supervising physician must review patient management, including at least ten medical records of the more complex cases each month to assure compliance with directions~~].

C. Alternate supervising physician. A physician serving as alternate supervising physician must comply with all of the requirements of Subsection A of 16.10.15.12 NMAC.

D. Compensation of physician assistants.

(1) The salary of a physician assistant may be paid by an agency or person other than the supervising physician.

(2) Under no circumstances can a physician assistant submit a separate bill to any patient of the physician.

[16.10.15.12 NMAC - Rp 16 NMAC 10.15.12, 7/15/01; A, 10/7/05]

16.10.15.13 SCOPE OF PRACTICE

A. Unless otherwise provided by law, physician assistants may provide medical services delegated to them by the supervising physician when such services are within the physician assistant's skills[~~,~~] and form a usual component of the physician's scope of practice[~~, and are rendered under the direction of the supervising physician or alternate supervising physician~~].

B. A physician assistant may assist a designated supervising physician in an inpatient or surgical health care institution within the institution's bylaws or policies [~~provided:~~] including act as a first surgical assistant in the performance of surgery, when permitted by the institution's bylaws or regulations.

[~~**(1)** The procedures a physician assistant is permitted to carry out must be carefully and specifically delineated by the credentials committee and approved by the institution's governing body.

(2) The supervising or the alternate supervising physician must countersign orders of a physician assistant appearing on patient's chart in accordance with the institution's bylaws.

(3) The physician assistant may act as a first surgical assistant in the performance of surgery, when permitted by the institution's bylaws or regulations.

C. A physician assistant may deliver babies if it is within the supervising physician's field of practice.

D. A physician assistant may suture minor lacerations as defined by written protocol of the supervising physician or after consultations with their supervising physician, which may be by oral communication.]

E. The physician assistant may treat the human foot within the supervising physician's field of practice.~~]

[16.10.15.13 NMAC - Rp 16 NMAC 10.15.9, 7/15/01; A, 10/7/05]

16.10.15.14 PRACTICE LIMITATIONS:

[~~A. In addition to the prohibitions stated in Section 61-6-9(B) NMSA 1978, the board may in the exercise of its discretion, after investigation and evaluation, place limitations on the tasks a physician assistant may perform under the authority and direction of a supervising physician.~~

~~B. A physician assistant cannot assume the duties of a physician if the supervising physician or alternate supervising physician is not available to their practice for any reason.~~

~~C.~~] A. Except as provided in ~~[Paragraph 3 of]~~ Subsection B of 16.10.15.13 NMAC, a physician assistant shall not suture major lacerations. A major laceration is one that extends to or through the deep fascia, muscles, nerves, tendons or major blood vessels.

[~~D.~~] B. Except as provided in [~~Paragraph 3 of~~] Subsection B of 16.10.15.13 NMAC, a physician assistant may render first aid and immobilize fractures, but they may not manipulate or reduce a fracture when such manipulation requires [~~local,~~] regional or general anesthesia unless they are acting as first surgical assistant with a physician.

[16.10.15.14 NMAC - Rp 16 NMAC 10.15.14, 7/15/01; A, 10/7/05]

NEW MEXICO PUBLIC REGULATION COMMISSION

INSURANCE DIVISION

The Public Regulation Commission, Insurance Division repeals its rule entitled Health Insurance For Seniors, 13.10.8 NMAC (filed 9/02/03), effective January 1, 2006.

NEW MEXICO PUBLIC REGULATION COMMISSION

INSURANCE DIVISION

TITLE 13 INSURANCE
CHAPTER 8 INSURANCE POLICIES AND RATES
PART 6 PERSONAL INSURANCE CREDIT INFORMATION

13.8.6.1 ISSUING AGENCY: New Mexico Public Regulation Commission Insurance Division.
[13.8.6.1 NMAC - N, 1/1/06]

13.8.6.2 SCOPE: This rule applies to personal insurance written by an insurer or a group of affiliated insurers authorized to do business in New Mexico or written pursuant to the FAIR Plan Act, but does not apply to commercial insurance or any other types of insurance.
[13.8.6.2 NMAC - N, 1/1/06]

13.8.6.3 STATUTORY AUTHORITY: Section 59A-2-9 NMSA 1978 and the Personal Insurance Credit Information Act, Chapter 59A, Article 17A NMSA 1978 (being Laws 2005, Chapter 275).
[13.8.6.3 NMAC - N, 1/1/06]

13.8.6.4 DURATION: Permanent.
[13.8.6.4 NMAC - N, 1/1/06]

13.8.6.5 EFFECTIVE DATE: January 1, 2006, unless a later date is cited at the end of a section.
[13.8.6.5 NMAC - N, 1/1/06]

13.8.6.6 OBJECTIVE: The purpose of this rule is to implement portions of the Personal Insurance Credit Information Act, Chapter 59A, Article 17A NMSA 1978 (being Laws 2005, Chapter 275).
[13.8.6.6 NMAC - N, 1/1/06]

13.8.6.7 DEFINITIONS: [Reserved]

13.8.6.8 ADVERSE ACTION NOTIFICATION:

A. The notification to consumers required by 59A-17A-8 NMSA 1978 and 13.8.6 NMAC shall be in one document, shall address the consumer by name and shall, in addition to the information described in Subsections A and B of 59A-17A-8 NMSA 1978, provide the consumer with the following information:

(1) the name, address, and telephone number of the consumer reporting agency or third party vendor that provided the information and how the consumer can obtain a free copy of his credit report from that entity;

(2) the insurer, and not the consumer reporting agency or third party vendor, made the decision regarding insurance and the consumer reporting agency or third party vendor cannot provide the consumer with the reasons for the adverse action;

(3) if the consumer finds inaccurate or incomplete information in his credit report and so notifies the consumer reporting agency or third party vendor, the consumer reporting agency is required to investigate and correct any information that it determines is inaccurate or incomplete, or concerning which the accuracy can no longer be verified;

(4) if the consumer reporting agency corrects any information in the credit report, the consumer must instruct the consumer reporting agency to notify the insurer in order for the insurer to know of this correction;

(5) how the consumer can obtain an annual free copy of his credit report from each of the major national consumer reporting agencies, under federal law; and

(6) the life circumstances considered by the insurer in its extraordinary life circumstances exception policy are those that have occurred within three years of the date of application for or renewal of personal insurance coverage and include the following:

(a) an acute or chronic medical condition, illness, injury or disease;

(b) divorce;

(c) death of a spouse, child or parent;

(d) involuntary loss of employment for more than three consecutive months;

(e) identity theft; or

(f) total or other loss that makes a home uninhabitable.

B. An insurer may provide the following language in the notice to comply with the requirements of Subsection A of 13.8.6.8 NMAC. A sample form of notice is posted on the public regulation commission, insurance division website, www.nmprc.state.nm.us, at "insurance", then "property and casualty".

(1) Dear (*name of consumer*):

(2) We have (*describe the specific adverse action taken by using one of the following:*

(a) *"given you less than our best rates",*

(b) *"declined to renew your policy",*

(c) *"declined to offer you a policy",*

(d) *"canceled your policy", or*

(e) *"restricted the coverage that we will provide you"*) due in part to your credit information.

(3) The most important (insert the words "credit-related" if applicable) factors that negatively affected your insurance score are:

(a) (*list the most important factor*);

(b) (*list the second most important factor, if applicable*);

(c) (*list the third most important factor, if applicable*); and

(d) (*list the fourth most important factor, if applicable*).

(4) Your credit information was obtained from (*name the consumer reporting agency*) consumer credit reporting agency. You have a right to a free copy of your consumer credit report by contacting them at (*list their toll-free number*) or at (*list their mail address*) within 60 days. Please note that (*name the consumer reporting agency*) cannot provide you with the reasons for our decision regarding insurance with us.

(5) If you dispute information in your report, contact (*name the consumer reporting agency*). (*Name the consumer reporting agency*) is required to investigate your dispute and get back to you in less than 60 days. If they find that the information is inaccurate, incomplete or can't be verified, they are required to promptly correct your report.

(6) While some errors may have a noticeable impact on our decision regarding your insurance or on your premium, other errors may not. (*Name the consumer reporting agency*) might not alert us to the error correction unless you tell them to do so. You should also notify us once your report has been corrected.

(7) If you correct errors with one reporting agency it may not fix those errors with other reporting agencies. Therefore you may wish to check your consumer credit report from each of the major national reporting agencies.

(8) Once a year you can get a free copy of your report from each of the major reporting agencies by calling (*list toll-free phone number*), by visiting (*list website*), or by writing to (*list mailing address*).

(9) If your credit information has been adversely impacted by an extraordinary life circumstance that has occurred within the last 3 years, you may request in writing that we consider this when using your credit information. These extraordinary life circumstances include:

(a) an acute or chronic medical condition, illness, injury or disease;

(b) divorce;

(c) death of a spouse, child or parent;

(d) involuntary loss of employment for more than three consecutive months;

(e) identity theft; or

(f) total or other loss that makes your home uninhabitable.

(10) If you believe any of these applies to you and has impacted your credit, please contact (*use one of the following: "us", "your insurance agent", "us or your insurance agent"*). We may require you to provide reasonable documentation of this circumstance and explain how it has negatively affected your credit.

[13.8.6.8 NMAC - N, 1/1/06]

13.8.6.9 INSURANCE SCORING FILINGS: Insurers shall include in the heading of the cover letter for filings made pursuant to 59A-17A-9 NMSA 1978 the following words in bold uppercase type: **CONFIDENTIAL INSURANCE SCORING FILING**.

[13.8.6.9 NMAC - N, 1/1/06]

HISTORY OF 13.8.6 NMAC: [RESERVED]

NEW MEXICO PUBLIC REGULATION COMMISSION

INSURANCE DIVISION

TITLE 13 INSURANCE
CHAPTER 10 HEALTH INSURANCE
PART 8 HEALTH INSURANCE FOR SENIORS

13.10.8.1 ISSUING AGENCY: Public Regulation Commission, Insurance Division.

[13.10.8.1 NMAC - Rp, 13.10.8.1 NMAC, 1-1-06]

13.10.8.2 SCOPE: Except as otherwise specifically provided, this rule shall apply to all policies, certificates, or contracts issued pursuant to Chapter 59A, Article 24A NMSA 1978.

[13.10.8.2 NMAC - Rp, 13.10.8.2 NMAC, 1-1-06]

13.10.8.3 STATUTORY AUTHORITY: Sections 59A-2-9 and 59A-24A-1 et. seq. NMSA 1978.

[13.10.8.3 NMAC - Rp, 13.10.8.3 NMAC, 1-1-06]

13.10.8.4 DURATION: Permanent.

[13.10.8.4 NMAC - Rp, 13.10.8.4 NMAC, 1-1-06]

13.10.8.5 EFFECTIVE DATE: January 1, 2006, unless a later date is cited at the end of a section.

[13.10.8.5 NMAC - Rp, 13.10.8.5 NMAC, 1-1-06]

13.10.8.6 OBJECTIVE: The purpose of this rule is to provide for the reasonable standardization of coverage and simplification of terms and benefits of medicare supplement policies, to facilitate public understanding and comparison of such policies; to eliminate provisions contained in such policies which may be misleading or confusing in connection with the purchase of such policies or with the settlement of claims; and to provide for full disclosure in the sale of health insurance coverages to persons eligible for medicare.

[13.10.8.6 NMAC - Rp, 13.10.8.6 NMAC, 1-1-06]

13.10.8.7 DEFINITIONS:

A. "Activities of daily living" include, but are not limited to, bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings.

B. "Applicant" means:

(1) in the case of an individual medicare supplement policy or subscriber contract, the person who seeks to contract for insurance benefits; and

(2) in the case of a group medicare supplement policy the proposed certificateholder.

C. "At-home recovery benefit" means coverage for services to provide short term at-home assistance with activities of daily living for those recovering from an illness, injury or surgery.

D. "At-home recovery visit" means the period of a visit required to provide at home recovery care, without limit on the duration of the visit, except each consecutive 4 hours in a 24-hour period of services provided by a care provider is one visit.

E. "Bankruptcy" means that medicare advantage organization that is not an issuer has filed, or has had filed against it, a petition for declaration of bankruptcy and has ceased doing business in the state.

F. "Care provider" means a duly qualified or licensed home health aide/homemaker, personal care aide or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry.

G. "Certificate" means any certificate delivered or issued for delivery in this state under a group medicare supplement policy.

H. "Certificate form" means the form on which the certificate is delivered or issued for delivery by the issuer.

I. "Complaint" means any dissatisfaction expressed by an individual concerning a medicare select issuer or its network providers.

J. "Continuous period of creditable coverage" means the period during which an individual was covered by creditable coverage, if during the period of the coverage the individual had no breaks in coverage greater than sixty-three (63) days.

K. "Creditable coverage"

(1) means, with respect to an individual, coverage of the individual provided under any of the following:

(a) a group health plan;

(b) health insurance coverage;

(c) Part A or Part B of Title XVIII of the Social Security Act (medicare);

(d) Title XIX of the Social Security Act (medicaid), other than coverage consisting solely of benefits under section 1928;

(e) Chapter 55 of Title 10 United States Code (CHAMPUS);

(f) a medical care program of the Indian health service or of a tribal organization;

(g) a state health benefits risk pool;

(h) a health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program);

(i) a public health plan as defined in federal regulation; and

(j) a health benefit plan under Section 5(e) of the Peace Corps Act (22 United States Code 2504(e)).

(2) shall not include one or more, or any combination of, the following:

(a) coverage only for accident or disability income insurance, or any combination thereof;

(b) coverage issued as a supplement to liability insurance;

(c) liability insurance, including general liability insurance and automobile liability insurance;

(d) workers' compensation or similar insurance;

(e) automobile medical payment insurance;

(f) credit-only insurance;

(g) coverage for on-site medical clinics; and

(h) other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

(3) shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:

(a) limited scope dental or vision benefits;

(b) benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and

(c) such other similar, limited benefits as are specified in federal regulations.

(4) shall not include the following benefits if offered as independent, noncoordinated benefits:

(a) coverage only for a specified disease or illness; and

(b) hospital indemnity or other fixed indemnity insurance.

(5) shall not include the following if it is offered as a separate policy, certificate or contract of insurance:

(a) medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act;

(b) coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code; and

(c) similar supplemental coverage provided to coverage under a group health plan.

L. "Employee welfare benefit plan" means a plan, fund or program of employee benefits as defined in 29 U.S.C. Section 1002 (Employee Retirement Income Security Act).

M. "Form" means the language, format, type size, type proportional spacing, bold character, and line spacing.

N. "Grievance" means dissatisfaction expressed in writing by an individual insured under a medicare select policy or certificate with the administration, claims practices, or provision of services concerning a medicare select issuer or its network providers.

O. "Home" shall mean any place used by the insured as a place of residence, provided that such place would qualify as a residence for home health care services covered by medicare. A hospital or skilled nursing facility shall not be considered the insured's place of residence.

P. "Issuer" includes insurance companies, fraternal benefit societies, nonprofit health care plans, health maintenance organizations and any other entity delivering or issuing for delivery in this state medicare supplement policies or certificates.

Q. "Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

R. Medicare advantage plan" means a plan of coverage for health benefits under medicare part C as defined in 42 U.S.C. 1395w-28(b)(1), and includes:

(1) coordinated care plans which provide health care services, including but not limited to health maintenance organization plans (with or without a point-of-service option), plans offered by provider-sponsored organizations, and preferred provider organization plans;

(2) medicare medical savings account plans coupled with a contribution into a medicare advantage medical savings account; and

(3) medicare advantage private fee-for-service plans.

S. "Medicare select issuer" means an issuer offering, or seeking to offer, a medicare select policy or certificate.

T. "Medicare select policy or medicare select certificate" means respectively, a medicare supplement policy or certificate that contains restricted network provisions.

U. "Medicare supplement policy" means (unless defined to the contrary in this rule) a group policy issued pursuant to Chapter 59A, Article 23 NMSA 1978, group and blanket health insurance contracts, or an individual policy issued pursuant to Chapter 59A, Article 22 NMSA 1978, health insurance contracts, or a group or individual certificate of health insurance or a subscriber contract issued pursuant to Chapter 59A, Article 47 NMSA 1978, nonprofit health care plans, or Chapter 59A, Article 46 NMSA 1978, health maintenance organizations, or by a hospital and medical service association other than a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act (42 U.S.C. Section 1395 et. seq.) or an issued policy under a demonstration project specified in 42 U.S.C. section 1395ss(g)(1), which is advertised, marketed or designed as a supplement to reimbursements under medicare for the hospital, medical or surgical expenses of persons eligible for medicare. Medicare supplement policy does not include medicare advantage plans established under medicare part C, outpatient prescription drug plans established under medicare part D, or any health care prepayment plan (HCPP) that provides benefits pursuant to an agreement under Section 1833(a)(1)(A) of the Social Security Act.

V. "Network provider" means a provider of health care, or a group of providers of health care which has entered into a written agreement with the issuer to provide benefits insured under a medicare select policy.

W. "Policy form" means the form on which the policy is delivered or issued for delivery by the issuer.

X. "Restricted network provision" means any provision which conditions the payment of benefits, in whole or in part, on the use of network providers.

Y. "Secretary" means the secretary of the United States department of health and human services.

Z. "Service area" means the geographic area approved by the superintendent within which an issuer is authorized to offer a medicare select policy.

AA. "Structure, language, and format" means style, arrangement and overall content of a benefit.

[13.10.8.7 NMAC - Rp, 13.10.8.7 NMAC, 1-1-06]

13.10.8.8 REQUIRED POLICY DEFINITIONS AND TERMS: No insurance policy or certificate may be advertised, solicited or issued for delivery in the state as a medicare supplement policy or certificate unless such policy or certificate contains or conforms to the following definitions or terms:

A. Accident, accidental injury, or accidental means shall be defined to employ "result" language and shall not include words which establish an accidental means test or use words such as "external, violent, visible wounds" or simi-

lar words of description or characterization.

(1) The definition shall not be more restrictive than the following: "Injury or injuries for which benefits are provided means accidental bodily injury sustained by the insured person which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while insurance coverage is in force."

(2) Such definition may provide that injuries shall not include injuries for which benefits are provided under any workers' compensation, employer's liability or similar law or motor vehicle no-fault plan, unless prohibited by law.

B. Benefit period or **medicare benefit period** shall not be defined more restrictively than it is defined in the medicare program.

C. Convalescent nursing home, **extended care facility**, or **skilled nursing facility** shall not be defined more restrictively than it is defined in the medicare program.

D. Health care expenses means, for purposes of 13.10.8.40 NMAC, expenses of health maintenance organizations associated with the delivery of health care services, which expenses are analogous to incurred losses of insurers.

E. Hospital may be defined in relation to its status, facilities and available services or to reflect its accreditation by the joint commission on accreditation of hospitals, but not more restrictively than it is defined in the medicare program.

F. Medicare shall be defined in the policy and certificate. Medicare may be substantially defined as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended," or "Title I, Part I of Public Law 89-97, as enacted by the eighty-ninth congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof," or words of similar import.

G. Medicare eligible expenses shall mean expenses of the kinds covered by medicare, parts A and B, to the extent recognized as reasonable and medically necessary by medicare.

H. Physician shall not be defined more restrictively than it is defined in the medicare program.

I. Sickness shall not be defined more restrictively than:

(1) "Sickness means illness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force."

(2) The definition may be further modified to exclude sicknesses or diseases for which benefits are provided under any workers' compensation, occupational disease, employer's liability or similar law.

[13.10.8.8 NMAC - Rp, 13.10.8.8 NMAC, 1-1-06]

13.10.8.9 PROHIBITED POLICY PROVISIONS:

A. Except for permitted preexisting condition clauses as described in Subsection A of 13.10.8.11 and Subsection A of 13.10.8.15 NMAC, no policy or certificate may be advertised, solicited or issued for delivery in this state as a medicare supplement policy if such policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of medicare.

B. No medicare supplement policy or certificate may use waivers to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions.

C. No medicare supplement policy or certificate in force in the state shall contain benefits which duplicate benefits provided by medicare.

D. Outpatient prescription drugs:

(1) Subject to Subsection D of 13.10.8.11 NMAC, Subsections A through D of 13.10.8.12 NMAC, Subsection F of 13.10.8.12 NMAC, Subsection D of 13.10.8.15 NMAC, and Subsections A through F of 13.10.8.16 NMAC, a medicare supplement policy with benefits for outpatient prescription drugs in existence prior to January 1, 2006 shall be renewed for current policyholders who do not enroll in part D at the option of the policyholder.

(2) A medicare supplement policy with benefits for outpatient prescription drugs shall not be issued after December 31, 2005.

(3) After December 31, 2005, a medicare supplement policy with benefits for outpatient prescription drugs may not be renewed after the policyholder enrolls in medicare part D unless:

(a) the policy is modified to eliminate outpatient prescription coverage for expenses of outpatient prescription drugs incurred after the effective date of the individual's coverage under a part D plan; and

(b) premiums are adjusted to reflect the elimination of outpatient prescription drug coverage at the time of medicare part D enrollment, accounting for any claims paid, if applicable.

[13.10.8.9 NMAC - Rp, 13.10.8.9 NMAC, 1-1-06]

13.10.8.10 MINIMUM STANDARDS FOR POLICIES OR CERTIFICATES ISSUED FOR DELIVERY PRIOR TO JULY 1, 1992: No policy or certificate may be advertised, solicited or issued for delivery in this state as a medicare supplement policy unless it meets or exceeds the standards prescribed in 13.10.8.11, 13.10.8.12 and 13.10.8.13 NMAC. These are minimum standards and do not preclude the inclusion of other provision or benefits which are not inconsistent with these standards.

[13.10.8.10 NMAC - Rp, 13.10.8.10 NMAC, 1-1-06]

13.10.8.11 GENERAL STANDARDS FOR POLICIES OR CERTIFICATES ISSUED FOR DELIVERY PRIOR TO JULY 1, 1992: The standards prescribed in 13.10.8.11 and 13.10.8.12 NMAC apply to medicare supplement policies and certificates and are in addition to all other requirements of this rule:

A. A medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition. The policy or certificate shall not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.

B. A medicare supplement policy or certificate shall not indemnify against losses resulting from a sickness on a different basis than losses resulting from accidents.

C. A medicare supplement policy or certificate shall contain a provision which provides that benefits designed to cover cost sharing amounts under medicare will be changed automatically to coincide with any changes in the applicable medicare deductible amount and co-payment percentage factors. Premiums may be modified to correspond with such changes.

D. A "non-cancelable," "guaranteed renewable," or "non-cancelable and guaranteed renewable" medicare supplement policy shall not:

(1) provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the non-payment of premium; or

(2) be canceled or non-renewed by the issuer solely on the grounds of deterioration of health.

[13.10.8.11 NMAC - Rp, 13.10.8.11 NMAC, 1-1-06]

13.10.8.12 RENEWAL AND CONTINUATION OF COVERAGE FOR POLICIES OR CERTIFICATES ISSUED FOR DELIVERY PRIOR TO

JULY 1, 1992:

A. Except as authorized by the superintendent of this state, an issuer shall neither cancel nor non-renew a medicare supplement policy or certificate for any reason other than non-payment of premium or material misrepresentation.

B. If a group medicare supplement policy is terminated by the group policyholder and not replaced as provided in Subsection D of 13.10.8.12 NMAC, the issuer shall offer certificateholders an individual medicare supplement policy. The insurer, non-profit provider or health maintenance organization shall offer the certificateholder at least the following choices:

(1) an individual medicare supplement policy currently offered by the issuer having comparable benefits to those contained in the terminated group medicare supplement policy; and

(2) an individual medicare supplement policy which provides only such benefits as are required to meet the minimum standards as defined in 13.10.8.18 NMAC.

C. If membership in a group is terminated, the issuer shall:

(1) offer the certificateholder such conversion opportunities as are described in Subsection B of 13.10.8.12 NMAC; or

(2) at the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy.

D. If a group medicare supplement policy is replaced by another group medicare supplement policy purchased by the same policyholder, the succeeding issuer shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new group policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

E. Termination of a medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or to payment of the maximum benefits. Receipt of medicare part D benefits will not be considered in determining a continuous loss.

F. If a medicare supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the modified policy shall be deemed to satisfy the guaranteed renewal requirements of this section.

[13.10.8.12 NMAC - Rp, 13.10.8.12 NMAC, 1-1-06]

13.10.8.13 MINIMUM BENEFIT STANDARDS FOR POLICIES OR CERTIFICATES ISSUED FOR DELIVERY PRIOR TO JULY 1, 1992: Medicare supplement insurance policies shall cover:

A. coverage of part A medicare eligible expenses for hospitalization to the extent not covered by medicare from the 61st day throughout the 90th day in any medicare benefit period;

B. coverage for either all or none of the medicare part A inpatient hospital deductible amount;

C. coverage of part A medicare eligible expenses incurred as daily hospital charges during use of medicare's lifetime hospital inpatient reserve days;

D. upon exhaustion of all medicare hospital inpatient coverage including the lifetime reserve days, coverage of ninety percent (90 percent) of all medicare part A eligible expenses for hospitalization not covered by medicare subject to a lifetime maximum benefit of an additional 365 days;

E. coverage under medicare part A for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulation) unless replaced in accordance with federal regulation or already paid for under part B;

F. coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of medicare eligible expenses under part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket amount equal to the medicare part B deductible; and

G. effective January 1, 1990, coverage under medicare part B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations), unless replaced in accordance with federal regulations or already paid for under part A, subject to the medicare deductible amount.

[13.10.8.13 NMAC - Rp, 13.10.8.13 NMAC, 1-1-06]

13.10.8.14 BENEFIT STANDARDS FOR POLICIES OR CERTIFICATES ISSUED FOR DELIVERY AFTER JULY 1, 1992: The standards prescribed in 13.10.8.15 through 13.10.8.23 NMAC are applicable to all medicare supplement policies and certificates delivered or issued for delivery in this state on or after July 1, 1992. No policy or certificate may be advertised, solicited, delivered or issued for delivery in the state as a medicare supplement policy or certificate unless it complies with these benefit standards.

[13.10.8.14 NMAC - Rp, 13.10.8.14 NMAC, 1-1-06]

13.10.8.15 GENERAL STANDARDS FOR POLICIES OR CERTIFICATES ISSUED FOR DELIVERY AFTER JULY 1, 1992: The standards prescribed in 13.10.8.15, 13.10.8.16 and 13.10.8.17 NMAC apply to medicare supplement policies and certificates and are in addition to all other requirements of this rule.

A. A medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.

B. A medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

C. A medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under medicare will be changed automatically to coincide with any changes in the applicable medicare deductible amount and co-payment percentage factors. Premiums may be modified to correspond with such changes.

D. No medicare supplement policy or certificate shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured other than the nonpayment of premium.

[13.10.8.15 NMAC - Rp, 13.10.8.15 NMAC, 1-1-06]

13.10.8.16 RENEWAL AND CONTINUATION OF COVERAGE FOR POLICIES OR CERTIFICATES ISSUED FOR DELIVERY AFTER JULY 1, 1992: Each medicare supplement policy shall be guaranteed renewable.

A. The issuer shall not cancel or nonrenew the policy solely on the ground of health status of the individual.

B. The issuer shall not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation.

C. If the medicare supplement policy is terminated by the group policyholder and is not replaced as provided under Subsection E of 13.10.8.16 NMAC,

the issuer shall offer certificateholders an individual medicare supplement policy which (at the option of the certificateholder):

(1) provides for continuation of the benefits contained in the group policy; or

(2) provides for such benefits as otherwise meets the requirements of this subsection.

D. If an individual is a certificateholder in a group medicare supplement policy and the individual terminates membership in the group, the issuer shall:

(1) offer the certificateholder the conversion opportunity described in Subsection E of 13.10.8.16 NMAC; or

(2) at the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy.

E. If a group medicare supplement policy is replaced by another group medicare supplement policy purchased by the same policyholder, the succeeding issuer shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

F. If a medicare supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug, Improvement and Modernization Act of 2003, the modified policy shall be deemed to satisfy the guaranteed renewal requirements of this section.

G. Termination of a medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Receipt of medicare part D benefits will not be considered in determining a continuous loss.

[13.10.8.16 NMAC - Rp, 13.10.8.16 NMAC, 1-1-06]

13.10.8.17 COORDINATION WITH MEDICAL ASSISTANCE UNDER TITLE XIX OF THE SOCIAL SECURITY ACT:

A. A medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificateholder for the period (not to exceed twenty-four months) in which the policyholder or certificateholder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificateholder notifies the issuer of such policy or certificate within ninety (90) days after the date the individual becomes entitled to such assistance.

B. If such suspension occurs and if the policyholder or certificateholder loses entitlement to such medical assistance, such policy or certificate shall be automatically reinstituted (effective as of the date of termination of such entitlement) as of the termination of such entitlement if the policyholder or certifications provides notice of loss of such entitlement within ninety (90) days after the date of such loss and pays the premium attributable to the period, effective as of the date of termination of such entitlement.

C. Each medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended (for the period provided by federal regulation) at the request of the policyholder if the policyholder is entitled to benefits under Section 226(b) of the Social Security Act and is covered under a group health plan (as defined in Section 1862(b)(1)(A)(v) of the Social Security Act). If suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, the policy shall be automatically reinstituted (effective as of the date of loss of coverage) if the policyholder provides notice of loss of coverage within 90 days after the date of such loss.

D. Reinstitution of such coverages:

(1) shall not provide for any waiting period with respect to treatment of preexisting conditions;

(2) shall provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of such suspension. If the suspended medicare supplement policy provided coverage for outpatient prescription drugs, reinstitution of the policy for medicare part D enrollees shall be without coverage for outpatient prescription drugs and shall otherwise provide substantially equivalent coverage to the coverage in effect before the date of suspension; and

(3) shall provide for classification of premiums on terms at least as favorable to the policyholder or certificateholder as the premium classification terms that would have applied to the policyholder or certificateholder had the coverage not been suspended.

[13.10.8.17 NMAC - Rp, 13.10.8.17 NMAC, 1-1-06]

13.10.8.18 STANDARDS FOR BASIC ("CORE") BENEFITS COMMON TO BENEFIT PLANS A - J FOR POLICIES OR CERTIFICATES ISSUED FOR DELIVERY AFTER JULY 1, 1992: Every issuer shall make available a policy or certificate including only the following basic "core" package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other medicare supplement insurance benefit plans in addition to the basic "core" package but not in lieu thereof.

A. Coverage of part A medicare eligible expenses for hospitalization to the extent not covered by medicare from the 61st day through the 90th day in any medicare benefit period.

B. Coverage of part A medicare eligible expenses incurred for hospitalization to the extent not covered by medicare for each medicare lifetime inpatient reserve day used.

C. Upon exhaustion of the medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100 percent of the medicare part A, eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.

D. Coverage under medicare parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations.

E. Coverage for the coinsurance amount or, in the case of hospital outpatient department services under a prospective payment system, the copayment amount of medicare eligible expenses under medicare part B regardless of hospital confinement, subject to the medicare part B deductible.

[13.10.8.18 NMAC - Rp, 13.10.8.18 NMAC, 1-1-06]

13.10.8.19 STANDARDS FOR ADDITIONAL BENEFITS FOR POLICIES OR CERTIFICATES ISSUED FOR DELIVERY AFTER JULY 1, 1992: The following additional benefits shall be included in medicare supplement benefit plans "B" through "J" only as provided by 13.10.8.24 and 13.10.8.25 NMAC:

A. Medicare Part A deductible: Coverage for all of the medicare part A inpatient hospital deductible amount per benefit period.

B. Skilled nursing facility care: Coverage for the actual billed

charges up to the coinsurance amount from the 21st day through the 100th day in a medicare benefit period for posthospital skilled nursing facility care eligible under medicare part A:

C. Medicare Part B deductible: Coverage for all of the medicare part B deductible amount per calendar year regardless of hospital confinement.

D. Eighty percent (80 percent) of the medicare Part B excess charges: Coverage for eighty percent of the difference between the actual medicare part B charge as billed, not to exceed any charge limitation established by the medicare program or state law, and the medicare-approved part B charge.

E. One hundred (100 percent) percent of the medicare Part B excess charges: Coverage for all of the difference between the actual medicare part B charge as billed, not to exceed any charge limitation established by the medicare program or state law, and the medicare-approved part B charge.

F. Basic outpatient prescription drug benefit: Coverage for 50 percent of outpatient prescription drug charges, after a $250 calendar year deductible, to a maximum of $1,250 in benefits received by the insured per calendar year, to the extent not covered by medicare. The outpatient prescription drug benefit may be included for sale or issuance in a medicare supplement policy until January 1, 2006.

G. Extended outpatient prescription drug benefit: Coverage for 50 percent of outpatient prescription drug charges, after a two hundred fifty dollar ($250) calendar year deductible to a maximum of $3,000 in benefits received by the insured per calendar year, to the extent not covered by medicare. The outpatient prescription drug benefit may be included for sale or issuance in a medicare supplement policy until January 1, 2006.

H. Medically necessary emergency care in a foreign country: Coverage to the extent not covered by medicare for (80 percent) of the billed charges for medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by medicare if provided in the United States and which care began during the first 60 consecutive days of each trip outside the United States, subject to a calendar year deductible of $250 and a lifetime maximum benefit of $50,000. For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

I. Preventive medical care benefit: Coverage as described in 13.10.8.20 NMAC.

J. At-home recovery benefit: Coverage as described in 13.10.8.21 NMAC.

[13.10.8.19 NMAC - Rp, 13.10.8.19 NMAC, 1-1-06]

13.10.8.20 PREVENTIVE MEDICAL CARE BENEFIT: Coverage for the following preventive health services not covered by medicare:

A. An annual clinical preventive medical history and physical examination that may include tests and services from Subsection B of 13.10.8.20 NMAC and patient education to address preventive health care measures.

B. Preventive screening tests or preventive services, the selection and frequency of which is determined to be medically appropriate by the attending physician:

C. Reimbursement shall be for the actual charges up to 100 percent of the medicare-approved amount for each service, as if medicare were to cover the service as identified in American medical association current procedural terminology (AMA CPT) codes, to a maximum of $120 annually under this benefit. This benefit shall not include payment for any procedure covered by medicare.

[13.10.8.20 NMAC - Rp, 13.10.8.20 NMAC, 1-1-06]

13.10.8.21 AT-HOME RECOVERY COVERAGE REQUIREMENTS AND LIMITATIONS:

A. At-home recovery services provided must be primarily services which assist in activities of daily living.

B. The insured's attending physician must certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by medicare.

C. Coverage is limited to:

(1) no more than the number and type of at-home recovery visits certified as necessary by the insured's attending physician; the total number of at-home recovery visits shall not exceed the number of medicare approved home health care visits under a medicare approved home care plan of treatment;

(2) the actual charges for each visit up to a maximum reimbursement of $40 per visit;

(3) one thousand six hundred dollars ($1,600) per calendar year;

(4) seven (7) visits in any one week;

(5) care furnished on a visiting basis in the insured's home;

(6) services provided by a care provider as defined in this section;

(7) at-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded; and

(8) at-home recovery visits received during the period the insured is receiving medicare approved home care services or no more than 8 weeks after the service date of the last medicare approved home health care visit.

D. Coverage is excluded for:

(1) home care visits paid for by medicare or other government programs; and

(2) care provided by family members, unpaid volunteers or providers who are not care providers.

[13.10.8.21 NMAC - Rp, 13.10.8.21 NMAC, 1-1-06]

13.10.8.22 NEW OR INNOVATIVE BENEFITS: An issuer may, with the prior approval of the superintendent, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. Such new or innovative benefits may include benefits that are appropriate to medicare supplement insurance, new or innovative, not otherwise available, cost-effective, and offered in a manner which is consistent with the goal of simplification of medicare supplement policies. After December 31, 2005, the innovative benefit shall not include an out patient prescription drug benefit.

[13.10.8.22 NMAC - Rp, 13.10.8.22 NMAC, 1-1-06]

13.10.8.23 STANDARDS FOR PLANS K AND L:

A. Standardized medicare supplement benefit plan "K" shall consist of the following:

(1) coverage of 100 percent of the part A hospital coinsurance amount for each day used from the 61st through the 90th day in any medicare benefit period;

(2) coverage of 100 percent of the part A hospital coinsurance amount for each medicare lifetime inpatient reserve day used from the 91st through the 150th day in any medicare medicare benefit period;

(3) upon exhaustion of the medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100 percent of the medicare part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the

insured for any balance;

(4) medicare part A deductible: Coverage for 50 percent of the medicare part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in Paragraph (10) of 13.10.8.23 NMAC;

(5) skilled nursing facility care: Coverage for 50 percent of the coinsurance amount for each day used from the 21st day through the 100th day in a medicare benefit period for post-hospital skilled nursing facility care eligible under medicare part A until the out-of-pocket limitation is met as described in Paragraph (10) of 13.10.8.23 NMAC;

(6) hospice care: Coverage for 50 percent of cost sharing for all part A medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in Paragraph (10) of 13.10.8.23 NMAC;

(7) coverage for 50 percent, under medicare part A or B, of the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in Paragraph (10) of 13.10.8.23 NMAC;

(8) except for coverage provided in Paragraph (9) of 13.10.8.23 NMAC, coverage for 50 percent of the cost sharing otherwise applicable under medicare part B after the policyholder pays the part B deductible until the out-of-pocket limitation is met as described in Paragraph (10) of 13.10.8.23 NMAC;

(9) coverage of 100 percent of the cost sharing for medicare part B preventive services after the policyholder pays the part B deductible; and

(10) coverage of 100 percent of all cost sharing under medicare parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under medicare parts A and B of $4000 in 2006, indexed each year by the appropriate inflation adjustment specified by the secretary of the U.S. department of health and human services.

B. Standardized medicare supplement benefit plan "L" shall consist of the following:

(1) the benefits described in Paragraphs (1), (2), (3) and (9) of 13.10.8.23 NMAC;

(2) the benefit described in Paragraphs (4), (5), (6), (7) and (8) of 13.10.8.23 NMAC, but substituting 75 percent for 50 percent; and

(3) the benefit described in Paragraph (10) of 13.10.8.23 NMAC, but substituting $2000 for $4000.

[13.10.8.23 NMAC - N, 1-1-06]

13.10.8.24 STANDARD MEDICARE SUPPLEMENT BENEFIT PLANS:

A. An issuer shall make available to each prospective policyholder and certificateholder a policy form or certificate form containing only the basic "core" benefits, as defined in 13.10.8.18 NMAC.

B. No groups, packages or combinations of medicare supplement benefits other than those listed in 13.10.8.25 NMAC shall be offered for sale in this state, except as may be permitted in 13.10.8.22 and 13.10.8.26 through 13.10.8.30 NMAC.

C. Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans "A" through "L" listed in this Subsection and conform to the definitions in 13.10.8.7 NMAC. Each benefit shall be structured in accordance with the format provided in 13.10.8.18 through 13.10.8.21 NMAC, or 13.10.8.23 NMAC, and list the benefits in the order shown in 13.10.8.25 NMAC.

D. An issuer may use, in addition to the benefit plan designations required in Subsection C of 13.10.8.24 NMAC, other designations to the extent permitted by law.

[13.10.8.24 NMAC - Rp, 13.10.8.23 NMAC, 1-1-06]

13.10.8.25 MAKE-UP OF STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLANS: Each standardized medicare benefit supplement plan shall consist only of the benefits indicated:

A. Plan A: The basic ("core") benefits common to all benefit plans, as defined in 13.10.8.18 NMAC.

B. Plan B: The core benefit as defined in 13.10.8.18 NMAC, plus the medicare part A deductible as defined in Subsection A of 13.10.8.19 NMAC.

C. Plan C: The core benefit as defined in13.10.8.18 NMAC, plus the medicare part A deductible, skilled nursing facility care, medicare part B deductible and medically necessary emergency care in a foreign country as defined in Subsections A, B, C and H of 13.10.8.19 NMAC.

D. Plan D: The core benefit as defined in 13.10.8.18 NMAC, plus the medicare part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country and the at-home recovery benefit as defined in Subsections A, B and H of 13.10.8.19 NMAC and 13.10.8.21 NMAC.

E. Plan E: The core benefit as defined in 13.10.8.18 NMAC, plus the medicare part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country and preventive medical care as defined in Subsections A, B and H of 13.10.8.19 and 13.10.8.20 NMAC.

F. Plan F: The core benefit as defined in 13.10.8.18 NMAC, plus the medicare part A deductible, the skilled nursing facility care, the Part B deductible, one hundred percent (100 percent) of the medicare part B excess charges, and medically necessary emergency care in a foreign country as defined in Subsections A, B, C, E and H of 13.10.8.19 NMAC.

G. High deductible plan F: 100 percent of covered expenses following the payment of the annual high deductible plan F deductible. The covered expenses include the core benefit as defined in 13.10.8.18 NMAC, plus the medicare part A deductible, skilled nursing facility care, the medicare part B deductible, 100 percent of the medicare part B excess charges, and medically necessary emergency care in a foreign country as defined in Subsections A, B, C, E and H of 13.10.8.19 NMAC. The annual high deductible plan F deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the medicare supplement plan F policy, and shall be in addition to any other specific benefit deductibles. The annual high deductible plan F deductible shall be $1500 for 1998 and 1999, and shall be based on the calendar year. It shall be adjusted annually thereafter by the secretary to reflect the change in the consumer price index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of $10.

H. Plan G: The core benefit as defined in 13.10.8.18 NMAC, plus the medicare part A deductible, skilled nursing facility care, 80 percent of the medicare part B excess charges, medically necessary emergency care in a foreign country and the at-home recovery benefit as defined in Subsections A, B, D and H of 13.10.8.19 and 13.10.8.21 NMAC.

I. Plan H: The core benefit as defined in 13.10.8.18 NMAC, plus the medicare part A deductible, skilled nursing facility care, basic prescription drug benefit and medically necessary emergency care in a foreign country as defined in Subsections A, B, F and H of 13.10.8.19 NMAC. The outpatient prescription drug benefit shall not be included in a medicare supplement policy sold after December 31, 2005.

J. Plan I: The core benefit as defined in 13.10.8.18 NMAC, plus the medicare part A deductible, skilled nursing facility care, 100 percent of the medicare part B excess charges, basic prescription drug benefit medically necessary emergency care in a foreign country and recov-

ery benefit as defined in Subsections A, B, E, F and H of 13.10.8.19 and 13.10.8.21 NMAC. The outpatient prescription drug benefit shall not be included in a medicare supplement policy sold after December 31, 2005.

K. Plan J: The core benefit as defined in 13.10.8.18 NMAC, plus the medicare part A deductible, skilled nursing facility care, medicare Part B deductible, 100 percent of the medicare part B excess charges, extended prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care and at-home recovery benefit as defined in Subsections A, B, C, E, G and H of 13.10.8.19 NMAC, and 13.10.8.20 and 13.10.8.21 NMAC. The outpatient prescription drug benefit shall not be included in a medicare supplement policy sold after December 31, 2005.

L. High-deductible plan J: 100 percent of covered expenses following the payment of the annual high deductible plan J deductible. The covered expenses include the core benefit as defined in 13.10.8.18 NMAC, plus the medicare part A deductible, skilled nursing facility care, medicare part B deductible, 100 percent of the medicare part B excess charges, extended outpatient prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care benefit and at-home recovery benefit as defined in Subsections A, B, C, E, G and H of 13.10.8.19, 13.10.8.20 and 13.10.8.21 NMAC. The annual high deductible plan J deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the medicare supplement plan J policy, and shall be in addition to any other specific benefit deductibles. The annual deductible shall be $1500 for 1998 and 1999, and shall be based on a calendar year. It shall be adjusted annually thereafter by the secretary to reflect the change in the consumer price index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of $10. The outpatient prescription drug benefit shall not be included in a medicare supplemnet policy sold after December 31, 2005.

M. Plan K mandated by The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA): Only those benefits described in Subsection A of 13.10.8.23 NMAC.

N. Plan L mandated by The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA): Only those benefits described in Subsection B of 13.10.8.23 NMAC.

[13.10.8.25 NMAC - Rp, 13.10.8.24 NMAC, 1-1-06]

13.10.8.26 MEDICARE SELECT POLICIES AND CERTIFICATES:

A. No policy or certificate may be advertised as a medicare select policy or certificate unless it meets the requirements of 13.10.8.26 through 13.10.8.30 NMAC.

B. The superintendent may authorize an issuer to offer a medicare select policy or certificate, pursuant to this section and section 4358 of the Omnibus Budget Reconciliation Act (OBRA) of 1990 if the superintendent finds that the issuer has satisfied all of the requirements of this rule.

C. A medicare select issuer shall not issue a medicare select policy or certificate in this state until its plan of operation has been approved by the superintendent.

D. A medicare select issuer shall file a proposed plan of operation with the superintendent in a format prescribed by the superintendent. The plan of operation shall contain the information required by 13.10.8.27 NMAC.

E. A medicare select policy or certificate shall not restrict payment for covered services provided by non-network provider if:

(1) the services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury, or a condition; and

(2) it is not reasonable to obtain such services through a network provider

F. A medicare select policy or certificate shall provide payment for full coverage under the policy for covered services that are not available through network providers.

G. A medicare select issuer shall make full and fair disclosure in writing of the provisions, restrictions, and limitations of the medicare select policy or certificate to each applicant. This disclosure shall include the information required by 13.10.8.28 NMAC.

H. Prior to the sale of a medicare select policy or certificate, a medicare select issuer shall obtain from the applicant, a signed and dated form stating that the applicant has received the information provided pursuant to Subsection G of 13.10.8.26 NMAC and that the applicant understands the restrictions of the medicare select policy or certificate.

I. At the time of initial purchase, a medicare select issuer shall make available to each application for a medicare select policy or certificate the opportunity to purchase any medicare supplement policy or certificate otherwise offered by the issuer.

J. A medicare select issuer shall comply with reasonable requests for data made by state or federal agencies, including the United States department of health and human services, for the purpose of evaluating the medicare select program.

[13.10.8.26 NMAC - Rp, 13.10.8.25 NMAC, 1-1-06]

13.10.8.27 CONTENTS OF PLAN OF OPERATION: The plan of operation shall contain:

A. evidence that all covered services that are subject to restricted network provisions are available and accessible through network providers, including a demonstration that:

(1) such services can be provided by network providers with reasonable promptness with respect to geographic location, hours of operation, and after-hour care. The hours of operation and availability of after-hour care shall reflect unusual practice in the local area. Geographic availability shall reflect the usual travel times within the community;

(2) the number of network providers in the service area is sufficient, with respect to current and expected policyholders; either:

(a) to deliver adequately all services that are subject to a restricted network provision; or

(b) to make appropriate referrals;

(3) there are written agreements with network providers describing specific responsibilities;

(4) emergency care is available twenty-four hours per day and seven days per week; and

(5) in the case of covered services that are subject to a restricted network provision and are provided on a prepaid basis, there are written agreements with network providers prohibiting such providers from billing or otherwise seeking reimbursement from or recourse against any individual insured under a medicare select policy or certificate; this paragraph shall not apply to supplemental charges or coinsurance amounts as stated in the medicare select policy or certificate;

B. a statement or map providing a clear description of the service area;

C. a description of the grievance procedure to be utilized;

D. a description of the quality assurance program, including:

(1) the formal organization structure;

(2) the written criteria for selection, retention, and removal of network providers; and

(3) the procedures of re-evaluating quality of care provided by network providers, and the process to initiate correc-

tive action when warranted.

E. a list and description, by specialty, of the network providers;

F. copies of the written information proposed to be used by the issuer to comply with Subsection G of 13.10.8.26 NMAC; and

G. any other information requested by the superintendent.

H. updating plan of operation:

(1) a medicare select issuer shall file any proposed changes to the plan of operation, except for changes to the list of network provider, with the superintendent prior to implementing such changes; such changes shall be considered approved by the superintendent after thirty days unless specifically disapproved;

(2) an updated list of network providers shall be filed with the superintendent at least quarterly.

[13.10.8.27 NMAC - Rp, 13.10.8.26 NMAC, 1-1-06]

13.10.8.28 DISCLOSURE REQUIRED FOR MEDICARE SELECT POLICIES:

A. An outline of coverage sufficient to permit the applicant to compare the coverage and premiums of the medicare select policy or certificate with:

(1) other medicare supplement policies or certificates offered by the issuer; and

(2) other medicare select policies or certificates.

B. A description (including address, phone number and hours of operation) of the network providers, including primary care physicians, specialty physicians, hospitals and other providers.

C. A description of the restricted network provisions, including payments for coinsurance and deductibles when providers other than network providers are utilized. Except to the extent specified in the policy or certificate, expenses incurred when using out of network providers do not count toward the out-of-pocket annual limit contained in plans K and L.

D. A description of coverage of emergency and urgently needed care and other out-of-service area coverage.

E. A description of limitations on referrals to restricted network providers and to other providers.

F. A description of the policyholder's rights to purchase any other medicare supplement policy or certificate otherwise offered by the issuer.

G. A description of the medicare select issuer's quality assurance program and grievance procedure.

[13.10.8.28 NMAC - Rp, 13.10.8.27 NMAC, 1-1-06]

13.10.8.29 GRIEVANCE PROCEDURE: A medicare select issuer shall have and use procedures for hearing complaints and resolving written grievances from the subscribers. Such procedures shall be aimed at mutual agreement for settlement and may include arbitration procedures.

A. The grievance procedure shall be described in the policy and certificates and in the outline of coverage.

B. At the time the policy or certificate is issued, the issuer shall provide detailed information to the policyholder describing how a grievance may be registered with the issuer.

C. Grievances shall be considered in a timely manner and shall be transmitted to appropriate decision makers who have authority to fully investigate the issuer and take corrective action.

D. If a grievance is found to be valid, corrective action shall be taken promptly.

E. All concerned parties shall be notified about the results of a grievance.

F. The issuer shall report no later than each March 31st to the superintendent regarding its grievance procedure. The report shall be in a format prescribed by the superintendent and shall contain the number of grievances filed in the past year and a summary of the subject, nature, and resolution of such grievances.

[13.10.8.29 NMAC - Rp, 13.10.8.28 NMAC, 1-1-06]

13.10.8.30 CONTINUATION OF COVERAGE TO A NON-SELECT POLICY:

A. At the individual insured's option.

(1) At the request of an individual insured under a medicare select policy or certificate, a medicare select issuer shall make available to the individual insured the opportunity to purchase a medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make such policies or certificates available without requiring evidence of insurability after the medicare select policy or certificate has been in force six months.

(2) For the purposes of this subsection, a medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the medicare select policy or certificate being replaced. For the purpose of this paragraph, a significant benefit means coverage for the medicare part A deductible, coverage for at-home recovery services, or coverage for part B excess charges.

B. In the event of discontinuance of the select program. Medicare select policies and certificates shall provide for continuation of coverage in the event the secretary of health and human services determines that medicare select policies and certificates issued pursuant to this section should be discontinued due to either the failure of the medicare select program to be reauthorized under law or its substantial amendment.

(1) Each medicare select issuer shall make available to each individual insured under a medicare select policy or certificate the opportunity to purchase any medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restriction network provision. The issuer shall make such policies and certificates available without requiring evidence of insurability.

(2) For the purposes of this subsection, a medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the medicare select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the medicare part A deductible, coverage or at-home recovery services, or coverage for part B excess charges.

[13.10.8.30 NMAC - Rp, 13.10.8.29 NMAC, 1-1-06]

13.10.8.31 OPEN ENROLLMENT:

A. No issuer shall deny or condition the issuance or effectiveness of any medicare supplement policy or certificate available for sale in this state, nor discriminate in the pricing of such a policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant in the case of an application for a policy or certificate that is submitted prior to or during the six month period beginning with the first day of the first month in which an individual is 65 years of age or older and is first enrolled for benefits under medicare part B. Each medicare supplement policy and certificate currently available from an insurer shall be made available to all applicants who qualify under this subsection without regard to age.

B. If an applicant qualifies under Subsection A of 13.10.8.31 NMAC and submits an application during the time period referenced in Subsection A of 13.10.8.31 NMAC and, as of the date of application, has had a continuous period of

creditable coverage of at least six months, the issuer shall not exclude benefits based on a preexisting condition.

C. If the applicant qualifies under Subsection A of 13.10.8.31 NMAC and submits an application during the time period referenced in Subsection A of 13.10.8.31 NMAC and, as of the date of application, has had a continuous period of creditable coverage that is less than six months, the issuer shall reduce the period of any preexisting condition exclusion by the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date. The secretary shall specify the manner of the reduction under this subsection.

D. Except as provided in Subsections B and C of 13.10.8. 31 and Sections 13.10.8.32 through 13.10.8.37, and 13.10.8.58 NMAC, Subsection A of 13.10.8.31 NMAC shall not be construed as preventing the exclusion of benefits under a policy, during the first six months, based on a pre-existing condition for which the policyholder or certificateholder received treatment or was otherwise diagnosed during the six months before it became effective.

[13.10.8.31 NMAC - Rp, 13.10.8.30 NMAC, 1-1-06]

13.10.8.32 GUARANTEED ISSUE:

A. Eligible persons are those individuals described in 13.10.8. 33 NMAC who seek to enroll under the policy during the period specified in 13.10.8.34 NMAC, and who submit evidence of the date of termination, disenrollment, or medicare part D enrollment with the application for a medicare supplement policy.

B. With respect to eligible persons, an issuer shall not deny or condition the issuance or effectiveness of a medicare supplement policy described in 13.10.8.36 NMAC that is offered and is available for issuance to new enrollees by the issuer, shall not discriminate in the pricing of such a medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition, and shall not impose an exclusion of benefits based on a preexisting condition under such a medicare supplement policy.

[13.10.8.32 NMAC - Rp, 13.10.8.31 NMAC, 1-1-06]

13.10.8.33 ELIGIBLE PERSONS: An eligible person is an individual described in any of the following paragraphs.

A. The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under medicare; and the plan terminates, or the plan ceases to provide all such supplemental health benefits to the individual.

B. The individual is enrolled with a medicare advantage organization under a medicare advantage plan under part C of medicare, and any of the following circumstances apply, or the individual is 65 years of age or older and is enrolled with a program of all-inclusive care for the elderly (PACE) provider under Section 1894 of the Social Security Act, and there are circumstances similar to those described below that would permit discontinuance of the individual's enrollment with such provider if such individual were enrolled in a medicare advantage plan.

(1) The certification of the organization or plan has been terminated.

(2) The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides.

(3) The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the secretary, but not including termination of the individual's enrollment on the basis described in section 1851(g)(3)(B) of the federal Social Security Act (where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under section 1856), or the plan is terminated for all individuals within a residence area.

(4) The individual demonstrates, in accordance with guidelines established by the secretary, that:

(a) the organization offering the plan substantially violated a material provision of the organizations contract under this part in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or

(b) the organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plans provisions in marketing the plan to the individual.

(5) The individual meets such other exceptional conditions as the secretary may provide.

C. The individual is enrolled with one of the following organizations and the enrollment ceases under the same circumstances that would permit discontinuance of an individuals election of coverage under Subsection B of 13.10.8.33 NMAC:

(1) an eligible organization under a contract under Section 1876 (medicare cost);

(2) a similar organization operating under demonstration project authority, effective for periods before April 1, 1999;

(3) an organization under an agreement under Section 1833(a)(1)(A) (health care prepayment plan); or

(4) an organization under a medicare select policy.

D. The individual is enrolled under a medicare supplement policy and the enrollment ceases because:

(1) of an order issued in a delinquency proceeding held pursuant to Chapter 59A, Article 41 NMSA 1978, or the bankruptcy of the nonissuer organization;

(2) of other involuntary termination of coverage or enrollment under the policy;

(3) the issuer of the policy substantially violated a material provision of the policy; or

(4) the issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual.

E. The individual was enrolled under a medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any medicare advantage organization under a medicare advantage plan under part C of medicare, any eligible organization under a contract under Section 1876 (medicare cost), any similar organization operating under demonstration project authority, any PACE program under Section 1984 of the Social Security Act, an organization under an agreement under section 1833(a)(1)(A) (health care prepayment plan), or a medicare select policy; and the subsequent enrollment is terminated by the enrollee during any period within the first twelve months of such subsequent enrollment (during which the enrollee is permitted to terminate such subsequent enrollment under section 1851(e) of the federal Social Security Act).

F. The individual, upon first becoming eligible for benefits under part A of medicare at age 65, enrolls in a medicare advantage plan under part C of medicare, or in a PACE program under Section 1984, and disenrolls from the plan or program by not later than twelve months after the effective date of enrollment.

G. The individual enrolls in a medicare part D plan during the initial enrollment period and, at the time of enrollment in part D, was enrolled under a medicare supplement policy that covers outpatient prescription drugs and the individual terminates enrollment in the medicare supplement policy and submits evidence of enrollment in medicare part D along with the application for a policy described in Subsection D of 13.10.8.36 NMAC.

[13.10.8.33 NMAC - Rp, 13.10.8.32 NMAC, 1-1-06]

13.10.8.34 GUARANTEED ISSUE TIME PERIODS:

A. In the case of an individual described in Subsection A of 13.10.8.33 NMAC, the guaranteed issue period begins on the later of:

(1) the date the individual receives a notice of termination or cessation of all supplemental health benefits (or, if a notice is not received, notice that a claim has been denied because of such a termination or cessation); or

(2) the date that the applicable coverage terminates or ceases; and

(3) ends sixty-three (63) days thereafter.

B. In the case of an individual described in Subsections B, C, E and F of 13.10.8.33 NMAC whose enrollment is terminated involuntarily, the guaranteed issue period begins on the date that the individual receives a notice of termination and ends sixty-three (63) days after the date the applicable coverage is terminated.

C. In the case of an individual described in Paragraphs (1) and (2) of Subsection D of 13.10.8.33 NMAC, the guaranteed issue period begins on the earlier of:

(1) the date that the individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other such similar notice if any; and

(2) the date that the applicable coverage is terminated, and

(3) ends on the date that is sixty-three (63) days after the date the coverage is terminated.

D. In the case of an individual described in Subsection B of 13.10.8.33, Paragraphs (3) and (4) of Subsection D of 13.10.8.33, Subsection E of 13.10.8.33, or Subsection F of 13.10.8.33 NMAC who disenrolls voluntarily, the guaranteed issue period begins on the date that is sixty (60) days before the effective date of the disenrollment and ends on the date that is sixty-three (63) days after the effective date.

E. In the case of an individual described in Subsection G of 13.10.8.33 NMAC, the guaranteed issue period begins on the date the individual receives notice pursuant to Section 1882(v)(2)(B) of the Social Security Act from the medicare supplement issuer during the sixty-day period immediately preceding the initial part D enrollment period and ends on the date that is sixty-three (63) days after the effective date of the individual's coverage under medicare part D.

F. In the case of an individual described in 13.10.8.33 NMAC but not described in the preceding provisions of this section, the guaranteed issue period begins on the effective date of disenrollment and ends on the date that is sixty-three (63) days after the effective date.

[13.10.8.34 NMAC - N, 1-1-06]

13.10.8.35 EXTENDED MEDIGAP ACCESS FOR INTERRUPTED TRIAL PERIODS

A. In the case of an individual described in Subsection E of 13.10.8.33 NMAC (or deemed to be so described, pursuant to this subsection) whose enrollment with an organization or provider described in Subsection E of 13.10.8.33 NMAC is involuntarily terminated within the first twelve (12) months of enrollment, and who, without an intervening enrollment, enrolls with another such organization or provider, the subsequent enrollment shall be deemed to be an initial enrollment described in Subsection E of 13.10.8.33 NMAC.

B. In the case of an individual described in Subsection F of 13.10.8.33 NMAC, (or deemed to be so described, pursuant to this subsection) whose enrollment with a plan or in a program described in Subsection F of 13.10.8.33 NMAC is involuntarily terminated within the first twelve (12) months of enrollment, and who, without an intervening enrollment, enrolls in another such plan or program, the subsequent enrollment shall be deemed to be an initial enrollment described in Subsection F of 13.10.8.33 NMAC.

C. For purposes of Subsections E and F of 13.10.8.33 NMAC, no enrollment of an individual with an organization or provider described in Subsection E of 13.10.8.33 NMAC, or with a plan or in a program described in Subsection F of 13.10.8.33 NMAC, may be deemed to be an initial enrollment under this paragraph after the two year period beginning on the date on which the individual first enrolled with such an organization, provider, plan or program.

[13.10.8.35 NMAC - N, 1-1-06]

13.10.8.36 PRODUCTS TO WHICH ELIGIBLE PERSONS ARE ENTITLED: The medicare supplement policy to which eligible persons are entitled under:

A. Subsections A, B, C and D of 13.8. 33 NMAC, is a medicare supplement policy which has a benefit package classified as plan A, B, C F (including F with a high deductible), K or L offered by any issuer;

B. Subsection E of 13.10.8. 33 NMAC is the same medicare supplement policy in which the individual was most recently previously enrolled, if available from the same issuer, or, if not so available, a policy described in Subsection A of 13.10.8. 36 NMAC, provided that after December 31, 2005, if the individual was most recently enrolled in a medicare supplement policy with an outpatient prescription drug benefit, a medicare supplement policy described in this subsection is:

(1) the policy available from the same issuer but modified to remove outpatient prescription drug coverage; or

(2) at the election of the policyholder, an A, B, C, F (including F with a high deductible), K or L policy that is offered by any issuer;

C. Subsection F of 13.10.8. 33NMAC shall include any medicare supplement policy offered by any issuer; or

D. Subsection G of 13.10.8.33 is a medicare supplement policy that has a benefit package classified as plan A, B, C, F (including F with a high deductible), K or L, and that is offered and is available for issuance to new enrollees by the same issuer that issued the individual's medicare supplement policy with outpatient prescription drug coverage.

[7-1-98; 13.10.8.36 NMAC - Rp, 13 NMAC 10.8.33 NMAC, 1-1-04]

13.10.8.37 NOTIFICATION PROVISIONS:

A. At the time of an event described in 13.10.8.33 NMAC because of which an individual loses coverage or benefits due to the termination of a contract or agreement, policy, or plan, the organization that terminates the contract or agreement, the issuer terminating the policy, or the administrator of the plan being terminated, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of medicare supplement policies under 13.10.8.32 NMAC. Such notice shall be communicated contemporaneously with the notification of termination.

B. At the time of an event described in 13.10.8.33 NMAC because of which an individual ceases enrollment under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the issuer offering the policy, or the administrator of the plan, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of medicare supplement policies under 13.10.8.32 NMAC. Such notice shall be communicated within ten working days of the issuer receiving notification of disenrollment.

[13.10.8.37 NMAC - Rp, 13.10.8.34 NMAC, 1-1-06]

13.10.8.38 STANDARDS FOR

CLAIMS PAYMENT:

A. An issuer shall comply with section 1882(c)(3) of the Social Security Act (as enacted by section 4081(b)(2)(c) of the Omnibus Budget Reconciliation Act of 1987 (OBRA) (P.L. 100-203)) by:

(1) accepting a notice from a medicare carrier on dually assigned claims submitted by participating physicians and suppliers as a claim for benefits in place of any other claim form otherwise required and making a payment determination on the basis of the information contained in that notice;

(2) notifying the participating physician or supplier and the beneficiary of the payment determination;

(3) paying the participating physician or supplier directly;

(4) furnishing, at the time of enrollment, each enrollee with a card listing the policy name, number and a central mailing address to which notices from a medicare carrier may be sent;

(5) paying user fees for claim notices that are transmitted electronically or otherwise; and

(6) providing to the secretary of health and human services, at least annually, a central mailing address to which all claims may be sent by medicare carriers.

B. Compliance with the requirements set forth in Subsection A of 13.10.8.38 NMAC shall be certified on the medicare supplement insurance experience reporting form.

[13.10.8.38 NMAC - Rp, 13.10.8.35 NMAC, 1-1-06]

13.10.8.39 CERTAIN INDIVIDUAL CONTRACTS TREATED AS GROUP POLICIES: Medicare supplement policies, including certificates of a master policy, issued as a result of solicitations of individuals by agents or through the mail or mass media advertising, including both print and broadcast advertising, shall be treated as individual policies, except that for purposes of 13.10.8.40, 13.10.8.43 and 13.10.8.44 NMAC such policies issued under a group master contract after April 1, 1990 shall be considered group policies.

[13.10.8.39 NMAC - Rp, 13.10.8.36 NMAC, 1-1-06]

13.10.8.40 LOSS RATIO STANDARD:

A. All medicare supplement policies, certificates or other policies or certificates in force in this state designed to reimburse or pay as a result of hospitalization, medical or surgical expenses of persons eligible for medicare shall return to policyholders in the form of aggregate benefits (not including anticipated refunds or credits) under the policy, for the entire period for which rates are computed to provide coverage, commencing with the later of January 1, 1989, or the inception of the policy, on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis and earned premiums for such period and in accordance with accepted actuarial principles and practices:

(1) at least 75 percent of the aggregate amount of premiums earned in the case of group policies; or

(2) at least 65 percent of the aggregate amount of premium earned in the case of individual policies.

B. Incurred health care expenses where coverage is provided by a health maintenance organization shall not include:

(1) home office and overhead costs;

(2) advertising costs;

(3) commissions and other acquisition costs;

(4) taxes;

(5) capital costs;

(6) administrative costs; and

(7) claims processing costs.

C. All filings of rates, actuarial memorandums and rating schedules for 1989 and thereafter shall demonstrate that expected claims in relation to premiums comply with the requirements of 13.10.8.40 through 13.10.8.44 NMAC when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards.

D. For purposes of applying Subsections A and B of 13.10.8. 40 NMAC and Subsection C of 13.10.8.46 NMAC, policies issued as a result of solicitations of individuals through the mails or by mass media advertising (including both print and broadcast advertising) shall be deemed to be group policies.

[13.10.8.40 NMAC - Rp, 13.10.8.37 NMAC, 1-1-06]

13.10.8.41 REFUND OR CREDIT CALCULATION:

A. An issuer shall collect and file with the superintendent by May 31 of each year the data contained in the reporting form prescribed in 13.10.8.75 NMAC for each type in a standard medicare supplement benefit plan.

B. If on the basis of the experience as reported the benchmark ratio since inception (ratio 1) exceeds the adjusted experience ratio since inception (ratio 3), then a refund or credit calculation is required. The refund calculation shall be done on a statewide basis for each type in a standard medicare supplement benefit plan. For purposes of the refund or credit calculation, experience on policies issued within the reporting year shall be excluded.

C. For the purposes of this section policies or certificates issued prior to July 1, 1992, the issuer shall make the refund or credit calculation separately for all individual policies (including all group policies subject to an individual loss ratio standard when issued) combined and all other group policies combined for experience after January 1, 1996. The first such report shall be due by May 31, 1998.

D. A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds a de minimis level. Such refund shall include interest from the end of the calendar year to the date of the refund or credit at a rate specified by the secretary of health and human services, but in no event shall it be less than the average rate of interest for 13-week treasury notes. A refund or credit against premium due shall be made by September 30 following the experience year upon which the refund or credit is based.

[13.10.8.41 NMAC - Rp, 13.10.8.38 NMAC, 1-1-06]

13.10.8.42 ANNUAL FILING OF PREMIUM RATES:

A. An issuer of medicare supplement policies and certificates issued before and after the effective date of this rule in this state shall file annually its rates, rating schedule, actuarial memorandums and supporting documentation including ratios of incurred losses to earned premiums by policy duration for approval by the superintendent in accordance with the filing requirements and procedures prescribed by the superintendent. The supporting documentation shall also demonstrate in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. Such demonstration shall exclude active life reserves.

B. An expected third-year loss ratio which is greater than or equal to the applicable percentage shall be demonstrated for policies, subscriber contracts or certificates in force less than three years.

[13.10.8.42 NMAC - Rp, 13.10.8.39 NMAC, 1-1-06]

13.10.8.43 PREMIUM ADJUSTMENTS: As soon as practicable, but prior to the effective date of enhancements in medicare benefits, every issuer of medicare supplement policies or certificates in this state shall file with the superintendent, in

accordance with the applicable filing procedures of this state:

A. Appropriate premium adjustments necessary to produce loss ratios as anticipated for the current premium for the applicable policies or certificates. The supporting documents necessary to justify the adjustments shall accompany the filing. An issuer shall make premium adjustments necessary to produce an expected loss ratio under the policy or certificate to conform to minimum loss ratio standards for medicare supplement policies and which are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the issuer for the medicare supplement policies or certificates. No premium adjustment which would modify the loss ratio experience under the policy other than the adjustments described herein shall be made with respect to a policy at any time other than upon its renewal date or anniversary date.

B. If an issuer fails to make premium adjustments acceptable to the superintendent, the superintendent may order premium adjustment, refunds or premium credits deemed necessary to achieve the loss ratio required by this section.

C. Any appropriate riders, endorsements or policy forms needed to accomplish the medicare supplement policy or certificate modifications necessary to eliminate benefit duplications with medicare. Such riders, endorsements or policy forms shall provide a clear description of the medicare supplement benefits provided by the policy or certificate.

[13.10.8.43 NMAC - Rp, 13.10.8.40 NMAC, 1-1-06]

13.10.8.44 PUBLIC HEARINGS: The superintendent in addition to the superintendent's other powers to call a hearing, may conduct a public hearing to gather information concerning a request by an issuer for an increase in a rate for a policy form or certificate form issued before or after the effective date of this rule if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard. The determination of compliance is made without consideration of any refund or credit for such reporting period. Public notice of such hearing shall be furnished in a manner deemed appropriate by the superintendent.

[13.10.8.44 NMAC - Rp, 13.10.8.41 NMAC, 1-1-06]

13.10.8.45 FILING AND APPROVAL OF POLICIES AND CERTIFICATES AND PREMIUM RATES:

A. Policies and certificates.

(1) An issuer shall not deliver or issue for delivery a policy or certificate to a resident of this state unless the policy form or certificate form has been filed with and approved by the superintendent in accordance with filing requirements and procedures prescribed in Chapter 59A, Articles 15, 18, 44, 46 and 47 NMSA 1978.

(2) An issuer shall file any riders or amendments to policy or certificate forms to delete outpatient prescription drug benefits as required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 with the superintendent in accordance with the filing requirements and procedures prescribed in Chapter 59A, Articles 15, 18, 44, 46 and 47 NMSA 1978.

B. Rates. An issuer shall not use or change premium rates for a medicare supplement policy or certificate or other policies or certificates designed to reimburse or pay as a result of hospitalization, medical and surgical expense of persons eligible for medicare unless the rates, rating schedule and supporting documentation have been filed with and approved by the superintendent in accordance with the filing requirements and procedures prescribed in 13.10.8.42 NMAC and in Chapter 59A, Articles 15, 18, 23, 44, 46 and 47 NMSA 1978.

[13.10.8.45 NMAC - Rp, 13.10.8.42 NMAC, 1-1-06]

13.10.8.46 RESTRICTIONS ON NUMBER OF FORMS FILED:

A. Except as provided in Subsection B of 13.10.8.46 NMAC, an issuer shall not file for approval more than one form of a policy or certificate of each type for each standard medicare supplement benefit plan.

B. An issuer may offer, with the approval of the Superintendent, up to 4 additional policy forms or certificate forms of the same type for the same standard medicare supplement benefit plan, one for each of the following cases:

(1) the inclusion of new or innovative benefits;

(2) the addition of either direct response or agent marketing methods;

(3) the addition of either guaranteed issue or underwritten coverage; and

(4) the offering of coverage to individuals eligible for medicare by reason of disability.

C. For the purpose of this section, "type" means an individual policy or a group policy.

[13.10.8.46 NMAC - Rp, 13.10.8.43 NMAC, 1-1-06]

13.10.8.47 AVAILABILITY OF APPROVED FORMS:

A. Except as provided in Paragraph (1) of Subsection A of 13.10.8.47 NMAC, an issuer shall continue to make available for purchase any policy form or certificate form issued after the effective date of this rule that has been approved by the superintendent. A policy form or certificate form shall not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous twelve months.

(1) An issuer may discontinue the availability of a policy form or certificate form if the issuer provides to the superintendent in writing its decision at least sixty days prior to discontinuing the availability of the form of the policy or certificate. After receipt of the notice by the Superintendent, the issuer shall no longer offer for sale the policy form or certificate form in this state.

(2) An issuer that discontinues the availability of a policy form or certificate form pursuant to Paragraph (1) of Subsection A of 13.10.8.47 NMAC shall not file for approval a new policy form or certificate form of the same type for the same standard medicare supplement benefit plan as the discontinued form for a period of five years after the issuer provides notice to the superintendent of the discontinuance. The period may be reduced if the superintendent determines that a shorter period is appropriate.

B. The sale or other transfer of medicare supplement business to another issuer shall be considered a discontinuance for the purposes of this subsection.

C. A change in the rating structure or methodology shall be considered a discontinuance under Subsection A of 13.10.8.47 NMAC unless the issuer complies with the following requirements.

(1) The issuer provides an actuarial memorandum in a form and manner prescribed by the superintendent, describing the manner in which the revised rating methodology and resultant rates differ from the existing rating methodology and resultant rates.

(2) The issuer does not subsequently put into effect a change or rates or rating factors that would cause the discontinued and subsequent rates as described in the actuarial memorandum to change. The superintendent may approve a change to the differential which is in the public interest.

[13.10.8.47 NMAC - Rp, 13.10.8.44 NMAC, 1-1-06]

13.10.8.48 COMBINING FORMS PERMITTED:

A. Except as provided in Subsection B of 13.10.8.48 NMAC the experience of all policy forms or certificate forms of the same type in a standard medicare supplement benefit plan shall be combined for purposes of the refund or

credit calculation prescribed in 13.10.8.41 NMAC.

B. Forms assumed under an assumption reinsurance agreement shall not be combined with the experience of other forms for purposes of the refund or credit calculation.

[13.10.8.48 NMAC - Rp, 13.10.8.45 NMAC, 1-1-06]

13.10.8.49 PERMITTED COMPENSATION ARRANGEMENTS:

A. An issuer or other entity may provide commission or other compensation to an agent or other representative for the sale of a medicare supplement policy or certificate only if the first year commission or other first year compensation is no more than two hundred percent of the commission or other compensation paid off selling or servicing the policy or certificate in the second year or period.

B. The commission or other compensation provided in subsequent (renewal) years must be the same as that provided in the second year or period and must be provided for no fewer than five renewal years.

C. No issuer or other entity shall provide compensation to its agents or other producers and no agent or producer shall receive compensation greater than the renewal compensation payable by the replacing insurer on renewal policies or certificates if an existing policy or certificate is replaced.

D. For purposes of this section, "compensation" includes pecuniary or non-pecuniary remuneration of any kind relating to the sale or renewal of the policy or certificate including, but not limited to, bonuses, gifts, prizes, awards and finders fees.

[13.10.8.49 NMAC - Rp, 13.10.8.46 NMAC, 1-1-06]

13.10.8.50 REQUIRED DISCLOSURE PROVISIONS:

A. Medicare supplement policies and certificates shall include a renewal or continuation provision. The language or specifications of such provision must be consistent with the type of contract issued. Such provision shall be appropriately captioned, and shall appear on the first page of the policy and shall include any reservation by the issuer of the right to change premiums and any automatic renewal premium increases based on the policyholder's age.

B. Except for riders or endorsements by which the issuer effectuates a request made in writing by the insured, exercises a specifically reserved right under a medicare supplement policy, or is required to reduce or eliminate benefits to avoid duplication of medicare benefits, all riders or endorsements added to a medicare supplement policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in this policy shall require a signed acceptance by the insured. After the date of policy, or certificate issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term shall, unless the benefits are required by the minimum standards for medicare supplement policies, be agreed to in writing and signed by the insured, except if the increased benefits or coverage is required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such premium charge shall be set forth in the policy.

C. Medicare supplement policies or certificates issued or delivered after July 1, 1992 shall not provide for the payment of benefits based on standards described as "unusual and customary" or words of similar import.

D. If a medicare supplement policy or certificate contains any limitations with respect to preexisting conditions, such limitations shall appear as a separate paragraph of the policy and be labeled as "preexisting condition limitations."

E. Medicare supplement policies and certificates shall have a notice prominently printed on the first page of the policy or certificate or attached thereto stating in substance that the policyholder or certificateholder shall have the right to return the policy or certificate within thirty days of its delivery and to have the premium refunded within thirty days after its return if, after examination of the policy or certificate, the insured is not satisfied for any reason.

F. Issuers of health insurance policies or certificates which provide hospital or medical expense coverage on an expense incurred or indemnity basis, to a person(s) eligible for medicare shall provide to all applicants a guide to health insurance for people with medicare in the form developed jointly by the national association of insurance commissioners and the centers for medicare and medicaid services (CMS) and in a type size no smaller than 12 point type. Delivery of the guide shall be made whether or not such policies or certificates are advertised, solicited or issued as medicare supplement policies or certificates as defined in the rule. Except in the case of direct response issuers delivery of the guide shall be made to the applicant at the time of application and acknowledgment of the guide shall be obtained by the issuer. Direct response issuers shall deliver the guide to the applicant upon request but no later than at the time the policy is delivered.

[13.10.8.50 NMAC - Rp, 13.10.8.47 NMAC, 1-1-06]

13.10.8.51 NOTICE REQUIREMENTS:

A. As soon as practicable, but no later than thirty days prior to the annual effective date of any medicare benefits changes, an issuer shall notify its policyholders and certificateholders of modifications it has made to medicare supplement insurance policies or certificates in a format approved by the superintendent. In addition, such notice shall:

(1) include a description of revisions to the medicare program and a description of each modification made to the coverage provided under the medicare supplement policy or certificate; and

(2) inform each policyholder or certificateholder as to when any premium adjustment is to be made, due to changes in medicare.

B. The notice of benefit modifications and any premium adjustments shall be in outline form and in clear and simple term so as to facilitate comprehension.

C. Such notices shall not contain or be accompanied by any solicitation.

D. MMA notice requirements: Issuers shall comply with any notice requirements of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

[13.10.8.51 NMAC - Rp, 13.10.8.48 NMAC, 1-1-06]

13.10.8.52 OUTLINE OF COVERAGE REQUIREMENTS OF MEDICARE SUPPLEMENT POLICIES:

A. Issuers shall provide an outline of coverage to all applicants at the time application is presented to the prospective applicant and except for direct response policies, shall obtain an acknowledgment of receipt of such outline from the applicant.

B. If an outline of coverage is provided at the time of application and the medicare supplement policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate shall accompany such policy or certificate when it is delivered and contain the following statement, in no less than twelve point type, immediately above the company name: "NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued."

C. The outline of coverage provided to applicants pursuant to 13.10.8.60 NMAC consists of four parts: a

cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the issuer.

D. The outline of coverage shall be in the language, format, and order prescribed in 13.10.8.60 NMAC in no less than twelve point type. All plans A - L shall be shown on the cover page, and the plan(s) that are offered by the issuer shall be prominently identified. Premium information for plans that are offered shall be shown on the cover page or immediately following the cover page and shall be prominently displayed. The premium and mode shall be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant shall be illustrated.

E. Notice regarding policies, or certificates which are not medicare supplement policies.

(1) Any health insurance policy or certificate other than a medicare supplement policy; a policy issued pursuant to a contract under Section 1876 of the Federal Social Security Act (42 U.S.C. 1395 et. seq.); disability income policy; other policies identified in Section 59A-24A-2B NMSA 1978, issued for delivery in the state to persons eligible for medicare shall notify insureds under the policy that the policy is not a medicare supplement policy or certificate. The notice shall either be printed or attached to the first page of the outline of coverage delivered to insureds under the policy, or if no outline of coverage is delivered, to the first page of the policy or certificate delivered to insured. The notice shall be in no less than twelve (12) point type and shall contain the following language: "THIS (POLICY OR CERTIFICATE) IS NOT A MEDICARE SUPPLEMENT (POLICY OR CONTRACT). If you are eligible for medicare, review the *guide to health insurance for people with medicare* available from the company."

(2) Applications provided to persons eligible for medicare for the health insurance policies or certificates described in Paragraph (1) of Subsection E of 13.10.8.52NMAC shall disclose, using the applicable statement in 13.10.8.77 or 13.10.8.78 NMAC, the extent to which the policy duplicates medicare. The disclosure statement shall be provided as part of, or together with, the application for the policy or certificate.

[13.10.8.52 NMAC - Rp, 13.10.8.49 NMAC, 1-1-06]

13.10.8.53 REQUIREMENTS FOR APPLICATION FORMS AND REPLACEMENT COVERAGE:

A. Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant currently has medicare supplement, medicare advantage, medicaid coverage or another health insurance policy or certificate in force or whether a medicare supplement policy or certificate is intended to replace any other accident and sickness policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent containing the questions and statements in 13.10.8.73 NMAC may be used.

B. Agents shall list any other health insurance policies they have sold to the applicant, including the following.

(1) Policies sold which are still in force.

(2) Policies sold in the past five years which are no longer in force.

C. In the case of a direct response issuer, a copy of the application or supplemental form, signed by the applicant, and acknowledged by the insurer, shall be returned to the applicant by the insurer upon delivery of the policy.

D. Upon determining that a sale will involve replacement of medicare supplement coverage, any issuer, other than a direct response issuer, or its agent, shall furnish the applicant, prior to issuance or delivery of the medicare supplement policy or certificate, a notice regarding replacement of health medicare supplement coverage. One copy of such notice signed by the applicant and the agent, except where the coverage is sold without an agent, shall be provided to the applicant and an additional signed copy shall be retained by the issuer. A direct response issuer shall deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of health medicare supplement coverage.

E. The notice required by Subsection D of 13.10.8.53 NMAC for an issuer shall be provided in substantially the form in 13 10.8.74 NMAC in no less than twelve (12) point type.

F. Paragraphs a and b of the replacement notice (applicable to preexisting conditions) may be deleted by an issuer if the replacement does not involve application of a new preexisting condition limitation.

[13.10.8.53 NMAC - Rp, 13.10.8.51 NMAC, 1-1-06]

13.10.8.54 FILING REQUIREMENTS FOR ADVERTISING: Every issuer of medicare supplement insurance policies or certificates, including medicare-risk contracts, in this state shall provide a copy of any medicare supplement advertisement intended for use in this state whether through written, radio or television medium to the superintendent for review and approval. The advertisement shall comply with all applicable laws of this state. No representative or marketer of medicare supplement insurance policies or certificates shall advertise any medicare supplement insurance policies or certificates in this state unless a copy of such advertising was submitted by the issuer and received the superintendent's approval.

[13.10.8.54 NMAC - Rp, 13.10.8.52 NMAC, 1-1-06]

13.10.8.55 STANDARDS FOR MARKETING:

A. An issuer, directly or through its producers, shall:

(1) establish marketing procedures to assure that any comparison of policies by its agents or other producers will be fair and accurate;

(2) establish marketing procedures to assure excessive insurance is not sold or issued;

(3) display prominently by type, stamp or other appropriate means, on the first page of the policy the following: "Notice to buyer: This policy may not cover all of your medical expenses;"

(4) inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for a medicare supplement insurance already has health insurance and the types and amounts of any such insurance; and

(5) establish auditable procedures for verifying compliance with this subsection.

B. In addition to the practices prohibited in Chapter 59A, Article 16 NMSA 1978, the following acts and practices are prohibited.

(1) High pressure tactics. Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether expressed or implied, or undue pressure to purchase or recommend the purchase of insurance; and

(2) Cold lead advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurer in a conspicuous manner.

C. The terms "medicare supplement," "medigap," "medicare wraparound" and words of similar import shall not be used unless the policy is issued in compliance with this rule.

[13.10.8.55 NMAC - Rp, 13.10.8.53 NMAC, 1-1-06]

13.10.8.56 APPROPRIATE-

NESS OF RECOMMENDED PURCHASE AND EXCESSIVE INSURANCE:

A. In recommending the purchase or replacement of any medicare supplement policy or certificate an agent shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

B. Any sale of a medicare supplement policy or certificate that will provide an individual more than one medicare supplement, policy or certificate is prohibited.

C. An issuer shall not issue a medicare supplement policy or certificate to an individual enrolled in medicare part C unless the effective date of the coverage is after the termination date of the individual's part C coverage.

[13.10.8.56 NMAC - Rp, 13.10.8.54 NMAC, 1-1-06]

13.10.8.57 REPORTING OF MULTIPLE POLICIES:

A. On or before March 1 of each year, an issuer shall report the following information for every individual resident of this state for which the issuer has in force more than one medicare supplement policy or certificate:

(1) policy and certificate number; and

(2) date of issuance.

B. The items in Subsection A of 13.10.8.57 NMAC must be grouped by individual policyholder.

[13.10.8.57 NMAC - Rp, 13.10.8.55 NMAC, 1-1-06]

13.10.8.58 PROHIBITION AGAINST PRE-EXISTING CONDITIONS, WAITING PERIODS, ELIMINATION PERIODS, AND PROBATIONARY PERIODS IN REPLACEMENT POLICIES OR CERTIFICATES:

A. If a medicare supplement policy or certificate replaces another medicare supplement policy or certificate, the replacing issuer shall waive any time periods applicable to the preexisting conditions, waiting periods, elimination periods and probationary periods in the new medicare supplement policy to the extent such time was spent under the original policy.

B. If a medicare supplement policy or certificate replaces another medicare supplement policy or certificate which has been in effect for at least six months, the replacing policy shall not provide any time period applicable to preexisting conditions, waiting periods, elimination periods and probationary periods for benefits similar to those contained in the original policy or certificate.

[13.10.8.58 NMAC - Rp, 13.10.8.56 NMAC, 1-1-06]

13.10.8.59 INSTRUCTIONS FOR USE OF THE DISCLOSURE STATEMENTS FOR HEALTH INSURANCE POLICIES SOLD TO MEDICARE BENEFICIARIES THAT DUPLICATE MEDICARE:

A. Section 1882 (d) of the federal Social Security Act (42 U.S.C. 1395ss) prohibits the sale of a health insurance policy (the term policy or policies includes certificates) to medicare beneficiaries that duplicate medicare benefits unless it will pay benefits without regard to other health coverage and it includes the prescribed disclosure statement on or together with the application.

B. All types of health insurance policies that duplicate medicare shall include one of the attached disclosure statements, according to the particular policy type involved, on the application or together with the application. The disclosure statement may not vary from the attached statements in terms of language or format (type size, type proportional spacing, bold character, line spacing, and usage of boxes around text).

C. State and federal law prohibits insurers from selling a medicare supplement policy to a person that already has a medicare supplement policy except as a replacement.

D. Property/casualty and life insurance policies are not considered health insurance.

E. Disability income policies are not considered to provide benefits that duplicate medicare.

F. Long-term care insurance policies that coordinate with medicare and other health insurance are not considered to provide benefits that duplicate medicare.

G. The federal law does not pre-empt state laws that are more stringent than the federal requirements.

H. The federal law does not pre-empt existing state form filing requirements.

I. Section 1882 of the federal Social Security Act was amended in Subsection (d)(3)(A) to allow for alternative disclosure statements. Carriers may use either the original disclosure statements provided in 13.10.8.77 NMAC with the requisite insurance product or the alternative disclosure statements provided in 13.10.8.78 NMAC but may not use both simultaneously.

[13.10.8.59 NMAC - Rp, 13.10.8.57 NMAC, 1-1-06]

13.10.8.60 OUTLINE OF COVERAGE: The following language shall be included in the outline of coverage in the order prescribed below. A sample form of the outline of coverage is posted on the public regulation commission, insurance division website, www.nmprc.state.nm.us, at "insurance," then "life and health."

A. (COMPANY NAME).

B. Outline of Medicare Supplement Coverage — Cover Page: 1 of 2.

C. Benefit Plan(s) ____ *(insert letter(s) of plan(s) being offered).*

D. These charts show the benefits included in each of the standard medicare supplement plans. Every company must make available plan "A." Some plans may not be available in your state.

E. See Outlines of Coverage sections for details about ALL plans.

F. Basic benefits for plans A - J.

(1) Hospitalization. Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

(2) Medical expenses. Part B coinsurance (generally 20 percent of Medicare-approved expenses), or copayments for hospital outpatient services).

(3) Blood. First three pints of blood each year.

G. First chart:

(1) Plan A. Basic benefits.

(2) Plan B.

(a) Basic benefits.

(b) Part A deductible.

(3) Plan C.

(a) Basic benefits.

(b) Skilled nursing facility coinsurance.

(c) Part A deductible.

(d) Part B deductible.

(e) Foreign travel emergency.

(4) Plan D.

(a) Basic benefits.

(b) Skilled nursing facility coinsurance.

(c) Part A deductible.

(d) Foreign travel emergency.

(e) At-home recovery.

(5) Plan E.

(a) Basic benefits.

(b) Skilled nursing facility coinsurance.

(c) Part A deductible.

(d) Foreign travel emergency.

(e) Preventative care NOT covered by Medicare.

(6) Plan F.

(a) Basic benefits.

(b) Skilled nursing facility coinsurance.

(c) Part A deductible.

(d) Part B deductible.

(e) Part B excess 100 percent.

(f) Foreign travel emergency.

(g) High deductible plan F option.

This high deductible plan pays the same benefits as plan F after one has paid a calendar year ($1690) deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are ($1690). Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the medicare deductibles for part A and part B, but do not include the plan's separate foreign travel emergency deductible.

(7) Plan G.

(a) Basic benefits.

(b) Skilled nursing facility coinsurance.

(c) Part A deductible.

(d) Part B excess 80 percent.

(e) Foreign travel emergency.

(f) At-home recovery.

(8) Plan H.

(a) Basic benefits.

(b) Skilled nursing facility coinsurance.

(c) Part A deductible.

(d) Foreign travel emergency

(9) Plan I.

(a) Basic benefits.

(b) Skilled nursing facility coinsurance.

(c) Part A deductible.

(d) Part B excess 100 percent.

(e) Foreign travel emergency.

(f) At-home recovery.

(10) Plan J.

(a) Basic benefits.

(b) Skilled nursing facility coinsurance.

(c) Part A deductible.

(d) Part B deductible.

(e) Part B excess 100 percent.

(f) Foreign travel emergency.

(g) At-home recovery.

(h) Preventive care NOT covered by medicare.

(i) High deductible plan J option. This high deductible plan pays the same benefits as plan J after one has paid a calendar year ($1690) deductible. Benefits from high deductible plan J will not begin until out-of-pocket expenses are ($1690). Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the medicare deductibles for part A and part B, but do not include the plan's separate foreign travel emergency deductible.

H. (COMPANY NAME).

I. Outline of medicare supplement coverage - cover page 2.

J. Basic benefits for plans K and L include similar services as plans A - J, but cost-sharing for the basic benefits is at different levels.

K. Second chart.

(1) Plan J.

(a) Basic benefits.

(b) Skilled nursing coinsurance.

(c) Part A deductible.

(d) Part B deductible.

(e) Part B excess 100 percent.

(f) Foreign travel emergency.

(g) At-home recovery.

(h) Preventive care NOT covered by medicare.

(2) Plan K. Plan K provides for different cost-sharing for items and services than plans A - J. Once you reach the annual limit, the plan pays 100 percent of the medicare copayments, coinsurance, and deductibles for the rest of the calendar year. The out-of-pocket annual limit does NOT include charges from your provider that exceed medicare-approved amounts, called "excess charges." You will be responsible for paying excess charges.

(a) One hundred percent of part A hospitalization coinsurance plus coverage for 365 days after medicare benefits end.

(b) Fifty percent hospice cost-sharing.

(c) Fifty percent of medicare-eligible expenses for the first three pints of blood.

(d) Fifty percent part B coinsurance, except 100 percent coinsurance for part B preventive services.

(e) Fifty percent skilled nursing facility coinsurance.

(f) Fifty percent part A deductible.

(g) (Four thousand dollars) out of pocket annual limit. **The out-of-pocket annual limit will increase each year for inflation.**

(3) Plan L. Plan L provides for different cost-sharing for items and services than plans A - J. Once you reach the annual limit, the plan pays 100 percent of the medicare copayments, coinsurance, and deductibles for the rest of the calendar year. The out-of-pocket annual limit does NOT include charges from your provider that exceed medicare-approved amounts, called "excess charges." You will be responsible for paying excess charges.

(a) One hundred percent of part A hospitalization coinsurance plus coverage for 365 days after medicare benefits end.

(b) Seventy five percent hospice cost-sharing.

(c) Seventy five percent of medicare eligible expenses for the first three pints of blood.

(d) Seventy five percent part B coinsurance, except 100 percent coinsurance for part B preventive services.

(e) Seventy five percent skilled nursing facility coinsurance.

(f) Seventy five percent part A deductible.

(g) (Two thousand dollars) out of pocket annual limit. **The out-of-pocket annual limit will increase each year for inflation.**

L. See Outlines of Coverage for details and exceptions.

M. PREMIUM INFORMATION (Boldface Type).

N. We (insert issuer's name) can only raise your premium if we raise the premium for all policies like yours in this state. (If the premium is based on the increasing age of the insured, include information specifying when premiums will change.)

O. DISCLOSURES (Boldface Type).

P. Use this outline to compare benefits and premiums among policies.

Q. READ YOUR POLICY VERY CAREFULLY (Boldface Type)

R. This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

S. RIGHT TO RETURN POLICY (Boldface Type).

T. If you find that you are not satisfied with your policy, you may return it to (insert issuer's address). If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

U. POLICY REPLACEMENT (Boldface Type).

V. If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

W. NOTICE (Boldface Type).

X. This policy may not fully cover all of your medical costs.

Y. (for agents:) Neither (*insert company name*) nor its agents are connected with Medicare.

Z. (for direct response:) (*insert company name*) is not connected with Medicare.

AA. This outline of coverage does not give all the details of medicare coverage. Contact your local social security office or consult "*medicare and you*" for more details.

BB. COMPLETE ANSWERS ARE VERY IMPORTANT (Boldface Type)

CC. When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and

refuse to pay any claims if you leave out or falsify important medical information. (If the policy or certificate is guaranteed issue, this paragraph need not appear.)

DD. Review the application carefully before you sign it. Be certain that all information has been properly recorded.

EE. (Include for each plan prominently identified in the cover page, a chart showing the services, medicare payments, plan payments and insured payments for each plan, using the same language, in the same order, using uniform layout and format as shown in the charts in 13.10.8.61 through 13.10.8.72 NMAC. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are included in this rule. An issuer may use additional benefit plan designations on these charts pursuant to Subsection D of 13.10.8.24 NMAC.)

FF. (Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the superintendent.)

[13.10.8.60 NMAC - Rp, 13.10.8.58 NMAC, 1-1-06]

13.10.8.61 PLAN A: The following language shall be used in the order prescribed below. A sample form is posted on the public regulation commission, insurance division website, www.nmprc.state.nm.us, at "insurance," then "life and health."

A. PLAN A: MEDICARE (PART A) HOSPITAL SERVICES PER BENEFIT PERIOD.

(1) Hospitalization. A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row. Semiprivate room and board, general nursing and miscellaneous services and supplies.

(a) First 60 days. Medicare pays all but $(876). Plan pays $0. You pay $(876) (part A deductible).

(b) 61st through 90th day. Medicare pays all but $(219) a day. Plan pays $(219) a day. You pay $0.

(c) 91st day and after - while using 60 lifetime reserve days. Medicare pays all but $(438) a day. Plan pays $(438) a day. You pay $0.

(d) 91st day and after - once lifetime reserve days are used. Additional 365 days. Medicare pays $0. Plan pays 100 percent of medicare eligible expenses. You pay $0. **NOTICE:** When your medicare part A hospital benefits are exhausted, the insurer stands in the place of medicare and will pay whatever amount medicare would have paid for up to an additional 365 days as provided in the policy's "core benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount medicare would have paid.

(e) 91st day and after - beyond the additional 365 days. Medicare pays $0. Plan pays $0. You pay all costs.

(2) Skilled Nursing Facility Care. A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row. You must meet medicare's requirements, including having been in a hospital for at least 3 days and entered a medicare-approved facility within 30 days after leaving the hospital.

(a) First 20 days. Medicare pays all approved amounts. Plan pays $0. You pay $0.

(b) 21st through 100th day. Medicare pays all but $(109.50) a day. Plan pays $0. You pay up to $(109.50) a day.

(c) 101st day and after. Medicare pays $0. Plan pays $0. You pay all costs.

(3) Blood.

(a) First 3 pints. Medicare pays $0. Plan pays 3 pints. You pay $0.

(b) Additional amounts. Medicare pays 100 percent. Plan pays $0. You pay $0.

(4) Hospice Care. Available as long as your doctor certifies you are terminally ill and you elect to receive these services. Medicare pays all but very limited coinsurance for outpatient drugs and inpatient respite care. Plan pays $0. You pay balance.

B. PLAN A (CONTINUED): MEDICARE (PART B) SERVICES PER CALENDAR YEAR. Once you have been billed $(100) of medicare-approved amounts for covered services (which are noted with an asterisk), your part B deductible will have been met for the calendar year.

(1) Medical expenses. In or out of the hospital and outpatient hospital treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.

(a) First $(100) of medicare approved amounts (asterisk). Medicare pays $0. Plan pays $0. You pay $(100) (part B deductible).

(b) Remainder of medicare approved amounts. Medicare pays generally 80 percent. Plan pays generally 20 percent. You pay $0.

(c) Part B excess charges (above medicare approved amounts). Medicare pays $0. Plan pays $0. You pay all costs.

(2) Blood.

(a) First 3 pints. Medicare pays $0. Plan pays all costs. You pay $0.

(b) Next $(100) of medicare approved amounts (asterisk). Medicare pays $0. Plan pays $0. You pay $(100) (part B deductible).

(c) Remainder of medicare approved amounts. Medicare pays 80 percent. Plan pays 20 percent. You pay $0.

(3) Clinical laboratory services. Tests for diagnostic services. Medicare pays 100 percent. Plan pays $0. You pay $0.

C. PLAN A (CONTINUED): PARTS A AND B. Home health care. Medicare approved services. Once you have been billed $(100) of medicare-approved amounts for covered services (which are noted with an asterisk), your part B deductible will have been met for the calendar year.

(1) Medically necessary skilled care services and medical supplies. Medicare pays 100 percent. Plan pays $0. You pay $0.

(2) Durable medical equipment.

(a) First $(100) of medicare approved amounts (asterisk). Medicare pays $0. Plan pays $0. You pay $(100) (part B deductible).

(b) Remainder of medicare approved amounts. Medicare pays 80 percent. Plan pays 20 percent. You pay $0.

[13.10.8.61 NMAC - Rp, 13.10.8.59 NMAC, 1-1-06]

13.10.8.62 PLAN B: The following language shall be used in the order prescribed below. A sample form is posted on the public regulation commission, insurance division website, www.nmprc.state.nm.us, at "insurance," then "life and health."

A. PLAN B: MEDICARE (PART A) HOSPITAL SERVICES PER BENEFIT PERIOD.

(1) Hospitalization. A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row. Semiprivate room and board, general nursing and miscellaneous services and supplies.

(a) First 60 days. Medicare pays all but $(876). Plan pays $(876) (part A deductible). You pay $0.

(b) 61st through 90th day. Medicare pays all but $(219) a day. Plan pays $(219) a day. You pay $0.

(c) 91st day and after - while using 60 lifetime reserve days. Medicare pays all but $(438) a day. Plan pays $(438) a day. You pay $0.

(d) 91st day and after - once lifetime reserve days are used. Additional 365 days. Medicare pays $0. Plan pays 100 percent of medicare eligible expenses. You

pay $0. **NOTICE:** When your medicare part A hospital benefits are exhausted, the insurer stands in the place of medicare and will pay whatever amount medicare would have paid for up to an additional 365 days as provided in the policy's "core benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount medicare would have paid.

(e) 91st day and after - beyond the additional 365 days. Medicare pays $0. Plan pays $0. You pay all costs.

(2) Skilled Nursing Facility Care. A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row. You must meet medicare's requirements, including having been in a hospital for at least 3 days and entered a medicare-approved facility within 30 days after leaving the hospital.

(a) First 20 days. Medicare pays all approved amounts. Plan pays $0. You pay $0.

(b) 21st through 100th day. Medicare pays all but $(109.50) a day. Plan pays $0. You pay up to $(109.50) a day.

(c) 101st day and after. Medicare pays $0. Plan pays $0. You pay all costs.

(3) Blood.

(a) First 3 pints. Medicare pays $0. Plan pays 3 pints. You pay $0.

(b) Additional amounts. Medicare pays 100 percent. Plan pays $0. You pay $0.

(4) Hospice Care. Available as long as your doctor certifies you are terminally ill and you elect to receive these services. Medicare pays all but very limited coinsurance for outpatient drugs and inpatient respite care. Plan pays $0. You pay balance.

B. PLAN B (CONTINUED): MEDICARE (PART B) SERVICES PER CALENDAR YEAR. Once you have been billed $(100) of medicare-approved amounts for covered services (which are noted with an asterisk), your part B deductible will have been met for the calendar year.

(1) Medical expenses. In or out of the hospital and outpatient hospital treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.

(a) First $(100) of medicare approved amounts (asterisk). Medicare pays $0. Plan pays $0. You pay $(100) (part B deductible).

(b) Remainder of medicare approved amounts. Medicare pays generally 80 percent. Plan pays generally 20 percent. You pay $0.

(c) Part B excess charges (above medicare approved amounts). Medicare pays $0. Plan pays $0. You pay all costs.

(2) Blood.

(a) First 3 pints. Medicare pays $0. Plan pays all costs. You pay $0.

(b) Next $(100) of medicare approved amounts (asterisk). Medicare pays $0. Plan pays $0. You pay $(100) (part B deductible).

(c) Remainder of medicare approved amounts. Medicare pays 80 percent. Plan pays 20 percent. You pay $0.

(3) Clinical laboratory services. Tests for diagnostic services. Medicare pays 100 percent. Plan pays $0. You pay $0.

C. PLAN B (CONTINUED): PARTS A AND B. Home health care. Medicare approved services. Once you have been billed $(100) of medicare-approved amounts for covered services (which are noted with an asterisk), your part B deductible will have been met for the calendar year.

(1) Medically necessary skilled care services and medical supplies. Medicare pays 100 percent. Plan pays $0. You pay $0.

(2) Durable medical equipment.

(a) First $(100) of medicare approved amounts (asterisk). Medicare pays $0. Plan pays $0. You pay $(100) (part B deductible).

(b) Remainder of medicare approved amounts. Medicare pays 80 percent. Plan pays 20 percent. You pay $0.

[13.10.8.62 NMAC - Rp, 13.10.8.60 NMAC, 1-1-06]

13.10.8.63 PLAN C: The following language shall be used in the order prescribed below. A sample form is posted on the public regulation commission, insurance division website, www.nmprc.state.nm.us, at "insurance," then "life and health."

A. PLAN C: MEDICARE (PART A) HOSPITAL SERVICES PER BENEFIT PERIOD.

(1) Hospitalization. A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row. Semiprivate room and board, general nursing and miscellaneous services and supplies.

(a) First 60 days. Medicare pays all but $(876). Plan pays $(876) (part A deductible). You pay $0.

(b) 61st through 90th day. Medicare pays all but $(219) a day. Plan pays $(219) a day. You pay $0.

(c) 91st day and after - while using 60 lifetime reserve days. Medicare pays all but $(438) a day. Plan pays $(438) a day. You pay $0.

(d) 91st day and after - once lifetime reserve days are used. Additional 365 days. Medicare pays $0. Plan pays 100 percent of medicare eligible expenses. You pay $0. **NOTICE:** When your medicare part A hospital benefits are exhausted, the insurer stands in the place of medicare and will pay whatever amount medicare would have paid for up to an additional 365 days as provided in the policy's "core benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount medicare would have paid.

(e) 91st day and after - beyond the additional 365 days. Medicare pays $0. Plan pays $0. You pay all costs.

(2) Skilled Nursing Facility Care. A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row. You must meet medicare's requirements, including having been in a hospital for at least 3 days and entered a medicare-approved facility within 30 days after leaving the hospital.

(a) First 20 days. Medicare pays all approved amounts. Plan pays $0. You pay $0.

(b) 21st through 100th day. Medicare pays all but $(109.50) a day. Plan pays $0. You pay up to $(109.50) a day.

(c) 101st day and after. Medicare pays $0. Plan pays $0. You pay all costs.

(3) Blood.

(a) First 3 pints. Medicare pays $0. Plan pays 3 pints. You pay $0.

(b) Additional amounts. Medicare pays 100 percent. Plan pays $0. You pay $0.

(4) Hospice Care. Available as long as your doctor certifies you are terminally ill and you elect to receive these services. Medicare pays all but very limited coinsurance for outpatient drugs and inpatient respite care. Plan pays $0. You pay balance.

B. PLAN C (CONTINUED): MEDICARE (PART B) SERVICES PER CALENDAR YEAR. Once you have been billed $(100) of medicare-approved amounts for services (which are noted with an asterisk), your part B deductible will have been met for the calendar year.

(1) Medical expenses. In or out of the hospital and outpatient hospital treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy,

diagnostic tests, durable medical equipment.

(a) First $(100) of medicare approved amounts (asterisk). Medicare pays $0. Plan pays $(100) (part B deductible). You pay $0.

(b) Remainder of medicare approved amounts. Medicare pays generally 80 percent. Plan pays generally 20 percent. You pay $0.

(c) Part B excess charges (above medicare approved amounts). Medicare pays $0. Plan pays $0. You pay all costs.

(2) Blood.

(a) First 3 pints. Medicare pays $0. Plan pays all costs. You pay $0.

(b) Next $(100) of medicare approved amounts (asterisk). Medicare pays $0. Plan pays $(100) (part B deductible). You pay $0.

(c) Remainder of medicare approved amounts. Medicare pays 80 percent. Plan pays 20 percent. You pay $0.

(3) Clinical laboratory services. Tests for diagnostic services. Medicare pays 100 percent. Plan pays $0. You pay $0.

C. PLAN C (CONTINTUED): PARTS A AND B. Home health care. Medicare approved services. Once you have been billed $(100) of medicare-approved amounts for covered services (which are noted with an asterisk), your part B deductible will have been met for the calendar year.

(1) Medically necessary skilled care services and medical supplies. Medicare pays 100 percent. Plan pays $0. You pay $0.

(2) Durable medical equipment.

(a) First $(100) of medicare approved amounts (asterisk). Medicare pays $0. Plan pays $(100) part B deductible). You pay $0.

(b) Remainder of medicare approved amounts. Medicare pays 80 percent. Plan pays 20 percent. You pay $0.

D. PLAN C (CONTINUED): OTHER BENEFITS NOT COVERED BY MEDICARE: Foreign travel not covered by medicare. Medically necessary emergency care services beginning during the first 60 days of each trip outside the United States of America.

(1) First $250 each calendar year. Medicare pays $0. Plan Pays $0. You pay $250.

(2) Remainder of charges. Medicare pays $0. Plan pays 80 percent to a lifetime maximum benefit of $50,000. You pay 20 percent and amounts over the $50,000 lifetime maximum.

[13.10.8.63 NMAC - Rp, 13.10.8.61 NMAC, 1-1-06]

13.10.8.64 PLAN D. The following language shall be used in the order prescribed below. A sample form is posted on the public regulation commission, insurance division website, www.nmprc.state.nm.us, at "insurance," then "life and health."

A. PLAN D: MEDICARE (PART A) HOSPITAL SERVICES PER BENEFIT PERIOD.

(1) Hospitalization. A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row. Semiprivate room and board, general nursing and miscellaneous services and supplies.

(a) First 60 days. Medicare pays all but $(876). Plan pays $(876) (part A deductible). You pay $0.

(b) 61st through 90th day. Medicare pays all but $(219) a day. Plan pays $(219) a day. You pay $0.

(c) 91st day and after - while using 60 lifetime reserve days. Medicare pays all but $(438) a day. Plan pays $(438) a day. You pay $0.

(d) 91st day and after - once lifetime reserve days are used. Additional 365 days. Medicare pays $0. Plan pays 100 percent of medicare eligible expenses. You pay $0. **NOTICE:** When your medicare part A hospital benefits are exhausted, the insurer stands in the place of medicare and will pay whatever amount medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount medicare would have paid.

(e) 91st day and after - beyond the additional 365 days. Medicare pays $0. Plan pays $0. You pay all costs.

(2) Skilled Nursing Facility Care. A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row. You must meet medicare's requirements, including having been in a hospital for at least 3 days and entered a medicare-approved facility within 30 days after leaving the hospital.

(a) First 20 days. Medicare pays all approved amounts. Plan pays $0. You pay $0.

(b) 21st through 100th day. Medicare pays all but $(109.50) a day. Plan pays up to $(109.50) a day. You pay $0.

(c) 101st day and after. Medicare pays $0. Plan pays $0. You pay all costs.

(3) Blood.

(a) First 3 pints. Medicare pays $0. Plan pays 3 pints. You pay $0.

(b) Additional amounts. Medicare pays 100 percent. Plan pays $0. You pay $0.

(4) Hospice Care. Available as long as your doctor certifies you are terminally ill and you elect to receive these services. Medicare pays all but very limited coinsurance for outpatient drugs and inpatient respite care. Plan pays $0. You pay balance.

B. PLAN D (CONTINUED): MEDICARE (PART B) SERVICES PER CALENDAR YEAR. Once you have been billed $(100) of medicare-approved amounts for covered services (which are noted with an asterisk), your part B deductible will have been met for the calendar year.

(1) Medical expenses. In or out of the hospital and outpatient hospital treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.

(a) First $(100) of medicare approved amounts (asterisk). Medicare pays $0. Plan pays $0. You pay $(100) (part B deductible).

(b) Remainder of medicare approved amounts. Medicare pays generally 80 percent. Plan pays generally 20 percent. You pay $0.

(c) Part B excess charges (above medicare approved amounts). Medicare pays $0. Plan pays $0. You pay all costs.

(2) Blood.

(a) First 3 pints. Medicare pays $0. Plan pays all costs. You pay $0.

(b) Next $(100) of medicare approved amounts (asterisk). Medicare pays $0. Plan pays $0. You pay $(100) (part B deductible).

(c) Remainder of medicare approved amounts. Medicare pays 80 percent. Plan pays 20 percent. You pay $0.

(3) Clinical laboratory services. Tests for diagnostic services. Medicare pays 100 percent. Plan pays $0. You pay $0.

C. PLAN D (CONTINUED): PARTS A AND B. Home health care. Once you have been billed $(100) of medicare-approved amounts for covered services (which are noted with an asterisk), your part B deductible will have been met for the calendar year

(1) Medicare approved services.

(a) Medically necessary skilled care services and medical supplies. Medicare pays 100 percent. Plan pays $0. You pay $0.

(b) Durable medical equipment. First $(100) of medicare approved amounts (asterisk): medicare pays $0; plan pays $0; and you pay $(100) (part B deductible). Remainder of medicare approved amounts: medicare pays 80 percent; plan pays 20 per-

cent and you pay $0.

(2) At-home recovery services not covered by medicare. Home care certified by your doctor, for personal care during recovery from an injury or sickness for which medicare approved a home care treatment plan.

(a) Benefit for each visit. Medicare pays $0. Plan pays actual charges to $40 a visit. You pay balance.

(b) Number of visits covered (must be received within 8 weeks of last medicare approved visit). Medicare pays $0. Plan pays up to the number of medicare approved visits, not to exceed 7 each week.

(c) Calendar year maximum. Medicare pays $0. Plan pays $1,000.

D. PLAN D (CONTINUED): OTHER BENEFITS NOT COVERED BY MEDICARE: Foreign travel not covered by Medicare. Medically necessary emergency care services beginning during the first 60 days of each trip outside the United States of America.

(1) First $250 each calendar year. Medicare pays $0. Plan Pays $0. You pay $250.

(2) Remainder of charges. Medicare pays $0. Plan pays 80 percent to a lifetime maximum benefit of $50,000. You pay 20 percent and amounts over the $50,000 lifetime maximum.

[13.10.8.64 NMAC - Rp, 13.10.8.62 NMAC, 1-1-06]

13.10.8.65 PLAN E. The following language shall be used in the order prescribed below. A sample form is posted on the public regulation commission, insurance division website, www.nmprc.state.nm.us, at "insurance," then "life and health."

A. PLAN E: MEDICARE (PART A) HOSPITAL SERVICES PER BENEFIT PERIOD.

(1) Hospitalization. A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row. Semiprivate room and board, general nursing and miscellaneous services and supplies.

(a) First 60 days. Medicare pays all but $(876). Plan pays $(876) (part A deductible). You pay $0.

(b) 61st through 90th day. Medicare pays all but $(219) a day. Plan pays $(219) a day. You pay $0.

(c) 91st day and after - while using 60 lifetime reserve days. Medicare pays all but $(438) a day. Plan pays $(438) a day. You pay $0.

(d) 91st day and after - once lifetime reserve days are used. Additional 365 days. Medicare pays $0. Plan pays 100 percent of medicare eligible expenses. You pay $0. **NOTICE:** When your medicare part A hospital benefits are exhausted, the insurer stands in the place of medicare and will pay whatever amount medicare would have paid for up to an additional 365 days as provided in the policy's "core benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount medicare would have paid.

(e) 91st day and after - beyond the additional 365 days. Medicare pays $0. Plan pays $0. You pay all costs.

(2) Skilled Nursing Facility Care. A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row. You must meet medicare's requirements, including having been in a hospital for at least 3 days and entered a medicare-approved facility within 30 days after leaving the hospital.

(a) First 20 days. Medicare pays all approved amounts. Plan pays $0. You pay $0.

(b) 21st through 100th day. Medicare pays all but $(109.50) a day. Plan pays up to $(109.50) a day. You pay $0.

(c) 101st day and after. Medicare pays $0. Plan pays $0; You pay all costs.

(3) Blood.

(a) First 3 pints. Medicare pays $0. Plan pays 3 pints. You pay $0.

(b) Additional amounts. Medicare pays 100 percent. Plan pays $0. You pay $0.

(4) Hospice Care. Available as long as your doctor certifies you are terminally ill and you elect to receive these services. Medicare pays all but very limited coinsurance for outpatient drugs and inpatient respite care. Plan pays $0. You pay balance.

B. PLAN E (CONTINUED): MEDICARE (PART B) SERVICES PER CALENDAR YEAR. Once you have been billed $(100) of medicare-approved amounts for covered services (which are noted with an asterisk), your part B deductible will have been met for the calendar year.

(1) Medical expenses. In or out of the hospital and outpatient hospital treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.

(a) First $(100) of medicare approved amounts (asterisk). Medicare pays $0. Plan pays $0. You pay $(100) (part B deductible).

(b) Remainder of medicare approved amounts. Medicare pays generally 80 percent. Plan pays generally 20 percent. You pay $0.

(c) Part B excess charges (above medicare approved amounts). Medicare pays $0. Plan pays $0. You pay all costs.

(2) Blood.

(a) First 3 pints. Medicare pays $0. Plan pays all costs. You pay $0.

(b) Next $(100) of medicare approved amounts (asterisk). Medicare pays $0. Plan pays $0. You pay $(100) (part B deductible).

(c) Remainder of medicare approved amounts. Medicare pays 80 percent. Plan pays 20 percent. You pay $0.

(3) Clinical laboratory services. Tests for diagnostic services. Medicare pays 100 percent. Plan pays $0. You pay $0.

C. PLAN E (CONTINUED): PARTS A AND B. Home health care. Medicare approved services. Once you have been billed $(100) of medicare-approved amounts for covered services (which are noted with an asterisk), your part B deductible will have been met for the calendar year.

(1) Medically necessary skilled care services and medical supplies. Medicare pays 100 percent. Plan pays $0. You pay $0.

(2) Durable medical equipment.

(a) First $(100) of medicare approved amounts (asterisk). Medicare pays $0. Plan pays $0. You pay $(100) (part B deductible).

(b) Remainder of medicare approved amounts. Medicare pays 80 percent. Plan pays 20 percent. You pay $0.

D. PLAN E (CONTINUED): OTHER BENEFITS NOT COVERED BY MEDICARE:

(1) Foreign travel not covered by Medicare. Medically necessary emergency care services beginning during the first 60 days of each trip outside the United States of America.

(a) First $250 each calendar year. Medicare pays $0. Plan Pays $0. You pay $250.

(b) Remainder of charges. Medicare pays $0. Plan pays 80 percent to a lifetime maximum benefit of $50,000. You pay 20 percent and amounts over the $50,000 lifetime maximum.

(2) Preventative medical care benefit not covered by medicare. Medicare benefits are subject to change. Please consult the latest *guide to health insurance for people with medicare.* Some annual physical and preventive tests administered or ordered by your doctor when not covered by medicare.

(a) First $120 each calendar year. Medicare pays $0. Plan pays $120. You

pay $0.

(b) Additional charges. Medicare pays $0. Plan pays $0. You pay all costs. [13.10.8.65 NMAC - Rp, 13.10.8.63 NMAC, 1-1-06]

13.10.8.66 PLAN F OR HIGH DEDUCTIBLE PLAN F. The following language shall be used in the order prescribed below. A sample form is posted on the public regulation commission, insurance division website, www.nmprc.state.nm.us, at "insurance," then "life and health." **This high deductible plan F pays the same benefits as plan F after one has paid a calendar year $(1690) deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are $(1690). Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the medicare deductibles for part A and part B, but does not include the plan's separate foreign travel emergency deductible.**

A. PLAN F OR HIGH DEDUCTIBLE PLAN F: MEDICARE (PART A) HOSPITAL SERVICES PER BENEFIT PERIOD

(1) Hospitalization. A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row. Semiprivate room and board, general nursing and miscellaneous services and supplies.

(a) First 60 days. Medicare pays all but $(876). (After you pay $(1,690) deductible,) plan pays $(876) (part A deductible). (In addition to $(1,690) deductible,) you pay $0.

(b) 61st through 90th day. Medicare pays all but $(219) a day. (After you pay $(1690) deductible,) plan pays $(219) a day. (In addition to $(1690) deductible,) you pay $0.

(c) 91st day and after - while using 60 lifetime reserve days. Medicare pays all but $(438) a day. (After you pay $(1690) deductible,) plan pays $(438) a day. (In addition to $(1690) deductible,] you pay $0.

(d) 91st day and after - once lifetime reserve days are used. Additional 365 days.) Medicare pays $0. (After you pay $(1690) deductible,) plan pays 100 percent of medicare eligible expenses. (In addition to $(1690) deductible,) you pay $0. **NOTICE:** When your medicare part A hospital benefits are exhausted, the insurer stands in the place of medicare and will pay whatever amount medicare would have paid for up to an additional 365 days as provided in the policy's "core benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount medicare would have paid.

(e) 91st day and after - beyond the additional 365 days. Medicare pays $0. (After you pay $(1690) deductible,) plan pays $0. (In addition to $(1690) deductible,) you pay all costs.

(2) Skilled Nursing Facility Care. A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row. You must meet medicare's requirements, including having been in a hospital for at least 3 days and entered a medicare-approved facility within 30 days after leaving the hospital.

(a) First 20 days. Medicare pays all approved amounts. (After you pay $(1690) deductible,) plan pays $0. (In addition to $(1690) deductible,) you pay $0.

(b) 21st through 100th day. Medicare pays all but $(109.50) a day. (After you pay $(1690) deductible,) plan pays up to $(109.50) a day. (In addition to $(1690) deductible,) you pay $0.

(c) 101st day and after. Medicare pays $0. (After you pay $(1690) deductible,) plan pays $0. (In addition to $(1690) deductible,) you pay all costs.

(3) Blood.

(a) First 3 pints. Medicare pays $0. (After you pay $(1690) deductible,) plan pays 3 pints. (In addition to $(1690) deductible,) you pay $0.

(b) Additional amounts. Medicare pays 100 percent. (After you pay $(1690) deductible,) plan pays $0. (In addition to $(1690) deductible,) you pay $0.

(4) Hospice Care. Available as long as your doctor certifies you are terminally ill and you elect to receive these services. Medicare pays all but very limited coinsurance for outpatient drugs and inpatient respite care. (After you pay $(1690) deductible,) plan pays $0. (In addition to $(1690) deductible,) you pay balance.

B. PLAN F OR HIGH DEDUCTIBLE PLAN F (CONTINUED): MEDICARE (PART B) SERVICES PER CALENDAR YEAR. Once you have been billed $(100) of medicare-approved amounts for covered services (which are noted with an asterisk), your part B deductible will have been met for the calendar year.

(1) Medical expenses. In or out of the hospital and outpatient hospital treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.

(a) First $(100) of medicare approved amounts (asterisk). Medicare pays $0. (After you pay $(1690) deductible,) plan pays $(100) (part B deductible). (In addition to $(1690) deductible,) you pay $0.

(b) Remainder of medicare approved amounts. Medicare pays generally 80 percent. (After you pay $(1690) deductible,) plan pays generally 20 percent. (In addition to $(1690) deductible,) you pay $0.

(c) Part B excess charges (above medicare approved amounts). Medicare pays $0. (After you pay $(1690) deductible,) plan pays 100 percent. (In addition to $(1690) deductible,) you pay $0.

(2) Blood.

(a) First 3 pints. Medicare pays $0. (After you pay $(1690) deductible,) plan pays all costs. (In addition to $(1690) deductible,) you pay $0.

(b) Next $(100) of medicare approved amounts (asterisk). Medicare pays $0. (After you pay $(1690) deductible,) plan pays $(100) (part B deductible). (In addition to $(1690) deductible,) you pay $0.

(c) Remainder of medicare approved amounts. Medicare pays generally 80 percent. (After you pay $(1690) deductible,) plan pays generally 20 percent. (In addition to $(1690) deductible,) you pay $0.

(3) Clinical laboratory services. Tests for diagnostic services. Medicare pays 100 percent. (After you pay $(1690) deductible,) plan pays $0. (In addition to $(1690) deductible,) you pay $0.

C. PLAN F OR HIGH DEDUCTIBLE PLAN F (CONTINUED): PARTS A AND B. Home health care. Medicare approved services. Once you have been billed $(100) of medicare-approved amounts for covered services (which are noted with an asterisk), your part B deductible will have been met for the calendar year.

(1) Medically necessary skilled care services and medical supplies. Medicare pays 100 percent. (After you pay $(1690) deductible,) plan pays $0. (In addition to $(16900 deductible,) you pay $0.

(2) Durable medical equipment.

(a) First $(100) of medicare approved amounts (asterisk). Medicare pays $0. (After you pay $(1690) deductible,) plan pays $(100) (part B deductible). (In addition to $(1690) deductible,) you pay $0.

(b) Remainder of medicare approved amounts. Medicare pays 80 percent. (After you pay $(1690) deductible,) plan pays 20 percent. (In addition to $(1690) deductible,) you pay $0.

D. PLAN F OR HIGH DEDUCTIBLE PLAN F (CONTINUED): OTHER BENEFITS NOT COV-

ERED BY MEDICARE. **Foreign travel not covered by Medicare**. Medically necessary emergency care services beginning during the first 60 days of each trip outside the United States of America.

(1) First $250 each calendar year. Medicare pays $0. (After you pay $(1690) deductible,) plan pays $0. (In addition to $(1690) deductible,) you pay $250.

(2) Remainder of charges. Medicare pays $0. (After you pay $(1690) deductible,) plan pays 80 percent to a lifetime maximum benefit of $50,000. (In addition to $(1690) deductible,) you pay 20 percent and amounts over the $50,000 lifetime maximum.

[13.10.8.66 NMAC - Rp, 13.10.8.64 NMAC, 1-1-06]

13.10.8.67 PLAN G. The following language shall be used in the order prescribed below. A sample form is posted on the public regulation commission, insurance division website, www.nmprc.state.nm.us, at "insurance," then "life and health."

A. PLAN G: MEDICARE (PART A) HOSPITAL SERVICES PER BENEFIT PERIOD.

(1) Hospitalization. A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row. Semiprivate room and board, general nursing and miscellaneous services and supplies.

(a) First 60 days. Medicare pays all but $(876). Plan pays $(876) (part A deductible). You pay $0.

(b) 61st through 90th day. Medicare pays all but $(219) a day. Plan pays $(219) a day. You pay $0.

(c) 91st day and after - while using 60 lifetime reserve days. Medicare pays all but $(438) a day. Plan pays $(438) a day. You pay $0.

(d) 91st day and after - once lifetime reserve days are used. Additional 365 days. Medicare pays $0. Plan pays 100 percent of medicare eligible expenses. You pay $0. **NOTICE:** When your medicare part A hospital benefits are exhausted, the insurer stands in the place of medicare and will pay whatever amount medicare would have paid for up to an additional 365 days as provided in the policy's "core benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount medicare would have paid.

(e) 91st day and after - beyond the additional 365 days. Medicare pays $0. Plan pays $0. You pay all costs.

(2) Skilled Nursing Facility Care. A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row. You must meet medicare's requirements, including having been in a hospital for at least 3 days and entered a medicare-approved facility within 30 days after leaving the hospital.

(a) First 20 days. Medicare pays all approved amounts. Plan pays $0. You pay $0.

(b) 21st through 100th day. Medicare pays all but $(109.50) a day. Plan pays up to $(109.50) a day. You pay $0.

(c) 101st day and after. Medicare pays $0. Plan pays $0. You pay all costs.

(3) Blood.

(a) First 3 pints. Medicare pays $0. Plan pays 3 pints. You pay $0.

(b) Additional amounts. Medicare pays 100 percent. Plan pays $0. You pay $0.

(4) Hospice Care. Available as long as your doctor certifies you are terminally ill and you elect to receive these services. Medicare pays all but very limited coinsurance for outpatient drugs and inpatient respite care. Plan pays $0. You pay balance.

B. PLAN G (CONTINUED): MEDICARE (PART B) SERVICES PER CALENDAR YEAR. Once you have been billed $(100) of medicare-approved amounts for covered services (which are noted with an asterisk), your part B deductible will have been met for the calendar year.

(1) Medical expenses. In or out of the hospital and outpatient hospital treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.

(a) First $(100) of medicare approved amounts (asterisk). Medicare pays $0. Plan pays $0. You pay $(100) (part B deductible).

(b) Remainder of medicare approved amounts. Medicare pays generally 80 percent. Plan pays generally 20 percent. You pay $0.

(c) Part B excess charges (above medicare approved amounts). Medicare pays $0. Plan pays 80 percent. You pay 20 percent.

(2) Blood.

(a) First 3 pints. Medicare pays $0. Plan pays all costs. You pay $0.

(b) Next $[100] of medicare approved amounts (asterisk). Medicare pays $0. Plan pays $0. You pay $(100) (part B deductible).

(c) Remainder of medicare approved amounts. Medicare pays 80 percent. Plan pays 20 percent. You pay $0.

(3) Clinical laboratory services. Tests for diagnostic services. Medicare pays 100 percent. Plan pays $0. You pay $0.

C. PLAN G (CONTINUED): PARTS A AND B. Home health care. Once you have been billed $(100) of medicare-approved amounts for covered services (which are noted with an asterisk), your part B deductible will have been met for the calendar year.

(1) Medicare approved services.

(a) Medically necessary skilled care services and medical supplies. Medicare pays 100 percent. Plan pays $0. You pay $0.

(b) Durable medical equipment. First $(100) of medicare approved amounts (asterisk), your part B deductible will have been met for the calendar year: medicare pays $0; plan pays $0; and you pay $(100) (part B deductible). Remainder of medicare approved amounts: medicare pays 80 percent; plan pays 20 percent; and you pay $0.

(2) At-home recovery services not covered by medicare. Home care certified by your doctor, for personal care during recovery from an injury or sickness for which medicare approved a home care treatment plan.

(a) Benefit for each visit. Medicare pays $0. Plan pays actual charges to $40 a visit. You pay balance.

(b) Number of visits covered (must be received within 8 weeks of last medicare approved visit). Medicare pays $0. Plan pays up to the number of medicare approved visits, not to exceed 7 each week.

(c) Calendar year maximum. Medicare pays $0. Plan pays $1,600.

D. PLAN G (CONTINUED): OTHER BENEFITS NOT COVERED BY MEDICARE: Foreign travel not covered by Medicare. Medically necessary emergency care services beginning during the first 60 days of each trip outside the United States of America.

(1) First $250 each calendar year. Medicare pays $0. Plan Pays $0. You pay $250.

(2) Remainder of charges. Medicare pays $0. Plan pays 80 percent to a lifetime maximum benefit of $50,000. You pay 20 percent and amounts over the $50,000 lifetime maximum.

[13.10.8.67 NMAC - Rp, 13.10.8.65 NMAC, 1-1-06]

13.10.8.68 PLAN H. The following language shall be used in the order prescribed below. A sample form is posted on the public regulation commission, insurance division website, www.nmprc.state.nm.us, at "insurance," then "life and health."

A. PLAN H:

MEDICARE (PART A) HOSPITAL SERVICES PER BENEFIT PERIOD.

(1) Hospitalization. A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row. Semiprivate room and board, general nursing and miscellaneous services and supplies.

(a) First 60 days. Medicare pays all but $(876). Plan pays $(876) (part A deductible). You pay $0.

(b) 61st through 90th day. Medicare pays all but $(219) a day. Plan pays $(219) a day. You pay $0

(c) 91st day and after - while using 60 lifetime reserve days. Medicare pays all but $(438) a day. Plan pays $(438) a day. You pay $0.

(d) 91st day and after - once lifetime reserve days are used. Additional 365 days. Medicare pays $0. Plan pays 100 percent of medicare eligible expenses. You pay $0. **NOTICE:** When your medicare part A hospital benefits are exhausted, the insurer stands in the place of medicare and will pay whatever amount medicare would have paid for up to an additional 365 days as provided in the policy's "core benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount medicare would have paid.

(e) 91st day and after - beyond the additional 365 days. Medicare pays $0. Plan pays $0. You pay all costs.

(2) Skilled Nursing Facility Care. A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row. You must meet medicare's requirements, including having been in a hospital for at least 3 days and entered a medicare-approved facility within 30 days after leaving the hospital.

(a) First 20 days. Medicare pays all approved amounts. Plan pays $0. You pay $0.

(b) 21st through 100th day. Medicare pays all but $(109.50) a day. Plan pays up to $(109.50) a day. You pay $0.

(c) 101st day and after. Medicare pays $0. Plan pays $0. You pay all costs.

(3) Blood.

(a) First 3 pints. Medicare pays $0. Plan pays 3 pints. You pay $0.

(b) Additional amounts. Medicare pays 100 percent. Plan pays $0. You pay $0.

(4) Hospice Care. Available as long as your doctor certifies you are terminally ill and you elect to receive these services. Medicare pays all but very limited coinsurance for outpatient drugs and inpatient respite care. Plan pays $0. You pay balance.

B. PLAN H (CONTINUED): MEDICARE (PART B) SERVICES PER CALENDAR YEAR. Once you have been billed $(100) of medicare-approved amounts for covered services (which are noted with an asterisk), your part B deductible will have been met for the calendar year.

(1) Medical expenses. In or out of the hospital and outpatient hospital treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.

(a) First $(100) of medicare approved amounts (asterisk). Medicare pays $0. Plan pays $0. You pay $(100) (part B deductible).

(b) Remainder of medicare approved amounts. Medicare pays generally 80 percent. Plan pays generally 20 percent. You pay $0.

(c) Part B excess charges (above medicare approved amounts). Medicare pays $0. Plan pays $0. You pay all costs.

(2) Blood.

(a) First 3 pints. Medicare pays $0. Plan pays all costs. You pay $0.

(b) Next $(100) of medicare approved amounts. Once you have been billed $100 of Medicare-approved amounts for covered medical expenses, your part B deductible will have been met for the calendar year. Medicare pays $0. Plan pays $0. You pay $(100) (part B deductible).

(c) Remainder of medicare approved amounts. Medicare pays 80 percent. Plan pays 20 percent. You pay $0.

(3) Clinical laboratory services. Tests for diagnostic services. Medicare pays 100 percent. Plan pays $0. You pay $0.

C. PLAN H (CONTINUED): PARTS A AND B. Home health care. Medicare approved services. Once you have been billed $(100) of medicare-approved amounts for covered services (which are noted with an asterisk), your part B deductible will have been met for the calendar year.

(1) Medically necessary skilled care services and medical supplies. Medicare pays 100 percent. Plan pays $0. You pay $0.

(2) Durable medical equipment.

(a) First $(100) of medicare approved amounts (asterisk). Medicare pays $0. Plan pays $0. You pay $(100) part B deductible).

(b) Remainder of medicare approved amounts. Medicare pays 80 percent. Plan pays 20 percent. You pay $0.

D. PLAN H (CONTINUED): OTHER BENEFITS NOT COVERED BY MEDICARE: Foreign travel not covered by Medicare. Medically necessary emergency care services beginning during the first 60 days of each trip outside the United States of America.

(1) First $250 each calendar year. Medicare pays $0. Plan Pays $0. You pay $250.

(2) Remainder of charges. Medicare pays $0. Plan pays 80 percent to a lifetime maximum benefit of $50,000. You pay 20 percent and amounts over the $50,000 lifetime maximum.

[13.10.8.68 NMAC - Rp, 13.10.8.66 NMAC, 1-1-06]

13.10.8.69 PLAN I. The following language shall be used in the order prescribed below. A sample form is posted on the public regulation commission, insurance division website, www.nmprc.state.nm.us, at "insurance," then life and health."

A. PLAN I: MEDICARE (PART A) HOSPITAL SERVICES PER BENEFIT PERIOD.

(1) Hospitalization. A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row. Semiprivate room and board, general nursing and miscellaneous services and supplies.

(a) First 60 days. Medicare pays all but $(876). Plan pays $(876) (part A deductible). You pay $0.

(b) 61st through 90th day. Medicare pays all but $(219) a day. Plan pays $(219) a day. You pay $0.

(c) 91st day and after - while using 60 lifetime reserve days. Medicare pays all but $(438) a day. Plan pays $(438) a day. You pay $0.

(d) 91st day and after - once lifetime reserve days are used. Additional 365 days. Medicare pays $0. Plan pays 100 percent of medicare eligible expenses. You pay $0. **NOTICE:** When your medicare part A hospital benefits are exhausted, the insurer stands in the place of medicare and will pay whatever amount medicare would have paid for up to an additional 365 days as provided in the policy's "core benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount medicare would have paid.

(e) 91st day and after - beyond the additional 365 days. Medicare pays $0. Plan pays $0. You pay all costs.

(2) Skilled Nursing Facility Care. A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of

the hospital and have not received skilled care in any other facility for 60 days in a row. You must meet medicare's requirements, including having been in a hospital for at least 3 days and entered a medicare-approved facility within 30 days after leaving the hospital.

(a) First 20 days. Medicare pays all approved amounts. Plan pays $0. You pay $0.

(b) 21st through 100th day. Medicare pays all but $(109.50) a day. Plan pays up to $(109.50) a day. You pay $0.

(c) 101st day and after. Medicare pays $0. Plan pays $0. You pay all costs.

(3) Blood.

(a) First 3 pints. Medicare pays $0. Plan pays 3 pints. You pay $0.

(b) Additional amounts. Medicare pays 100 percent. Plan pays $0. You pay $0.

(4) Hospice Care. Available as long as your doctor certifies you are terminally ill and you elect to receive these services. Medicare pays all but very limited coinsurance for outpatient drugs and inpatient respite care. Plan pays $0. You pay balance.

B. PLAN I (CONTINUED): MEDICARE (PART B) SERVICES PER CALENDAR YEAR. Once you have been billed $(100) of medicare-approved amounts for covered medical expenses, your part B deductible will have been met for the calendar year.

(1) Medical expenses. In or out of the hospital and outpatient hospital treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.

(a) First $(100) of medicare approved amounts (asterisk). Medicare pays $0. Plan pays $0. You pay $(100) (part B deductible).

(b) Remainder of medicare approved amounts. Medicare pays generally 80 percent. Plan pays generally 20 percent. You pay $0.

(c) Part B excess charges (above medicare approved amounts). Medicare pays $0. Plan pays $0. You pay all costs.

(2) Blood.

(a) First 3 pints. Medicare pays $0. Plan pays all costs. You pay $0.

(b) Next $(100) of medicare approved amounts (asterisk). Medicare pays $0. Plan pays $0. You pay $(100) (part B deductible).

(c) Remainder of medicare approved amounts. Medicare pays 80 percent. Plan pays 20 percent. You pay $0.

(3) Clinical laboratory services. Tests for diagnostic services. Medicare pays 100 percent. Plan pays $0. You pay $0.

C. PLAN I (CONTINUED): PARTS A AND B. Home health care. Once you have been billed $(100) of medicare-approved amounts for covered services (which are noted with an asterisk), your part B deductible will have been met for the calendar year.

(1) Medicare approved services.

(a) Medically necessary skilled care services and medical supplies. Medicare pays 100 percent. Plan pays $0. You pay $0.

(b) Durable medical equipment. First $(100) of medicare approved amounts (asterisk): medicare pays $0; plan pays $0; and you pay $(100) (part B deductible). Remainder of medicare approved amounts: medicare pays 80 percent; plan pays 20 percent; and you pay $0.

(2) At-home recovery services not covered by medicare. Home care certified by your doctor, for personal care during recovery from an injury or sickness for which medicare approved a home care treatment plan.

(a) Benefit for each visit. Medicare pays $0. Plan pays actual charges to $40 a visit. You pay balance.

(b) Number of visits covered (must be received within 8 weeks of last medicare approved visit). Medicare pays $0. Plan pays up to the number of medicare approved visits, not to exceed 7 each week.

(c) Calendar year maximum. Medicare pays $0. Plan pays $1,600.

D. PLAN I (CONTINUED) OTHER BENEFITS NOT COVERED BY MEDICARE. **Foreign travel not covered by Medicare.** Medically necessary emergency care services beginning during the first 60 days of each trip outside the United States of America.

(1) First $250 each calendar year. Medicare pays $0. Plan Pays $0. You pay $250.

(2) Remainder of charges. Medicare pays $0. Plan pays 80 percent to a lifetime maximum benefit of $50,000. You pay 20 percent and amounts over the $50,000 lifetime maximum.

[13.10.8.69 NMAC - Rp, 13.10.8.67 NMAC, 1-1-06]

13.10.8.70 PLAN J OR HIGH DEDUCTIBLE PLAN J. The following language shall be used in the order prescribed below. A sample form is posted on the public regulation commission, insurance division website, www.nmprc.state.nm.us, at "insurance," then "life and health." **This high deductible plan J pays the same benefits as plan J after one has paid a calendar year $(1690) deductible. Benefits from the high deductible plan J will not begin until out-of-pocket expenses are $(1690). Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the medicare deductibles for part A and part B, but does not include the plan's separate foreign travel emergency deductible.**

A. PLAN J OR HIGH DEDUCTIBLE PLAN J: MEDICARE (PART A) HOSPITAL SERVICES PER BENEFIT PERIOD.

(1) Hospitalization. A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row. Semiprivate room and board, general nursing and miscellaneous services and supplies.

(a) First 60 days. Medicare pays all but $(876). (After you pay $(1690) deductible,) plan pays $(876) (part A deductible). (In addition to $(1690) deductible,) you pay $0.

(b) 61st through 90th day. Medicare pays all but $(219) a day. (After you pay $(1690) deductible,(plan pays $(219) a day. (In addition to $(1690) deductible,) you pay $0.

(c) 91st day and after - while using 60 lifetime reserve days. Medicare pays all but $(438) a day. (After you pay $(1690) deductible,) plan pays $(438) a day. (In addition to $(1690) deductible,) you pay $0.

(d) 91st day and after - once lifetime reserve days are used. Additional 365 days. Medicare pays $0. (After you pay $(1690) deductible,) plan pays 100 percent of medicare eligible expenses. (In addition to $(1690) deductible,) you pay $0. **NOTICE:** When your medicare part A hospital benefits are exhausted, the insurer stands in the place of medicare and will pay whatever amount medicare would have paid for up to an additional 365 days as provided in the policy's "core benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount medicare would have paid.

(e) 91st day and after - beyond the additional 365 days. Medicare pays $0. (After you pay $(1690) deductible,) plan pays $0. (In addition to $(1690) deductible,) you pay all costs.

(2) Skilled Nursing Facility Care. A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row. You must meet medicare's requirements, including having been in a hospital for at least 3 days and entered a medicare-

approved facility within 30 days after leaving the hospital.

(a) First 20 days. Medicare pays all approved amounts. (After you pay $(1690) deductible,) plan pays $0. (In addition to $(1690) deductible,) you pay $0.

(b) 21st through 100th day. Medicare pays all but $(109.50) a day. (After you pay $(1690) deductible,) plan pays up to $(109.50) a day. (In addition to $(1690) deductible,) you pay $0.

(c) 101st day and after. Medicare pays $0. (After you pay $(1690) deductible,) plan pays $0. (In addition to $(1690) deductible,) you pay all costs.

(3) Blood.

(a) First 3 pints. Medicare pays $0. (After you pay $(1690) deductible,) plan pays 3 pints. (In addition to $(1690) deductible,) you pay $0.

(b) Additional amounts. Medicare pays 100 percent. (After you pay $(1690) deductible,) plan pays $0. (In addition to $(1690) deductible,) you pay $0.

(4) Hospice Care. Available as long as your doctor certifies you are terminally ill and you elect to receive these services. Medicare pays all but very limited coinsurance for outpatient drugs and inpatient respite care. (After you pay $(1690) deductible,) plan pays $0. (In addition to $(1690) deductible,) you pay balance.

B. PLAN J OR HIGH DEDUCTIBLE PLAN J (CONTINUED): MEDICARE (PART B) SERVICES PER CALENDAR YEAR. Once you have been billed $(100) of medicare approved amounts for covered medical services (which are noted with an asterisk), your part B deductible will have been met for the calendar year.

(1) Medical expenses. In or out of the hospital and outpatient hospital treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.

(a) First $(100) of medicare approved amounts (asterisk). Medicare pays $0. (After you pay $(1690) deductible,) plan pays $(100) (part B deductible). (In addition to $(1690) deductible,) you pay $0

(b) Remainder of medicare approved amounts. Medicare pays generally 80 percent. (After you pay $(1690) deductible,) plan pays generally 20 percent. (In addition to $(1690) deductible,) you pay $0.

(c) Part B excess charges (above medicare approved amounts). Medicare pays $0. (After you pay $(1690) deductible,) plan pays 100 percent. (In addition to $(1690) deductible,) you pay $0.

(2) Blood.

(a) First 3 pints. Medicare pays $0. (After you pay $(1690) deductible,) plan pays all costs. (In addition to $(1690) deductible,) you pay $0.

(b) Next $(100) of medicare approved amounts (asterisk). Medicare pays $0. (After you pay $(1690) deductible,) plan pays $(100) (part B deductible). (In addition to $(1690) deductible,) you pay $0.

(c) Remainder of medicare approved amounts. Medicare pays 80 percent. (After you pay $(1690) deductible,) plan pays 20 percent. (In addition to $(1690) deductible,) you pay $0.

(3) Clinical laboratory services. Tests for diagnostic services. Medicare pays 100 percent. (After you pay $(1690) deductible,) plan pays $0. (In addition to $(1690) deductible,) you pay $0.

C. PLAN J OR HIGH DEDUCTIBLE PLAN J (CONTINUED): PARTS A AND B. Home health care. Once you have been billed $(100) of medicare-approved amounts for covered services (which are noted with an asterisk), your part B deductible will have been met for the calendar year.

(1) Medicare approved services.

(a) Medically necessary skilled care services and medical supplies. Medicare pays 100 percent. (After you pay $(1690) deductible,) plan pays $0. (In addition to $(1690) deductible,) you pay $0.

(b) Durable medical equipment. First $(100) of medicare approved amounts (asterisk): medicare pays $0; (after you pay $(1690) deductible,) plan pays $(100) (part B deductible); (in addition to $(1690) deductible,) you pay $0). Remainder of medicare approved amounts: medicare pays 80 percent; (after you pay $(1690) deductible,) plan pays 20 percent and (in addition to $(1690) deductible,) you pay $0.

(2) At-home recovery services not covered by medicare. Home care certified by your doctor, for personal care during recovery from an injury or sickness for which medicare approved a home care treatment plan.

(a) Benefit for each visit. Medicare pays $0. (After you pay $(1690) deductible,) plan pays actual charges to $40 a visit. (In addition to $(1690) deductible,) you pay balance.

(b) Number of visits covered (must be received within 8 weeks of last medicare approved visit). Medicare pays $0. (After you pay $(1690) deductible,) plan pays up to the number of medicare approved visits, not to exceed 7 each week.

(c) Calendar year maximum. Medicare pays $0. (After you pay $(1690) deductible,) plan pays $1,600.

D. PLAN J OR HIGH DEDUCTIBLE PLAN J (CONTINUED): OTHER BENEFITS NOT COVERED BY MEDICARE.

(1) Foreign travel not covered by Medicare. Medically necessary emergency care services beginning during the first 60 days of each trip outside the United States of America.

(a) First $250 each calendar year. Medicare pays $0. (After you pay $(1690) deductible,) plan pays $0. (In addition to $(1690) deductible,) you pay $250.

(b) Remainder of charges. Medicare pays $0. (After you pay $(1690) deductible,) plan pays 80 percent to a lifetime maximum benefit of $50,000. (In addition to $(1690) deductible,) you pay 20 percent and amounts over the $50,000 lifetime maximum.

(2) Preventive medical care benefit not covered by medicare. Medicare benefits are subject to change. Please consult the latest guide to health insurance for people with medicare. Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by medicare.

(a) First $120 each calendar year. Medicare pays $0. (After you pay $(1690) deductible,) plan pays $120. (In addition to $(1690) deductible,) you pay $0.

(b) Additional charges. Medicare pays $0. (After you pay $(1690) deductible,) plan pays $0. (In addition to $(1690) deductible,) you pay all costs.

[13.10.8.70 NMAC - Rp, 13.10.8.68 NMAC, 1-1-06]

13.10.8.71 PLAN K. The following language shall be used in the order prescribed below. A sample form is posted on the public regulation commission, insurance division website, www.nmprc.state.nm.us, at "insurance," then "life and health." You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $(4000) each calendar year. The amounts that count toward your annual limit are noted with diamonds (diamond symbol) in the chart below. Once you reach the annual limit, the plan pays 100 percent of your medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed medicare-approved amounts (these are called "excess charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by medicare for the item or service.**

A. PLAN K: MEDICARE (PART A) HOSPITAL SERVICES PER BENEFIT PERIOD.

(1) Hospitalization. A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row. Semiprivate

room and board, general nursing and miscellaneous services and supplies.

(a) First 60 days. Medicare pays all but $(876). Plan pays $(438) (50 percent of part A deductible). You pay $(438) (50 percent of part A deductible)(diamond symbol).

(b) 61st through 90th day. Medicare pays all but $(219) a day. Plan pays $(219) a day. You pay $0.

(c) 91st day and after - while using 60 lifetime reserve days. Medicare pays all but $(438) a day. Plan pays $(438 a day). You pay $0.

(d) 91st day and after - once lifetime reserve days are used. Additional 365 days. Medicare pays $0. Plan pays 100 percent of medicare eligible expenses. You pay $0. **NOTICE:** When your medicare part A hospital benefits are exhausted, the insurer stands in the place of medicare and will pay whatever amount medicare would have paid for up to an additional 365 days as provided in the policy's "core benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount medicare would have paid.

(e) 91st day and after - beyond the additional 365 days. Medicare pays $0. Plan pays $0. You pay all costs.

(2) Skilled Nursing Facility Care. A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row. You must meet medicare's requirements, including having been in a hospital for at least 3 days and entered a medicare-approved facility within 30 days after leaving the hospital.

(a) First 20 days. Medicare pays all approved amounts. Plan pays $0. You pay $0.

(b) 21st through 100th day. Medicare pays all but $(109.50) a day. Plan pays up to $(54.75) a day. You pay up to $(54.75) a day (diamond symbol).

(c) 101st day and after. Medicare pays $0. Plan pays $0. You pay all costs.

(3) Blood.

(a) First 3 pints. Medicare pays $0. Plan pays 50 percent. You pay 50 percent (diamond symbol).

(b) Additional amounts. Medicare pays 100 percent. Plan pays $0. You pay $0.

(4) Hospice Care. Available as long as your doctor certifies you are terminally ill and you elect to receive these services. Medicare pays generally most medicare eligible expenses for out-patient drugs and inpatient respite care. Plan pays 50 percent of coinsurance or copayments. You pay 50 percent of coinsurance or copayments (diamond symbol).

B. PLAN K (CONTINUED): MEDICARE (PART B) SERVICES PER CALENDAR YEAR. Once you have been billed $(100) of medicare-approved amounts for covered services (which are noted with an asterisk), your part B deductible will have been met for the calendar year.

(1) Medical expenses. In or out of the hospital and outpatient hospital treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.

(a) First $(100) of medicare approved amounts (asterisk). Medicare pays $0. Plan pays $0. You pay $(100) (part B deductible)(asterisk)(diamond symbol).

(b) Preventive benefits for medicare covered services. Medicare pays generally 75 percent or more of medicare approved amounts. Plan pays remainder of medicare approved amounts. You pay all costs above medicare approved amounts.

(c) Remainder of medicare approved amounts. Medicare pays generally 80 percent. Plan pays generally 10 percent. You pay generally 10 percent (diamond symbol)

(d) Part B excess charges (above medicare approved amounts). Medicare pays $0. Plan pays $0. You pay all costs (and they do not count toward annual out-of-pocket limit of $(4000). This plan limits your annual out-of-pocket payments for medicare-approved amounts to $(4000) per year. **However, this limit does NOT include charges from your provider that exceed medicare-approved amounts (these are called "excess charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by medicare for the item or service.**

(2) Blood.

(a) First 3 pints. Medicare pays $0. Plan pays 50 percent. You pay 50 percent (diamond symbol).

(b) Next $(100) of medicare approved amounts (asterisk). Medicare pays $0. Plan pays $0. You pay $(100) (part B deductible)(asterisk)(diamond symbol).

(c) Remainder of medicare approved amounts. Medicare pays generally 80 percent. Plan pays generally 10 percent. You pay generally 10 percent (diamond symbol).

(3) Clinical laboratory services. Tests for diagnostic services. Medicare pays 100 percent. Plan pays $0. You pay $0.

C. PLAN K (CONTINUED): PARTS A AND B. Home health care. Medicare approved services.

(1) Medically necessary skilled care services and medical supplies. Medicare pays 100 percent. Plan pays $0. You pay $0.

(2) Durable medical equipment.

(a) First $(100) of medicare approved amounts. Medicare benefits are subject to change. Please consult the latest *guide to health insurance for people with medicare*. Medicare pays $0. Plan pays $0. You pay $(100) (part B deductible) (diamond symbol).

(b) Remainder of medicare approved amounts. Medicare pays 80 percent. Plan pays 10 percent. You pay 10 percent (diamond symbol).

[13.10.8.71 NMAC - N, 1-1-06]

13.10.8.72 PLAN L. The following language shall be used in the order prescribed below. A sample form is posted on the public regulation commission, insurance division website, www.nmprc.state.nm.us, at "insurance," then "life and health." You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $(2000) each calendar year. The amounts that count toward your annual limit are noted with diamonds (diamond symbol) in the chart below. Once you reach the annual limit, the plan pays 100 percent of your medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed medicare-approved amounts (these are called "excess charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by medicare for the item or service.**

A. PLAN L: MEDICARE (PART A) HOSPITAL SERVICES PER BENEFIT PERIOD.

(1) Hospitalization. A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row. Semiprivate room and board, general nursing and miscellaneous services and supplies.

(a) First 60 days. Medicare pays all but $(876). Plan pays $(657) (75 percent of part A deductible). You pay $(219) (25 percent of part A deductible)(diamond symbol).

(b) 61st through 90th day. Medicare pays all but $(219) a day. Plan pays $(219) a day. You pay $0.

(c) 91st day and after - while using 60 lifetime reserve days. Medicare pays all but $(438) a day. Plan pays $(438)

a day. You pay $0.

(d) 91st day and after - once lifetime reserve days are used. Additional 365 days. Medicare pays $0. Plan pays 100 percent of medicare eligible expenses. You pay $0. **NOTICE:** When your medicare part A hospital benefits are exhausted, the insurer stands in the place of medicare and will pay whatever amount medicare would have paid for up to an additional 365 days as provided in the policy's "core benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount medicare would have paid.

(e) 91st day and after - beyond the additional 365 days. Medicare pays $0. Plan pays $0. You pay all costs.

(2) Skilled Nursing Facility Care. A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row. You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.

(a) First 20 days. Medicare pays all approved amounts. Plan pays $0. You pay $0.

(b) 21st through 100th day. Medicare pays all but $(109.50) a day. Plan pays up to $(82.13) a day. You pay up to $(27.37) a day (diamond symbol).

(c) 101st day and after. Medicare pays $0. Plan pays $0. You pay all costs.

(3) Blood.

(a) First 3 pints. Medicare pays $0. Plan pays 75 percent. You pay 25 percent (diamond symbol).

(b) Additional amounts. Medicare pays 100 percent. Plan pays $0. You pay $0.

(4) Hospice Care. Available as long as your doctor certifies you are terminally ill and you elect to receive these services. Medicare pays generally most medicare eligible expenses for out-patient drugs and inpatient respite care. Plan pays 75 percent of coinsurance or copayments. You pay 25 percent of coinsurance or copayments (diamond symbol).

B. PLAN L (CONTINUED): MEDICARE (PART B) SERVICES PER CALENDAR YEAR. Once you have been billed $(100) of medicare-approved amounts for covered services (which are noted with an asterisk), your part B deductible will have been met for the calendar year.

(1) Medical expenses. In or out of the hospital and outpatient hospital treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.

(a) First $(100) of medicare approved amounts (asterisk). Medicare pays $0. Plan pays $0. You pay $(100) (part B deductible)(asterisk)(diamond symbol).

(b) Preventive benefits for medicare covered services. Medicare pays generally 75 percent or more of medicare approved amounts. Plan pays remainder of medicare approved amounts. You pay all costs above medicare approved amounts.

(c) Remainder of medicare approved amounts. Medicare pays generally 80 percent. Plan pays generally 15 percent. You pay generally 5 percent (diamond symbol)

(d) Part B excess charges (above medicare approved amounts). Medicare pays $0. Plan pays $0. You pay all costs and they do not count toward annual out-of-pocket limit of $(2000). This plan limits your annual out-of-pocket payments for medicare-approved amounts to $(2000) per year. **However, this limit does NOT include charges from your provider that exceed medicare-approved amounts (these are called "excess charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by medicare for the item or service.**

(2) Blood.

(a) First 3 pints. Medicare pays $0. Plan pays 75 percent. You pay 25 percent (diamond symbol).

(b) Next $(100) of medicare approved amounts (asterisk). Medicare pays $0. Plan pays $0. You pay $(100) (part B deductible)(diamond symbol).

(c) Remainder of medicare approved amounts. Medicare pays generally 80 percent. Plan pays generally 15 percent. You pay generally 5 percent (diamond symbol).

(3) Clinical laboratory services. Tests for diagnostic services. Medicare pays 100 percent. Plan pays $0. You pay $0.

C. PLAN L (CONTINUED): PARTS A AND B. Home health care. Medicare approved services.

(1) Medically necessary skilled care services and medical supplies. Medicare pays 100 percent. Plan pays $0. You pay $0.

(2) Durable medical equipment.

(a) First $(100) of medicare approved amounts (asterisk). Medicare pays $0. Plan pays $0. You pay $(100) (part B deductible)(diamond symbol).

(b) Remainder of medicare approved amounts. Medicare pays 80 percent. Plan pays 15 percent. You pay 5 percent (diamond symbol).

[13.10.8.72 NMAC - N, 1-1-06]

13.10.8.73 APPLICATION FORM.

A. STATEMENTS.

(1) You do not need more than one medicare supplement policy.

(2) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

(3) You may be eligible for benefits under medicaid and may not need a medicare supplement policy.

(4) If, after purchasing this policy, you become eligible for medicaid, the benefits and premiums under your medicare supplement policy can be suspended, if requested, during your entitlement to benefits under medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for medicaid. If you are no longer entitled to medicaid, your suspended medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing medicaid eligibility. If the medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in medicare part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

(5) If you are eligible for, and have enrolled in a medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in medicare part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

(6) Counseling services may be available in your state to provide advice concerning your purchase of medicare supplement insurance and concerning medical assistance through the state medicaid program, including benefits as a qualified

medicare beneficiary (QMB) and a specified low-income medicare beneficiary (SLMB).

B. QUESTIONS.

(1) If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. PLEASE ANSWER ALL QUESTIONS.

(2) (Please mark Yes or No below with an "X").

(3) To the best of your knowledge.

(4) Did you turn age 65 in the last 6 months? Yes____ No____.

(a) Did you enroll in medicare part B in the last 6 months? Yes____ No____.

(b) If yes, what is the effective date? _____.

(5) Are you covered for medical assistance through the state medicaid program? (NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.) Yes____ No____ If yes:

(a) will medicaid pay your premiums for this medicare supplement policy? Yes____ No____.

(b) do you receive any benefits from Medicaid OTHER THAN payments toward your medicare part B premium? Yes____ No____.

(6) If you had coverage from any medicare plan other than original medicare within the past 63 days (for example, a medicare advantage plan, or a medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank. START __/__/__ END __/__/__.

(a) If you are still covered under the medicare plan, do you intend to replace your current coverage with this new medicare supplement policy? Yes____ No____.

(b) Was this your first time in this type of medicare plan? Yes____ No____.

(c) Did you drop a medicare supplement policy to enroll in the medicare plan? Yes____ No____.

(7) Do you have another medicare supplement policy in force? Yes____ No____.

(a) If so, with what company, and what plan do you have (optional for Direct Mailers)? _____.

(b) If so, do you intend to replace your current medicare supplement policy with this policy? Yes____ No____ .

(8) Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan) Yes____ No____.

(a) If so, with what company and what kind of policy?_____.

(b) What are your dates of coverage under the other policy? START __/__/__ END __/__/__ (If you are still covered under the other policy, leave "END" blank.).

[13.10.8.73 NMAC - Rp, 13.10.8.69 NMAC, 1-1-06]

13.10.8.74 NOTICE TO APPLICANT.

A. NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE INSURANCE OR MEDICARE ADVANTAGE.

B. (Insurance Company's Name and Address).

C. SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOUR FUTURE.

D. According to (your application) (information you have furnished), you intend to terminate existing medicare supplement or medicare advantage insurance and replace it with the policy to be issued by (company name) insurance company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

E. You should review this new coverage carefully. Compare it with all health coverage you now have, if, after due consideration, you find that purchase of the medicare supplement or medicare advantage coverage is a wise decision, you should terminate your present medicare supplement coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

F. STATEMENT TO APPLICANT BY ISSUER, AGENT (BROKER OR OTHER REPRESENTATIVE).

(1) I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this medicare supplement policy will not duplicate your existing medicare supplement, or, if applicable, medicare advantage coverage because you intend to terminate your existing medicare supplement coverage or leave your medicare advantage plan. The replacement policy is being purchased for the following reasons(s) (Check one).

(a) _____ Additional benefits.

(b) _____ No change in benefits, but lower premiums.

(c) _____ Fewer benefits and lower premiums.

(d) _____ My plan has outpatient prescription drug coverage and I am enrolling in part D.

(e) _____ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment. (optional only for Direct Mailers) _____.

(f) _____ Other. (please specify).

(2) Note: If the issuer of the medicare supplement policy being applied for does not, or is otherwise prohibited from imposing pre-existing condition limitations, please skip to statement 3 below. Health conditions which you may presently have (preexisting condition) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

(3) State law provides that your replacement or certificate, may not contain new preexisting conditions, waiting period, elimination periods or probationary periods. The issuer will waive any time periods, elimination periods, or probationary period in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

(4) If, you still wish to terminate your present policy 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 policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded. (If the policy or certificate is guaranteed issue, this paragraph need not appear.)

(5) Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

(6) _____.

(7) Signature of Agent, Broker or Other Representative (Signature not required for direct response. sales).

(8) (Typed name and Address of Issuer, Agent or Broker).

(9) _____.

(10) Applicant's Signature.

(11) _____.

(12) Date.

[13.10.8.74 NMAC - Rp, 13.10.8.70 NMAC, 1-1-06]

13.10.8.75 APPENDIX A:

A. Medicare Supplement Refund Calculation Form

Medicare Supplement Refund Calculation Form For Calendar Year _____

TYPE[1] _____ SMSBP[2] _____

For the State of _____ Company Name _____

NAIC Group Code _____ NAIC Company Code _____

Address _____ Person Completing This Exhibit _____

Title _____ Telephone Number _____

Line		(a) Earned Premium [3]	(b) Incurred Claims [4]
1.	Current Year's Experience		
	a. Total (all policy years)		
	b. Current year's issues [5]		
	c. Net (for reporting purposes = 1a 1b)		
2.	Past Year's Experience (all policy years)		
3.	Total Experi ence (Net Current Year + Past Year)		

4.	Refunds Last Year (Excluding Interest)	
5.	Previous Since Inception (Excluding Interest)	
6.	Refunds Since Inception (Excluding Interest)	
7.	Benchmark Ratio Since Inception *(see worksheet for Ratio 1)*	
8.	Experienced Ratio since Inception (Ratio 2) Total Actual Incurred Claims (line 3, col. b) Total Earned Prem. (line 3, col. a) Refunds Since Inception (line 6)	
9.	Life Years Exposed Since Inception (If the Experienced Ratio is less than the Benchmark R atio, and there are more than 500 life years exposure, then proceed to calculation of refund.)	
10	Tolerance Permitted (obtained from credibility table)	

Medicare Supplement Credibility Table

Life Years Exposed Since Inception	Tolerance
10,000 +	0.0%
5,000 9,999	5.0%
2,500 4,999	7.5%
1,000 2,499	10.0%
500 999	15.0%
If less than 500, no credibility	

[1] Individual, Group, Individual Medicare Select, or Group Medicare Select Only.

[2] "SMSBP" = Standardized Medicare Supplement Benefit Plan Use "P" for prestandardized plans.

[3] Includes model loadings and fees charged.

[4] Excludes Active Life Reserves.

[5] This is to be used as "Issue Year Earned Premium" for Year 1 of next year's " Worksheet for Calculation of Benchmark Ratios."

Medicare Supplement Refund Calculation Form For Calendar Year _____(continued)

TYPE[1] _____ SMSBP[2] _____
For the State of _____ Company Name _____
NAIC Group Code _____ NAIC Company Code _____
Address _____ Person Completing This Exhibit _____
Title _____ Telephone Number _____

11.	Adjustment to Incurred Claims for Credibility Ratio 3 = Ratio 2 + Tolerance	

If Ratio 3 is more than Benchmark Ratio (Ratio 1), a refund or credit to premium is not required.

12.	Adjusted Incurred Claims [Total Earned Premiums (line 3, col. a) Refunds Since Inception (line 6)] x Ratio 3 (line 11)	
13.	Refund = Total Earned Premiums (line 3, col. a) - Refunds Since Inception (line 6) -[Adjusted Incurred Claims (line 12) / Ben chmark Ratio (Ratio 1)]	

If Ratio 3 is less than the Benchmark Ratio, then proceed.
If the amount on line 13 is less than .005 times the annualized premium in force as of December 31 of the reporting year, then no refund is made. Otherwise, the amount on line 13 is to be refunded or credited, and a description of the refund and/or credit against premiums to be used must be attached to this form.

I certify that the above information and calculations are true and accurate to the best of my knowledge and belief.

_____
Signature

_____
Name Please Type

_____
Title Please Type

_____
Date

B. Reporting Form For The Calculation Of Benchmark Ratio Since Inception
Reporting Form For The Calculation Of Benchmark Ratio Since Inception
For Individual Policies For Calendar Year _____

TYPE(1) _____ SMSBP(2) _____
For the State of _____ Company Name _____
NAIC Group Code _____ NAIC Company Code _____
Address _____ Person Completing This Exhibit _____
Title _____ Telephone Number _____

	(b)(4)	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o)(5)
	Earned Premium	Factor	(b)x(c)	Cumulative Loss Ratio	(d)x(e)	Factor	(b)x(g)	Cumulative Loss Ratios	(h)x(i)	Policy Year Loss Ratios
		2.770		0.442		0.000		0.000		0.40
		4.175		0.493		0.000		0.000		0.55
		4.175		0.493		1.194		0.659		0.65
		4.175		0.493		2.245		0.669		0.67
		4.175		0.493		3.170		0.678		0.69
		4.175		0.493		3.998		0.686		0.71
		4.175		0.493		4.754		0.695		0.73
		4.175		0.493		5.445		0.702		0.75
		4.175		0.493		6.075		0.708		0.76
		4.175		0.493		6.650		0.713		0.76
		4.175		0.493		7.176		0.717		0.76
		4.175		0.493		7.655		0.720		0.77
		4.175		0.493		8.093		0.723		0.77
		4.175		0.493		8.493		0.725		0.77

		4.175		0.493		8.684		0.725		0.77
			(k):		(l):		(m):		(n):	

Benchmark Ratio Since Inception: (l + n) / (k + m):
(1) Individual, group, individual medicare select, or group medicare select only.
(2) "SMSBP" = standardized medicare supplement benefit plan.
(3) Year 1 is the current calendar year - 1. Year 2 is the current calendar year - 2; (etc.) (Example: If the current year is 1991, then year 1 is 1990; year 2 is 1989; etc.)
(4) For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.
(5) These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes only.
(6) To include the earned premium for all years prior as well as the 15th year prior to the current year.

C. Reporting Form For The Calculation Of Benchmark Ratio Since Inception

For Group Policies For Calendar Year ____

TYPE(1) _____ SMSBP(2) _____
For the State of _____ Company Name _____
NAIC Group Code _____ NAIC Company Code _____
Address _____ Person Completing This Exhibit _____
Title _____ Telephone Number _____

(a)(3)	(b)(4)	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o)(5)
Year	Earned Premium	Factor	(b)x(c)	Cumulative Loss Ratio	(d)x(e)	Factor	(b)x(g)	Cumulative Loss Ratios	(h)x(i)	Policy Year Loss Ratio
1		2.770		0.507		0.000		0.000		0.46
2		4.175		0.567		0.000		0.000		0.63
3		4.175		0.567		1.194		0.759		0.75
4		4.175		0.567		2.245		0.771		0.77
5		4.175		0.567		3.170		0.782		0.80
6		4.175		0.567		3.998		0.792		0.82
7		4.175		0.567		4.754		0.802		0.84
8		4.175		0.567		5.445		0.811		0.87
9		4.175		0.567		6.075		0.818		0.88
10		4.175		0.567		6.650		0.824		0.88
11		4.175		0.567		7.176		0.828		0.88
12		4.175		0.567		7.655		0.831		0.88
13		4.175		0.567		8.093		0.834		0.89
14		4.175		0.567		8.493		0.837		0.89
15+(6)		4.175		0.567		8.684		0.838		0.89
TOTAL:			(k):		(l):		(m):		(n):	

Benchmark Ratio Since Inception: (l + n)/(k + m): _____
(1) Individual, group, individual medicare select, or group medicare select only.
(2) "SMSBP" = standardized medicare supplement plan - use "P" for pre-standardized plans.
(3) Year 1 is the current calendar year - 1. Year 2 is the current calendar year - 2 (etc.) (Example: If the current year is 1991, then: year 1 is 1990; year 2 is 1989, etc.).
(4) For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.
(5) These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes only.
(6) To include the earned premium for all years prior to as well as the 15^{th} year prior to the current year.
[13.10.8.75 NMAC - Rp, 13.10.8.71 NMAC, 1-1-06]

13.10.8.76 APPENDIX B.

A. FORM FOR REPORTING
B. MEDICARE SUPPLEMENT POLICIES
C. Company Name:_____
D. Address: _____
E. Phone Number: _____
F. Due March 1, annually
G. The purpose of this form is to report the following information on each resident of this state who has in force more than one Medicare Supplement policy or certificate. The information is to be grouped by individual policyholder.

H. Policy and Certificate Number.
I. Date of Issuance.
J. _____
K. Signature
L. _____
M. Name and Title (Please Type)
N. _____
O. Date

[13.10.8.76 NMAC - Rp, 13.10.8.72 NMAC, 1-1-06]

13.10.8.77 APPENDIX C ORIGINAL DISCLOSURE STATEMENTS.

A. For policies that provide benefits for expenses incurred for an accidental injury only.

(1) IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS.

(2) THIS IS NOT MEDICARE SUPPLEMENT INSURANCE.

(3) This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your medicare deductibles or coinsurance and is not a substitute for medicare supplement insurance.

(4) *This insurance duplicates medicare benefits when it pays*
hospital or medical expenses up to the maximum stated in the policy.

(5) *Medicare generally pays for most or all of these expenses.*

(6) *Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:*

(a) hospitalization;

(b) physician services;

(c) (outpatient prescription drugs if you are enrolled in medicare part D);

(d) other approved items and services.

(7) BEFORE YOU BUY THIS INSURANCE.

(8) ___ Check the coverage in *all* health insurance policies you already have.

(9) ___ For more information about medicare and medicare supplement insurance, review the *guide to health insurance for people with medicare*, available from the insurance company.

(10) ___ For help in understanding your health insurance, contact your state insurance department or state (health) insurance (assistance) program (SHIP).

B. For policies that provide benefits for specified limited services.

(1) IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS.

(2) THIS IS NOT MEDICARE SUPPLEMENT INSURANCE.

(3) This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your medicare deductibles or coinsurance and is not a substitute for medicare supplement insurance.

(4) *This insurance duplicates Medicare benefits when* any of the services covered by the policy are also covered by medicare.

(5) *Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:*

(a) hospitalization;

(b) physician services;

(c) (outpatient prescription drugs if you are enrolled in medicare part D);

(d) other approved items and services.

(6) BEFORE YOU BUY THIS INSURANCE.

(7) ___ Check the coverage in *all* health insurance policies you already have.

(8) ___ For more information about medicare and medicare supplement insurance, review the *guide to health insurance for people with medicare*, available from the insurance company.

(9) ___ For help in understanding your health insurance, contact your state insurance department or state (health) insurance (assistance) program (SHIP).

C. For policies that reimburse expenses incurred for specified disease(s) or other specified impairment(s). This includes expense incurred cancer, specified disease and other types of health insurance policies that limit reimbursement to named medical conditions.

(1) IMPORTANT NOTICE TO PERSONS ON MEDICARE.

(2) THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS.

(3) THIS IS NOT MEDICARE SUPPLEMENT INSURANCE.

(4) This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. It does not pay your medicare deductibles or coinsurance and is not a substitute for medicare supplement insurance.

(5) *This insurance duplicates medicare benefits when it pays:*

(6) - hospital or medical expenses up to the maximum stated in the policy.

(7) *Medicare generally pays for most or all of these expenses.*

(8) *Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:*

(a) hospitalization

(b) physician services

(c) hospice

(d) (outpatient prescription drugs if you are enrolled in medicare part D)

(e) other approved items and services.

(9) BEFORE YOU BUY THIS INSURANCE

(10) ___ Check the coverage in *all* health insurance policies you already have.

(11) ___ For more information about medicare and medicare supplement insurance, review the *guide to health insurance for people with medicare*, available from the insurance company.

(12) ___ For help in understanding your health insurance, contact your state insurance department or state (health) insurance (assistance) program (SHIP).

D. For policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified diseases, and other health insurance policies that pay a scheduled benefit or specific payments based on diagnosis of the conditions named in the policy.

(1) IMPORTANT NOTICE TO PERSONS ON MEDICARE.

(2) THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS.

(3) THIS IS NOT MEDICARE SUPPLEMENT INSURANCE.

(4) This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your medicare deductibles or coinsurance and is not a substitute for medicare supplement insurance.

(5) *This insurance duplicates medicare benefits because medicare generally pays for most of the expenses for the diagnosis and treatment of the specific conditions or diagnoses named in the policy.*

(6) *Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:*

(a) hospitalization;

(b) physician services;

(c) hospice;

(d) (outpatient prescription drugs if you are enrolled in medicare part D);

(e) other approved items and services.

(7) BEFORE YOU BUY THIS INSURANCE

(8) ___ Check the coverage in *all* health insurance policies you already have.

(9) ___ For more information about medicare and medicare supplement insurance, review the *guide to health insurance for people with medicare*, available from the insurance company.

(10) ___ For help in understanding your health insurance, contact your state insurance department or state (health) insurance (assistance) program (SHIP).

E. For indemnity policies and other policies that pay a fixed dollar amount per day, excluding long-term care policies.

(1) IMPORTANT NOTICE TO PERSONS ON MEDICARE.

(2) THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS.

(3) THIS IS NOT MEDICARE SUPPLEMENT INSURANCE.

(4) This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your medicare deductibles or coinsurance and is not a substitute for medicare supplement insurance.

(5) *This insurance duplicates medicare benefits when:*

(6) - any expenses or services covered by the policy are also covered by medicare

(7) *Medicare generally pays for most or all of these expenses.*

(8) *Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:*

(a) hospitalization;

(b) physician services;

(c) hospice care;

(d) (outpatient prescription drugs if you are enrolled in medicare part D);

(e) other approved items and services.

(9) BEFORE YOU BUY THIS INSURANCE

(10) ___ Check the coverage in *all* health insurance policies you already have.

(11) ___ For more information about medicare and medicare supplement insurance, review the *guide to health insurance for people with medicare*, available from the insurance company.

(12) ___ For help in understanding your health insurance, contact your state insurance department or state (health) insurance (assistance) program (SHIP).

F. For policies that provide benefits upon both an expense-incurred and fixed indemnity basis.

(1) IMPORTANT NOTICE TO PERSONS ON MEDICARE.

(2) THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS.

(3) THIS IS NOT MEDICARE SUPPLEMENT INSURANCE.

(4) This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your medicare deductibles or coinsurance and is not a substitute for medicare supplement insurance.

(5) *This insurance duplicates medicare benefits when:*

(a) - any expenses or services covered by the policy are also covered by medicare, or

(b) - it pays the fixed dollar amount stated in the policy and medicare covers the same event.

(6) *Medicare generally pays for most or all of these expenses.*

(7) *Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:*

(a) - hospitalization;

(b) - physician services;

(c) - hospice care;

(d) - (outpatient prescription drugs if you are enrolled in medicare part D);

(e) - other approved items and services.

(8) BEFORE YOU BUY THIS INSURANCE

(9) ___ Check the coverage in *all* health insurance policies you already have.

(10) ___ For more information about medicare and medicare supplement insurance, review the *guide to health insurance for people with medicare*, available from the insurance company.

(11) ___ For help in understanding your health insurance, contact your state insurance department or state (health) insurance (assistance) program (SHIP).

G. For other health insurance policies not specifically identified in the previous statements.

(1) IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS INSURANCE. DUPLICATES SOME MEDICARE BENEFITS.

(2) THIS IS NOT MEDICARE SUPPLEMENT INSURANCE.

(3) This insurance provides limited benefits, if you meet the policy conditions listed in the policy. It does not pay your medicare deductibles or coinsurance and is not a substitute for medicare supplement insurance.

(4) *This insurance duplicates medicare benefits when it pays:*

(5) - the benefits stated in the policy and coverage for the same event is provided by medicare.

(6) *Medicare generally pays for most or all of these expenses.*

(7) *Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:*

(a) - hospitalization;

(b) - physician services;

(c) - hospice;

(d) - (outpatient prescription drugs if you are enrolled in medicare part

D);

(e) - other approved items and services.

(8) BEFORE YOU BUY THIS INSURANCE

(9) ___ Check the coverage in *all* health insurance policies you already have.

(10) ___ For more information about medicare and medicare supplement insurance, review the *guide to health insurance for people with medicare*, available from the insurance company.

(11) ___ For help in understanding your health insurance, contact your state insurance department or state (health) insurance (assistance) program (SHIP).

[13.10.8.77 NMAC - Rp, 13.10.8.73 NMAC, 1-1-06]

13.10.8.78 APPENDIX D ALTERNATIVE DISCLOSURE STATEMENTS.

A. For policies that provide benefits for expenses incurred for an accidental injury only.

(1) IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS IS NOT MEDICARE SUPPLEMENT INSURANCE.

(2) Some health care services paid for by medicare may also trigger the payment of benefits from this policy.

(3) This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your medicare deductibles or coinsurance and is not a substitute for medicare supplement insurance.

(4) Medicare generally pays for most or all of these expenses.

(5) *Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:*

(a) hospitalization;

(b) physician services;

(c) (outpatient prescription drugs if you are enrolled in medicare part D);

(d) other approved items and services.

(6) This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under medicare or other insurance.

(7) Before You Buy This Insurance.

(8) ___ Check the coverage in **all** health insurance policies you already have.

(9) ___ For more information about medicare and medicare supplement insurance, review the *guide to health insurance for people with medicare*, available from the insurance company.

(10) ___ For help in understanding your health insurance, contact your state insurance department or state (health) insurance (assistance) program (SHIP).

B. For policies that provide benefits for specified limited services.

(1) IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS IS NOT MEDICARE SUPPLEMENT INSURANCE.

(2) Some health care services paid for by medicare may also trigger the payment of benefits under this policy.

(3) This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your medicare deductibles or coinsurance and is not a substitute for medicare supplement insurance.

(4) *Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:*

(a) hospitalization;

(b) physician services;

(c) (outpatient prescription drugs if you are enrolled in medicare part D);

(d) other approved items and services.

(5) This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

(6) Before You Buy This Insurance.

(7) ___ Check the coverage in **all** health insurance policies you already have.

(8) ___ For more information about medicare and medicare supplement insurance, review the *guide to health insurance for people with medicare*, available from the insurance company.

(9) ___ For help in understanding your health insurance, contact your state insurance department or state (health) insurance (assistance) program (SHIP).

C. For policies that reimburse expenses incurred for specified diseases or other specified impairments. This includes expense-incurred cancer, specified disease and other types of health insurance policies that limit reimbursement to named medical conditions.

(1) IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS IS NOT MEDICARE SUPPLEMENT INSURANCE.

(2) Some health care services paid for by medicare may also trigger the payment of benefits from this policy. Medicare generally pays for most or all of these expenses.

(3) This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. It does not pay your medicare deductibles or coinsurance and is not a substitute for medicare supplement insurance.

(4) Medicare generally pays for most or all of these expenses.

(5) *Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:*

(a) - hospitalization;

(b) - physician services;

(c) - hospice;

(d) - (outpatient prescription drugs if you are enrolled in medicare part D);

(e) - other approved items and services.

(6) This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

(7) Before You Buy This Insurance.

(8) ___ Check the coverage in **all** health insurance policies you already have.

(9) ___ For more information about medicare and medicare supplement insurance, review the *guide to health insurance for people with medicare*, available from the insurance company.

(10) ___ For help in understanding your health insurance, contact your state insurance department or state (health) insurance (assistance) program (SHIP).

D. For policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.

(1) IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS IS NOT MEDICARE SUPPLEMENT INSURANCE.

(2) Some health care services paid for by medicare may also trigger the payment of benefits from this policy.

(3) This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your medicare deductibles or coinsurance and is not a substitute for medicare supplement insurance.

(4) *Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:*

(a) - hospitalization;

(b) - physician services;

(c) - hospice;

(d) - (outpatient prescription

drugs if you are enrolled in medicare part D);

(e) - other approved items and services.

(5) This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under medicare or other insurance.

(6) Before You Buy This Insurance.

(7) ___ Check the coverage in **all** health insurance policies you already have.

(8) ___ For more information about medicare and medicare supplement insurance, review the *guide to health insurance for people with medicare*, available from the insurance company.

(9) ___ For help in understanding your health insurance, contact your state insurance department or state (health) insurance (assistance) program (SHIP).

E. For indemnity policies and other policies that pay a fixed dollar amount per day, excluding long-term care policies.

(1) IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS IS NOT MEDICARE SUPPLEMENT INSURANCE.

(2) Some health care services paid for by medicare may also trigger the payment of benefits from this policy.

(3) This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your medicare deductibles or coinsurance and is not a substitute for medicare supplement insurance.

(4) Medicare generally pays for most or all of these expenses. Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

(a) - hospitalization;

(b) - physician services;

(c) - hospice;

(d) - (outpatient prescription drugs if you are enrolled in medicare part D);

(e) - other approved items and services.

(5) This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

(6) Before You Buy This Insurance.

(7) ___ Check the coverage in **all** health insurance policies you already have.

(8) ___ For more information about medicare and medicare supplement insurance, review the *guide to health insurance for people with medicare*, available from the insurance company.

(9) ___ For help in understanding your health insurance, contact your state insurance department or state (health) insurance (assistance) program (SHIP).

F. For policies that provide benefits upon both an expense-incurred and fixed indemnity basis.

(1) IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS IS NOT MEDICARE SUPPLEMENT INSURANCE.

(2) Some health care services paid for by medicare may also trigger the payment of benefits from this policy.

(3) This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your medicare deductibles or coinsurance and is not a substitute for medicare supplement insurance.

(4) Medicare generally pays for most or all of these expenses.

(5) *Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:*

(a) - hospitalization;

(b) - physician services;

(c) - hospice care;

(d) - (outpatient prescription drugs if you are enrolled in medicare part D);

(e) - other approved items & services.

(6) This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under medicare or other insurance.

(7) Before You Buy This Insurance.

(8) ___ Check the coverage in **all** health insurance policies you already have.

(9) ___ For more information about medicare and medicare supplement insurance, review the *guide to health insurance for people with medicare*, available from the insurance company.

(10) ___ For help in understanding your health insurance, contact your state insurance department or state (health) insurance (assistance) program (SHIP).

G. For other health insurance policies not specifically identified in the preceding statements.

(1) IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS IS NOT MEDICARE SUPPLEMENT INSURANCE.

(2) Some health care services paid for by medicare may also trigger the payment of benefits from this policy.

(3) This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your medicare deductibles or coinsurance and is not a substitute for medicare supplement insurance.

(4) *Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:*

(a) - hospitalization;

(b) - physician services;

(c) - hospice;

(d) - (outpatient prescription drugs if you are enrolled in medicare part D);

(e) - other approved items and services.

(5) This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under medicare or other insurance.

(6) Before You Buy This Insurance.

(7) ___ Check the coverage in **all** health insurance policies you already have.

(8) ___ For more information about medicare and medicare supplement insurance, review the *guide to health insurance for people with medicare*, available from the insurance company.

(9) ___ For help in understanding your health insurance, contact your state insurance department or state (health) insurance (assistance) program (SHIP).

[13.10.8.78 NMAC - Rp, 13.10.8.74 NMAC, 1-1-06]

HISTORY OF 13.10.8 NMAC

Pre-NMAC History: The material in this rule was previously filed with the state records center as:

ID 77-2, Article 11, Chapter 58, Rule 4, Regulations Governing Accident and Health Insurance Medicare Supplements, on October 26, 1977;

SCC-85-15, Insurance Department Regulation 24 Health Insurance for Seniors, on November 5, 1985;

SCC-88-197-IN-R, Insurance Department Rule 1 (Article 24) Health Insurance for Seniors, on October 31, 1988;

SCC-90-1, Insurance Department Rule 1 (Article 24) Health Insurance for Seniors, on February 28, 1990; and

SCC-92-1-IN, Article 24A, Rule 1 Health Insurance for Seniors, on May 27, 1992.

History of Repealed Material:

13 NMAC 10.8, Health Insurance for Seniors (filed 5-27-97), repealed 7-1-98.

13 NMAC 10.8, Health Insurance for Seniors (filed 9-2-03), repealed 1-1-06.

Other History:

SCC-92-1-IN, Article 24A, Rule 1 Health Insurance for Seniors (filed 5/27/1992) was renumbered, reformatted, amended and replaced by 13 NMAC 10.8, Health Insurance for Seniors, effective 7-1-97.

13 NMAC 10.8, Health Insurance for Seniors (filed 5-27-97) was replaced by 13 NMAC 10.8, Health Insurance for Seniors, effective 7-1-98.

13 NMAC 10.8, Health Insurance for

Seniors (filed 6-15-98) was renumbered, reformatted, amended and replaced by 13.10.8 NMAC, Health Insurance for Seniors, effective 1-1-04.
13.10.8 NMAC, Health Insurance for Seniors (filed 9-2-03) was replaced by 13.10.8 NMAC, Health Insurance for Seniors, effective 1-1-06.

NEW MEXICO SECRETARY OF STATE

TITLE 1 GENERAL GOVERNMENT ADMINISTRATION
CHAPTER 10 ELECTIONS AND ELECTED OFFICIALS
PART 26 INACTIVE VOTER LIST

1.10.26.1 ISSUING AGENCY: Office of the Secretary of State
[1.10.26.1 NMAC - N, 9-30-2005]

1.10.26.2 SCOPE: This rule applies to any special statewide election, general election, primary election, countywide election or elections to fill vacancies in the office of United States representative, municipal, special district elections and regular or special school district elections as modified by the School Election Law (Sections 1-22-1 to 1-22-19 NMSA 1978).
[1.10.26.2 NMAC - N, 9-30-2005]

1.10.26.3 STATUTORY AUTHORITY: Election Code, Section 1-2-1 NMSA 1978; Chapter 270, Laws 2005, Public Law 103-31, The National Voter Registration Act of 1993. The issuing authority shall issue rules in accordance with the provisions of the federal National Voter Registration Act of 1993.
[1.10.26.3 NMAC - N, 9-30-2005]

1.10.26.4 DURATION: Permanent.
[1.10.26.4 NMAC - N, 9-30-2005]

1.10.26.5 EFFECTIVE DATE: September 30, 2005 unless a later date is cited at the end of a section.
[1.10.26.5 NMAC - N, 9-30-2005]

1.10.26.6 OBJECTIVE: The Election Code (Section 1-1-1 NMSA through 1-24-4 NMSA 1978) was amended by Chapter 270, Laws 2005. The purpose of the amendment is compliance with the provisions of PL 103-31, effective January 1, 1995, which sets forth certain procedures for uniform, non-discriminatory maintenance of voter registration lists.
[1.10.26.6 NMAC - N, 9-30-2005]

1.10.26.7 DEFINITIONS:

A. "Active status" means a state of participation in the electoral process in which a voter informs a county clerk of any change of permanent residence address for the purpose of voter registration and voting.

B. "Active voter" means a qualified elector, registered to vote under the provisions of the Election Code and who has actively informed the county clerk of any change of residence for the purpose of voter registration and voting.

C. "Board of registration" means the voters of a county who are appointed by the board of county commission and serve under the provisions of Section 1-4-33 through 1-4-38, NMSA 1978.

D. "Confirmation card" means a postage pre-paid, pre-addressed return card, sent by forwardable mail on which the voter may state a current address.

E. "Confirmation mailing" means the state organized process of address verification of voters who have filed a change of address with the postal service, but have not changed their address for the purpose of voter registration and voting.

F. "Election" means any special statewide election, general election, primary election, countywide election or election to fill vacancies in the office of United States representative, municipal, special district elections and regular or special school district elections.

G. "Federal election" means any general election, primary election or special election to fill vacancies in the office of United States representative.

H. "Inactive status" means a state of non-participation in the electoral process in which a voter does not inform a county clerk of any change of permanent residence address for the purpose of voter registration and voting.

I. "Inactive voter" means a qualified elector, registered to vote under the provisions of the Election Code who has not informed the county clerk of any change of permanent residence address for the purpose of voter registration and voting.

J. "Removable status" means a registered voter ineligible to vote by reason of having moved from the jurisdiction, declaration of incompetence by a court of law, unrestored felon status, death, or request of the voter or cancellation of registration by the board of registration.

K. "Removable voter" means a qualified elector who is ineligible to vote in his or her jurisdiction due to having moved from the jurisdiction, received a declaration of incompetence by a court of law, is an unrestored felon, is deceased, has requested cancellation of the certificate of registration or has had their certificate of registration cancelled by the board of registration.

L. "Undeliverable mailing" means any item of mail sent to a voter and returned by the postal service because the voter is not at that address.

M. "Voter" means any person who is qualified to vote under the provisions of the constitution of New Mexico and the constitution of the United States and who is registered under the provisions of the Election Code of the state of New Mexico.

N. "Voter file" means all voter registration information required by law and by the secretary of state that has been extracted from the certificate of registration of each voter in the county, stored on data recording media and certified by the county clerk as the source of all information required by the Voter Records System Act.
[1.10.26.7 NMAC - N, 9-30-2005]

1.10.26.8 CONFIRMATION PROCESS:

A. By December of odd-numbered years, the secretary of state shall contract with a postal service approved vendor of the national change of address (NCOA) program. The entire state voter file shall be compared to the postal service NCOA listing.

B. Any voter appearing on the NCOA file who has not changed their residence address with the county clerk list shall be mailed a confirmation card requesting a current address. Confirmation cards must be returned by the voter in 60 days.

C. If a voter's confirmation card is returned undeliverable, the county clerk shall enter that voter on the voter file as inactive. If the voter returns the card with a new address in the same county, the county clerk shall use the confirmation mailing to update the voter's address on the voter file. If the voter returns the card and indicates they have moved to another jurisdiction, the county clerk shall enter the voter as removable on the voter file.

D. After four consecutive federal elections with an inactive status and failure to vote in any state or local election or to update the residence address, the voter shall be removed from the voter file through the board of registration cancellation process. An appearance to vote in any election restores a voter to active status.

E. All activities of the NCOA confirmation process shall be completed no later than ninety (90) days of the federal primary election.

F. Voters shall also be placed on inactive status whenever a general mailing returns mail as undeliverable. A general mailing may consist of absentee

ballots, voter identification cards, letters of information sent to all voters in a county, or any other mailing that is not targeted to a specific group or to non-voters.
[1.10.26.8 NMAC - N, 9-30-2005]

1.10.26.9 CANCELLATION PROCESS:

A. In March of odd-numbered years, the board of registration shall review a list of voters who have been on inactive status since the second previous primary election. Upon approval of the list by the board, each inactive voter shall receive a notice of intended cancellation.

B. Voters mailed a notice of intended cancellation shall be permitted sixty (60) days to respond to the notice. A voter who indicates on the cancellation card that they still reside at their registered residence within the jurisdiction shall be restored to active status.

C. Voters who fail to return a notice of intended cancellation shall be placed on removable status. The county clerk shall present a list of all voters to be removed to the board of registration. Voters may not be removed solely for non-voting.
[1.10.26.9 NMAC - N, 9-30-2005]

History of 1.10.26 NMAC: [RESERVED]

NEW MEXICO SECRETARY OF STATE

TITLE 1 GENERAL GOVERNMENT ADMINISTRATION
CHAPTER 10 ELECTIONS AND ELECTED OFFICIALS
PART 27 VOTER ACTION ACT

1.10.27.1 ISSUING AGENCY: Office of the Secretary of State
[1.10.27.1 NMAC - N, 9-30-2005]

1.10.27.2 SCOPE: This rule applies to any special statewide election, general election, primary election, county-wide election or elections to fill vacancies in the office of United States representative, municipal, special district elections and regular or special school district elections as modified by the School Election Law (Sections 1-22-1 to 1-22-19 NMSA 1978).
[1.10.27.2 NMAC - N, 9-30-2005]

1.10.27.3 STATUTORY AUTHORITY: Election Code, Section 1-2-1 NMSA 1978; Section 1-19A-1 to 1-19A-17 NMSA 1978.
[1.10.27.3 NMAC - N, 9-30-2005]

1.10.27.4 DURATION: Permanent.
[1.10.27.4 NMAC - N, 9-30-2005]

1.10.27.5 EFFECTIVE DATE: September 30, 2005 unless a later date is cited at the end of a section.
[1.10.27.5 NMAC - N, 9-30-2005]

1.10.27.6 OBJECTIVE: The secretary of state shall adopt rules to ensure effective administration of the Voter Action Act (Section 1-19A-1 to 1-19A-17 NMSA 1978) pursuant to Section 1-19A-15 NMSA 1978. The rules shall include procedures for qualifications, certification and disbursement of revenues and return of unspent fund revenues; obtaining qualifying contributions; certification of candidates; collection of revenues; and return of fund disbursements and other money to the fund.
[1.10.27.6 NMAC - N, 9-30-2005]

1.10.27.7 DEFINITIONS:

A. "Applicant candidate" means a candidate who is running for the office of public regulation commission in the primary and general election. A candidate becomes an applicant candidate upon submittal of documents in Section 1-19A-3 NMSA 1978.

B. "Certified candidate" means a candidate running for the office of public regulation commission who chooses to obtain financing pursuant to the Voter Action Act and is certified as a Voter Action Act candidate. An applicant candidate becomes a certified candidate upon submittal and the secretary of state determination under Sections 1-19A-4 to 1-19A-6 NMSA 1978.

C. "Comparable offices" or **"applicable elections"** means the state corporation commission.

D. "Election cycle" means the primary and general elections for the same term for the office of public regulation commission. The first day of the primary election is the first day of the election cycle and ends on the primary election date. The first day of the general election is first day after the primary election and ends on the general election date.
[1.10.27.7 NMAC - N, 9-30-2005]

1.10.27.8 QUALIFICATIONS AND CERTIFICATION:

A. A candidate choosing to obtain financing pursuant to the Voter Action Act shall abide by Section 1-19A-3 NMSA 1978 to become an applicant candidate.

B. A candidate choosing to become a certified candidate shall abide by Section 1-19A-4 NMSA 1978 for obtaining qualifying contributions.

C. A candidate choosing to become a certified candidate may abide by Section 1-19A-5 NMSA 1978 for obtaining seed money.

D. A candidate choosing to become a certified candidate shall abide by Section 1-19A-6 NMSA 1978 for submittal of certification documents.

E. The secretary of state shall determine whether an applicant candidate shall become a certified candidate pursuant to Section 1-19A-6 NMSA 1978.
[1.10.27.8 NMAC - N, 9-30-2005]

1.10.27.9 DETERMINATION OF FUND DISTRIBUTION:

A. On April 1, of every odd year, the secretary of state shall determine the amount of funds available for distribution pursuant to Section 1-19A-13 NMSA 1978.

B. To determine the amount available for a public regulation commission contested primary election, the secretary of state shall follow Subsection B of Section 1-19A-13 NMSA 1978.

C. To determine the amount available for a public regulation commission uncontested primary election, the secretary of state shall follow Subsection C of Section 1-19A-13 NMSA 1978.

D. To determine the amount available for a public regulation commission contested general election, the secretary of state shall follow Subsection D of Section 1-19A-13 NMSA 1978.

E. To determine the amount available for a public regulation commission uncontested general election, the secretary of state shall follow Subsection E of Section 1-19A-13 NMSA 1978.
[1.10.27.9 NMAC - N, 9-30-2005]

1.10.27.10 DISTRIBUTION OF FUND:

A. Once the certification for candidates for the primary election has been completed, the secretary of state shall calculate the total amount of money to be distributed in the primary election cycle based on the number of certified candidates and allocations specified in 1.10.27.9 NMAC.

B. The secretary of state shall abide by Subsection F of Section 1-19A-13 NMSA 1978 if the total needs to be adjusted.

C. The secretary of state shall calculate the total amount of money to be distributed in the general election pursuant to 1.10.26.9 NMAC and Subsection F of Section 1-19A-13 NMSA 1978.

D. If the allocation specified in Subsection F of Section 1-19A-13 is greater than the total amount available for distribution, then the amounts to be distributed to individual candidates shall be reduced pursuant to Subsection G of Section 1-19A-13 NMSA 1978.

E. The secretary of state shall abide by Section 1-19A-14 NMSA 1978 if the total needs to be adjusted due to the actions of a noncertified candidate.
[1.10.27.10 NMAC - N, 9-30-2005]

1.10.27.11 FUND REVENUES:

A. The legislature has set up the public election fund pursuant to Section 1-19A-10 NMSA 1978 governing the collection of revenues to provide for the fund.

B. A certified candidate shall return to the fund unspent fund revenues and any other relevant funds pursuant to Subsection E of Section 1-19A-5, Subsections B to E of Section 1-19A-7 and Subsection D of Section 1-19A-16 NMSA 1978.
[1.10.27.11 NMAC - N, 9-30-2005]

History of 1.10.27 NMAC: [RESERVED]

NEW MEXICO SECRETARY OF STATE

TITLE 1 GENERAL GOVERNMENT ADMINISTRATION
CHAPTER 10 ELECTIONS AND ELECTED OFFICIALS
PART 28 DISTRIBUTION OF VOTER IDENTIFICATION CARDS

1.10.28.1 ISSUING AGENCY: Office of the Secretary of State
[1.10.28.1 NMAC - N, 9-30-2005]

1.10.28.2 SCOPE: This rule applies to any primary election.
[1.10.28.2 NMAC - N, 9-30-2005]

1.10.28.3 STATUTORY AUTHORITY: Election Code, Section 1-2-1 NMSA 1978; Chapter 270, Laws 2005.
[1.10.28.3 NMAC - N, 9-30-2005]

1.10.28.4 DURATION: Permanent.
[1.10.28.4 NMAC - N, 9-30-2005]

1.10.28.5 EFFECTIVE DATE: September 30, 2005 unless a later date is cited at the end of a section.
[1.10.28.5 NMAC - N, 9-30-2005]

1.10.28.6 OBJECTIVE: The Election Code (Section 1-1-1 NMSA through 1-24-4 NMSA 1978) was amended by Chapter 270, Laws 2005. The purpose of the amendment is to ensure that each county clerk sends a voter identification card to every voter listed on the county register between sixty (60) and forty (40) days before each primary election.
[1.10.28.6 NMAC - N, 9-30-2005]

1.10.28.7 DEFINITIONS:

A. "County" means any county in this state.

B. "County register" means an official file of original certificates of registration.

C. "Primary election" means the election held pursuant to Section 1-8-11 NMSA 1978.

D. "Voter" means any person who is qualified to vote under the provisions of the constitution of New Mexico and the constitution of the United States and who is registered under the provisions of the Election Code of New Mexico.

E. "Voter file" means all voter registration information required by law and by the secretary of state that has been extracted from the certificate of registration of each voter in the county, stored on data recording media and certified by the county clerk as the source of all information required by the Voter System Records Act (Section 1-5-1 through 1-5-31 NMSA 1978).

F. "Voter's address" means the address where the voter receives mail delivery.

G. "Voter identification card" means a card indicating the voter's name; address; last four digits of the social security number; date of birth; election districts; party affiliation, if any and precinct polling place.
[1.10.28.7 NMAC - N, 9-30-2005]

1.10.28.8 VOTER IDENTIFICATION CARD MAILING:

A. Each county clerk shall, between sixty (60) and forty (40) days prior to a primary election, mail every voter in the county a voter identification card, based on information extracted from the county register and county voter file.

B. The voter identification card shall be mailed by first class mail to the voter's address.

C. Cardstock and envelopes for the mailing shall be provided to each county clerk by the office of secretary of state.
[1.10.28.8 NMAC - N, 9-30-2005]

1.10.28.9 SECRETARY OF STATE REIMBURSEMENT:

A. The office of the secretary of state, upon receiving documentation acceptable to the department of finance and administration from each county, shall reimburse the county for the cost of postage and other costs directly related to distribution of the cards.

B. The secretary of state shall, pursuant to 1.10.26 NMAC and the National Voter Registration Act of 1993, instruct each county clerk to mark as inactive any voter whose identification card is returned as undeliverable.
[1.10.28.9 NMAC - N, 9-30-2005]

History of 1.10.28 NMAC: [RESERVED]

NEW MEXICO SOIL AND WATER CONSERVATION COMMISSION

NOTICE OF REPEAL

21.9.2 NMAC, Conducting an Election of District Supervisors, filed November 12, 2003 is hereby repealed and replaced by 21.9.2 NMAC, Conducting an Election of District Supervisors, effective September 30, 2005.

NOTICE OF REPEAL

21.9.3 NMAC, Conducting a Referendum, filed November 26, 2003 is hereby repealed and replaced by 21.9.3 NMAC, effective September 30, 2005.

NEW MEXICO SOIL AND WATER CONSERVATION COMMISSION

TITLE 21 AGRICULTURE AND RANCHING
CHAPTER 9 SOIL AND WATER CONSERVATION DISTRICTS
PART 2 CONDUCTING AN ELECTION OF DISTRICT SUPERVISORS

21.9.2.1 ISSUING AGENCY: New Mexico Soil and Water Conservation Commission
[21.9.2.1 NMAC - Rp, 21.9.2.1 NMAC, 9-30-05]

21.9.2.2 SCOPE: This part applies to supervisor elections in all soil and water conservation districts.
[21.9.2.2 NMAC - Rp, 21.9.2.2 NMAC, 9-30-05]

21.9.2.3 STATUTORY AUTHORITY: This part is adopted pursuant to the Soil and Water Conservation District Act, Sections 73-20-25, et. seq. NMSA 1978.
[21.9.2.3 NMAC - Rp, 21.9.2.3 NMAC, 9-30-05]

21.9.2.4 DURATION: Permanent
[21.9.2.4 NMAC - Rp, 21.9.2.4 NMAC, 9-30-05]

21.9.2.5 EFFECTIVE DATE: September 30, 2005 unless a later date is cited at the end of a section.

[21.9.2.5 NMAC - Rp, 21.9.2.5 NMAC, 9-30-05]

21.9.2.6 OBJECTIVE: The objective of Part 2 of Chapter 9 is to provide standard procedures for the election of supervisors in accordance with law.
[21.9.2.6 NMAC - Rp, 21.9.2.6 NMAC, 9-30-05]

21.9.2.7 DEFINITIONS: Terms defined in Section 73-20-27 NMSA 1978 have the same definition in this part. Terms not defined in Section 73-20-27 NMSA 1978 are defined below:

A. "**Eligible voter**" shall mean a person who, at least 32 days prior to the election, is registered to vote in New Mexico pursuant to the provisions of the election code, and whose address of record on the voter registration is within the soil and water conservation district for which the election is being conducted.

B. "**Election**" shall mean an election held at one or more designated polling places which will be open a minimum of eight hours. Due notice must be given. Absentee voting as provided in these rules is permitted.

C. "**Election superintendent**" shall mean the person appointed to conduct the election of supervisors.

D. "**Canvassing board**" shall mean the persons appointed in accordance with these rules to certify and publish the election results, and give the commission notice of their canvass.
[21.9.2.7 NMAC - Rp, 21.9.2.7 NMAC, 9-30-05]

21.9.2.8 DEADLINES:

A. Deadlines associated with supervisor elections that fall on a weekend or holiday shall be carried over until the next business day.

B. The New Mexico soil and water conservation commission shall create and distribute an official election timeline by October 1 preceding the election.
[21.9.2.8 NMAC - N, 9-30-05]

21.9.2.9 DUTIES OF COMMISSION OR BOARD OF SUPERVISORS:

A. Conduct a supervisor election on the first Tuesday in May of even-numbered years to fill positions designated by the soil and water conservation commission as being eligible for election.

B. Notify the county clerks of all counties located within the district boundaries of the election by January 1, preceding the election. Each county clerk must be provided the following:

(1) district boundary description;

(2) district boundary map;

(3) date of the election;

(4) the official election timeline;

(5) a copy of the supervisor election rules.

C. Provide for "due notice" of the election. There must be two notices: the first notice between 51 and 65 days before the election and the second notice between 23 and 37 days before the election. The notice shall include but is not limited to:

(1) geographical area affected, including zone within the district if applicable;

(2) declare which terms expire by name of incumbent and position number, and zone represented if the district is zoned; [Supervisors serving positions #1, #2, #3 and #4, or candidates for those positions, must be resident owners of land within the district, and within the zone if the district is zoned. Position #5 is the supervisor-at-large who does not have to be an owner of land but must be resident within the district.]

(3) instructions on how to file a declaration of candidacy, including:

(a) dates, times and address where declarations of candidacy and declarations of intent to be a write-in candidate may be obtained,

(b) the date on which declarations of candidacy must be filed, and

(c) the date on which declarations of intent to be a write-in candidate must be filed;

(4) date, time and place ballots may be cast;

(5) instructions for absentee balloting, including the hours and days of the week that absentee ballot applications will be available;

(6) documentation required by the election officials to confirm eligibility to vote (voter registration card, utility bill or other proof of residency within the district);

(7) questions to be submitted to voters on the same ballot, if any; and

(8) name and telephone number of a person to contact in case of questions about the election.

D. Prepare and make available declaration of candidacy forms to persons who request them. Declarations of candidacy must be delivered in person by the candidate to the designated place 49 days before the election, and shall take substantially the following form:
"Declaration of Candidacy
Name of candidate (as it should appear on the ballot):
_____
Candidate's residence physical address:
_____
Candidate's mailing address:
_____
_____
Candidate's phone number:
_____
Description of land owned within the _____ soil and water conservation district, if different from physical address above:
_____

I desire to become a candidate for the office of supervisor, position number ___, at the election of supervisors to be held on the date set by law. I will be eligible to hold this office at the beginning of its term. I make the foregoing affidavit under oath, knowing that any false statement herein constitutes a felony punishable under the criminal laws of New Mexico.
Declarant's signature:
_____
Witness signature:
_____
Received by (signature, date, time):
_____"

E. Prepare ballots for the election. The names of persons for whom a declaration of candidacy was successfully completed shall appear on the ballot. The ballot must provide for write-in votes if any persons have declared their intent to be a write-in candidate on the appropriate declaration form filed 42 days prior to the election. Such persons shall not be entitled to have their name printed on the ballot.

F. In the event that no more than one candidate has filed a declaration of candidacy for each position to be filled, the board of supervisors shall certify such facts to the canvassing board. If there are no other questions on the ballot the canvassing board shall cancel the election as provided by these rules. The election superintendent shall notify applicants for absentee ballots of the cancellation. Unopposed candidates will assume the office of supervisor according to the Soil and Water Conservation District Act. In the case that there are no candidates for a position, incumbent supervisors continue in office until their successors are elected or appointed as in the case of any other vacancy.

G. At least 60 days prior to the election, appoint an election superintendent who must take the following oath of office before performing the required duties: "I, (name of person), do solemnly swear (or affirm) that I will support the constitution of the United States, and the constitution of the state of New Mexico, and I will faithfully discharge the duties of the office of election superintendent for the (name of district) soil and water conservation district."

H. Assure that candidates for office do not serve as election superintendent or on the canvassing board.

I. Assure that all polling places are staffed with at least two polling

officials during the entire voting period. At least one of the officials must not be a district supervisor, district employee, candidate, or immediate family member of any of the aforementioned. Arrange for substitutes if necessary. Polling officials and substitutes must take an oath of office similar to that of the election superintendent before assuming their duties.

J. Maintain a file of all records pertaining to the election in compliance with the applicable records retention schedule. [See 1.19.11 NMAC]

[21.9.2.9 NMAC - Rp, 21.9.2.9 NMAC, 9-30-05]

21.9.2.10 ABSENTEE BALLOTING: Eligible voters wishing to vote absentee must fill out an absentee ballot application. Applications for absentee ballots must be requested by mail, by phone, and in person only, beginning 30 days before the election until 20 days before the election. Only one absentee ballot application may be issued per eligible voter.

A. Upon receipt of the completed application and determination of the voter's eligibility an absentee ballot will be furnished.

B. The district must mail out requested absentee ballots at least 15 days before the election.

C. Absentee ballots must be distributed by the district with two envelopes, with a serial number and voter certification information on the outside of the larger envelope. Districts shall maintain an absentee ballot register by serial number.

D. Absentee ballots returned by mail and received by the district by closing of the polls on election day or before will be counted. Absentee ballots received after election day will not be opened or counted, but will be kept with the election records.

E. All unused absentee ballots shall be destroyed immediately following the close of the absentee balloting period. The destruction shall be certified by the election superintendent and one polling official.

F. Absentee ballots will not be issued if the election is cancelled pursuant to these rules.

[21.9.2.10 NMAC - Rp, 21.9.2.10 NMAC, 9-30-05]

21.9.2.11 ELECTION SUPERINTENDENT DUTIES:

A. Assure that all absentee ballots requested by eligible voters in writing are sent as indicated in the election notice, unless the election is cancelled, in which case eligible voters shall be notified. All applications will be compared with the absentee ballot register.

B. Conduct the voting during the period stated in the election notice.

C. If paper ballots are used, place all ballots in a sealed ballot box.

D. Prepare a complete list of all persons voting and those applying for a ballot and determined ineligible to vote.

E. Prepare documentation regarding all challenges of voter ineligibility.

F. Assist the canvassing board in properly securing, transporting, and storing ballot boxes, and cooperate fully with the canvassing board to determine voting results in a timely manner.

G. Prepare a list of eligible voters 28 days prior to the election, and make it available for inspection.

[21.9.2.11 NMAC - Rp, 21.9.2.11 NMAC, 9-30-05]

21.9.2.12 PROVISIONAL BALLOTS: Persons who are not on the eligible voter list and cannot show proof of eligibility must complete a provisional ballot.

A. A provisional ballot shall consist of a paper ballot, a plain envelope, and a voter certification form printed on a larger envelope.

B. Marked ballots must be sealed in the plain envelope. The plain envelope must be sealed in the larger envelope. Voters are determined to be eligible or ineligible using the voter certification information on the larger envelope, and supporting documentation provided by the voter.

C. The larger envelopes shall be opened only after all ineligible voters are given an opportunity to prove eligibility. The larger envelope of ineligible voters shall not be opened. All of the larger envelopes of eligible voters shall be opened and the plain envelopes placed in the ballot box. The plain envelopes are then removed from the ballot box and ballots are counted. The plain envelopes may be destroyed after the vote is counted, but the larger envelopes and the ballots must be maintained with the election records.

D. Persons who are determined to be ineligible to vote by polling officials must be notified by the polling officials using the most expedient means of communication. When contacted, ineligible voters must be informed of their right to challenge. Challenges must be in writing and be delivered to the contact person shown on the election notice no later than four days following the election.

[21.9.2.12 NMAC - Rp, 21.9.2.12 NMAC, 9-30-05]

21.9.2.13 VOTER CERTIFICATION:

I am a registered voter of precinct no. _____ of the county of _____, state of New Mexico. I reside at _____, within the boundaries of the _____ soil and water conservation district;

I make the foregoing affidavit under oath, knowing that any false statement herein constitutes a felony punishable under the criminal laws of New Mexico.

_____

(Voter) Printed name and signature

_____

(Mailing Address)

_____

(Residence Address)

_____

Telephone number (if voter wishes to be notified of ineligibility to vote)

NOTE: print the above information on a number 12-business size envelope. Use separate envelope for each voter. Use number 10 envelopes for ballots, only one ballot per envelope.

[21.9.2.13 NMAC - Rp, 21.9.2.13 NMAC, 9-30-05]

21.9.2.14 CANVASSING BOARD:

A. The canvassing board shall be composed of a minimum of three members:

(1) an owner of land within the district who is not a supervisor or employee of the district or members of their immediate family; and

(2) a supervisor of the district [See Subsection H of 21.9.2.9 NMAC.]; and

(3) a local elected official or his/her designee.

B. The canvassing board will:

(1) cancel the election upon being notified by the board of supervisors that no more than one candidate has filed a declaration of candidacy for each position to be filled, and there are no other questions on the ballot, and give due notice of such cancellation;

(2) establish appropriate procedures for securing, transporting, storing and tallying ballots;

(3) resolve any challenges of voter eligibility or conduct of election; and

(4) certify election results and report results to the soil and water conservation commission in Las Cruces within seven calendar days following completion of their canvass; a canvass is considered complete when all challenges have been

resolved to the satisfaction of the canvassing board; for each question, the highest number of votes shall decide the question without a runoff vote; a tie vote will be broken by lot.
[21.9.2.14 NMAC - Rp, 21.9.2.14 NMAC, 9-30-05]

HISTORY OF 21.9.2 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives under:
SSCC-200, Outline of Instructions for Conducting District Elections, filed 8/11/69.
SWCD 85-2, Procedures for Conducting an Election of Supervisors in Soil and Water Conservation Districts, filed 7/1/85.
SWCC 90-I, Rules for Conducting an Election of District Supervisors in Soil and Water Conservation Districts, filed 7/2/90.

History of Repealed Material:
21 NMAC 9.2, Conducting an Election of District Supervisors, filed 12/17/96 - Repealed effective 11/26/2003.
21.9.2 NMAC, Conducting an Election of District Supervisors, filed 11/12/2003 - Repealed effective 9/30/2005.

NEW MEXICO SOIL AND WATER CONSERVATION COMMISSION

TITLE 21 AGRICULTURE AND RANCHING
CHAPTER 9 SOIL AND WATER CONSERVATION DISTRICTS
PART 3 CONDUCTING A REFERENDUM

21.9.3.1 ISSUING AGENCY: New Mexico Soil and Water Conservation Commission
[21.9.3.1 NMAC - Rp, 21.9.3.1 NMAC, 9-30-05]

21.9.3.2 SCOPE: This part applies to soil and water conservation districts seeking voter approval for authority to levy taxes and the soil and water conservation commission when in the process of establishing new districts or modifying the boundaries of existing districts.
[21.9.3.2 NMAC - Rp, 21.9.3.2 NMAC, 9-30-05]

21.9.3.3 STATUTORY AUTHORITY: This part is adopted pursuant to the Soil and Water Conservation District Act, Sections 73-20-25, et. seq. NMSA 1978.
[21.9.3.3 NMAC - Rp, 21.9.3.3 NMAC, 9-30-05]

21.9.3.4 DURATION: Permanent.
[21.9.3.4 NMAC - Rp, 21.9.3.4 NMAC, 9-30-05]

21.9.3.5 EFFECTIVE DATE: September 30, 2005 unless a later date is cited at the end of a section.
[21.9.3.5 NMAC - Rp, 21.9.3.5 NMAC, 9-30-05]

21.9.3.6 OBJECTIVE: The objective of Part 3 of Chapter 9 is to provide for referenda to be conducted in accordance with law.
[21.9.3.6 NMAC - Rp, 21.9.3.6 NMAC, 9-30-05]

21.9.3.7 DEFINITIONS: Terms defined in Section 73-20-27 NMSA 1978 have the same definition in this part. Terms not defined in Section 73-20-27 NMSA 1978 are defined below:

A. "**Eligible voter**" shall mean a person who, at least 32 days prior to a referendum, is registered to vote in New Mexico pursuant to the provisions of the election code, and whose address of record on the voter registration is within the area affected by the referendum.

B. "**Referendum superintendent"** shall mean the person appointed to conduct the referendum.

C. "**Referendum**" shall mean an election to decide a question, which may be held at one or more designated polling places which will be open a minimum of eight hours, or conducted solely by mailed ballots as provided in these rules. Due notice must be given. Absentee voting as provided in these rules is permitted.

D. "**Canvassing board**" shall mean the persons appointed in accordance with these rules to certify and publish the election results, and give the commission notice of their canvass.
[21.9.3.7 NMAC - Rp, 21.9.3.7 NMAC, 9-30-05]

21.9.3.8 SCHEDULING A REFERENDUM: A referendum shall be held on the next succeeding first Tuesday in May, if practicable. A referendum shall not be held within 42 days prior to a statewide election. A referendum may be held in conjunction with election of supervisors.
[21.9.3.8 NMAC - Rp, 21.9.3.8 NMAC, 9-30-05]

21.9.3.9 DUTIES OF BOARD OF SUPERVISORS OR COMMISSION:

A. Provide for "due notice" of the referendum. There must be two notices: the first between 51 and 65 days before the referendum and the second between 23 and 37 days before the referendum. The notice shall include but is not limited to:

(1) geographical area affected;

(2) location of polling place(s), if any;

(3) date and time when ballots may be cast, or date by which mailed ballots must be received;

(4) the resolution of the board of supervisors or commission to hold the referendum;

(5) a statement that the commission has approved the referendum (only for mill levy referendum of a district); and

(6) instructions for absentee balloting, including the hours and days of the week that absentee ballot applications will be available.

B. Notify the county clerks of all counties located within the district boundaries of the referendum at least 120 days preceding the referendum. Each county clerk must be provided the following:

(1) district boundary description;

(2) district boundary map;

(3) date of the referendum;

(4) the referendum timeline; and

(5) a copy of the referendum rules.

C. At least 60 days prior to the referendum appoint a referendum superintendent who must take the following oath of office before performing the required duties: "I, (name of person) do solemnly swear (or affirm) that I will support the constitution of the United States, and the constitution of the state of New Mexico, and I will faithfully discharge the duties of the office of (referendum superintendent or polling officer) for the (name of district) soil and water conservation district.

D. Assure that all polling places are staffed with at least two polling officials during the entire voting period. At least one of the officials must not be a district supervisor, district employee, or immediate family member of any of the aforementioned. Arrange for substitutes if necessary. Polling officials and substitutes must take an oath of office similar to that of the election superintendent before assuming their duties.

E. Maintain a file of all records pertaining to the election in compliance with the state records retention schedule. [See 1.19.11 NMAC]

F. Prepare ballots for the election.
[21.9.3.9 NMAC - Rp, 21.9.3.9 NMAC, 9-30-05]

21.9.3.10 REFERENDUM SUPERINTENDENT DUTIES:

A. Assure that all absentee ballots requested by eligible voters in writ-

ing were sent as indicated in the referendum notice. All applications will be compared with the absentee ballot register.

B. Conduct the voting during the period stated in the "due notice".

C. If paper ballots are used, place all ballots in a sealed ballot box.

D. Prepare documentation regarding all challenges of voter ineligibility.

E. Assist the canvassing board in properly securing, transporting, and storing ballot boxes, and cooperate fully with the canvassing board to determine voting results in a timely manner.

F. Prepare a list of eligible voters 28 days prior to the election. The eligible voter list must be completed and available for inspection at least five days before the election.

G. Determine eligibility of voters. Persons who are not on the eligible voter list and cannot show proof of eligibility must complete a provisional ballot.

H. Prepare a complete list of all persons voting, and those applying for a ballot and determined ineligible to vote.

[21.9.3.10 NMAC - Rp, 21.9.3.10 NMAC, 9-30-05]

21.9.3.11 ABSENTEE BALLOTING: Eligible voters wishing to vote absentee must fill out an absentee ballot application. Applications for absentee ballots must be requested by mail, by phone, and in person only, beginning 30 days before the election until 20 days before the election. Only one absentee ballot application may be issued per eligible voter.

A. Upon receipt of the completed application and determination of the voters' eligibility an absentee ballot will be furnished.

B. The district must mail out requested absentee ballots at least 15 days before the election.

C. Absentee ballots must be distributed by the district with two envelopes, with a serial number and voter certification information on the outside of the larger envelope. Districts shall maintain an absentee ballot register by serial number.

D. Absentee ballots returned by mail and received by the district by closing of the polls on election day or before will be counted. Absentee ballots received after election day will not be opened or counted, but will be kept with the election records.

E. All unused absentee ballots shall be destroyed immediately following the close of the absentee balloting period. The destruction shall be certified by the election superintendent and one polling official.

[21.9.3.11 NMAC - Rp, 21.9.3.11 NMAC, 9-30-05]

21.9.3.12 PROVISIONAL BALLOTS: Persons who are not on the eligible voter list and cannot show proof of eligibility must complete a provisional ballot.

A. A provisional ballot shall consist of a paper ballot, a plain envelope, and a voter certification form printed on a larger envelope.

B. Marked ballots must be sealed in the plain envelope. The plain envelope must be sealed in the larger envelope. Voters are determined to be eligible or ineligible using the voter certification information on the larger envelope, and supporting documentation provided by the voter.

C. The larger envelopes shall be opened only after all ineligible voters are given an opportunity to prove eligibility. The larger envelope of ineligible voters shall not be opened. All of the larger envelopes of eligible voters shall be opened and the plain envelopes placed in the ballot box. The plain envelopes are then removed from the ballot box and ballots are counted. The plain envelopes may be destroyed after the vote is counted, but the larger envelopes and the ballots must be maintained with the election records.

D. Persons who are determined to be ineligible to vote by polling officials must be notified by the polling officials using the most expedient means of communication. When contacted, ineligible voters must be informed of their right to challenge. Challenges must be in writing and be delivered to the contact person shown on the election notice no later than four days following the election.

[21.9.3.12 NMAC - Rp, 21.9.3.12 NMAC, 9-30-05]

21.9.3.13 VOTER CERTIFICATION:

I am a registered voter of Precinct No. _____ of the county of _____, state of New Mexico. I reside at _____ , within the boundaries of the _____ _____ soil and water conservation district;

I make the foregoing affidavit under oath, knowing that any false statement herein constitutes a felony punishable under the criminal laws of New Mexico.

_____

(Voter) Printed name and signature

_____

(Mailing address)

_____

(Residence address)

_____

Telephone number (if voter wishes to be notified of ineligibility to vote)

NOTE: print the above information on a business size envelope. Use separate envelope for each voter. Use smaller envelopes for ballots, only one ballot per envelope.

[21.9.3.13 NMAC - Rp, 21.9.3.13 NMAC, 9-30-05]

21.9.3.14 CANVASSING BOARD:

A. The canvassing board shall be composed of a minimum of three members, who may not also serve as referendum superintendent or poll worker:

(1) an owner of land within the district who is not a supervisor or employee of the district or members of their immediate family; and

(2) a member of the governing body of the district; and

(3) a local elected public official or their designee.

B. The canvassing board will:

(1) establish appropriate procedures for securing, transporting, storing and opening ballot boxes;

(2) resolve any challenges of voter eligibility or conduct of election; and

(3) certify election results and report results to the soil and water conservation commission in Las Cruces within seven calendar days following completion of their canvass; a canvass is considered complete when all challenges have been resolved to the satisfaction of the canvassing board; for each question, the highest number of votes shall decide the question without a runoff vote; a tie vote will be broken by lot.

[21.9.3.14 NMAC - Rp, 21.9.3.14 NMAC, 9-30-05]

21.9.3.15 MAIL BALLOT REFERENDUM: Upon the adoption of a resolution by the commission or board of supervisors to conduct an election by an all-mailed ballot, each registered voter who would be eligible to vote in a polling place referendum shall be mailed an absentee ballot along with a statement that there will be no polling place for the referendum. The voter shall not be required to file an application for the absentee ballot. The ballot shall be mailed to each voter no earlier than the thirty-fifth day prior to the election, and the mailing shall be completed by the fifth day before the election.

A. The referendum superintendent may include in the mailing a

printed notice to the voters informing the voters that they shall return the voted ballot by mail.

B. The referendum superintendent shall prepare a checklist of eligible voters. The checklist of registered voters shall be marked indicating that the voter has returned his all-mail ballot immediately upon receipt.

C. A referendum conducted solely by mailed ballot shall not include names of candidates to be nominated for or elected to office.

[21.9.3.15 NMAC - Rp, 21.9.3.15 NMAC, 9-30-05]

21.9.3.16 DEADLINES: Deadlines in these rules which fall on a weekend or holiday shall be carried over until the next business day.

[21.9.3.16 NMAC - N, 9-30-05]

HISTORY OF 21.9.3 NMAC:

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

SWCD 84-1, Procedures for Conducting a Referendum for Soil and Water Conservation Districts, filed 7/26/84.

SWCC Rule 90-II, Rule for Conducting a Referendum by the Soil and Water Conservation Districts or by the Soil and Water Conservation Commission, filed 7/2/90.

History of Repealed Material:

SWCD 84-1, Procedures for Conducting a Referendum for Soil and Water Conservation Districts, filed 7/26/84 - Repealed 12/20/89.

21 NMAC 9.3, Conducting a Referendum, filed 12/17/96 - Repealed effective 12/15/2003.

21.9.3 NMAC, Conducting a Referendum, filed 11/26/2003 - Repealed effective 9/30/2005.

End of Adopted Rules Section

Other Material Related to Administrative Law

NEW MEXICO HUMAN SERVICES DEPARTMENT
INCOME SUPPORT DIVISION

NOTICE OF PUBLIC HEARING

The Human Services Department will receive public comment for the New Mexico State plan for administration of the Temporary Assistance for Needy Families (TANF) and file the plan with the Federal Department of Health and Human services, Administration for Children and Families (ACF). The hearing will be held at 9:00 am on Tuesday, November 15, 2005. The hearing will be held at the Income Support Division conference room, 2009 S. Pacheco St., Santa Fe, NM. The conference room is located in Room 120 on the lower level.

The Department proposes the New Mexico TANF State plan covering the period of January 1, 2006 to December 31, 2007. The 45-day comment period will begin October 1, 2005 and end at 5:00 P.M. on November 15, 2005. All comments received during the comment period will receive consideration for the New Mexico TANF State plan.

Individuals may submit written or recorded comments to the address below. Individuals may also submit comments electronically to: Ted.Roth@state.nm.us

A copy of the proposed TANF State plan is available as of October 1, 2005 on the Department's web site at: http://www.state.nm.us/hsd/isd.html. A copy of the proposed TANF State Plan can be requested by calling the Office of the Director, Income Support Division, in Santa Fe at 1-800-432-6217 or (505) 827-7250; or by writing to:

Human Services Department
Income Support Division
P.O. Box 2348
Pollon Plaza; Room 111
Santa Fe, NM 87504-2348

If you are a person with a disability and you require this information in an alternative format or require a special accommodation to participate in the public hearing, please contact the Department toll free at 1-800-432-6217, TDD 1-800-609-4TDD (4833), or through the New Mexico Relay System toll free at 1-800-659-8331. The Department requests at least a 10-day advance notice to provide requested alternative formats and special accommodations.

End of Other Related Material Section

2005

SUBMITTAL DEADLINES AND PUBLICATION DATES

Volume XVI	Submittal Deadline	Publication Date
Issue Number 1	January 3	January 14
Issue Number 2	January 18	January 31
Issue Number 3	February 1	February 14
Issue Number 4	February 15	February 28
Issue Number 5	March 1	March 15
Issue Number 6	March 16	March 31
Issue Number 7	April 1	April 14
Issue Number 8	April 15	April 29
Issue Number 9	May 2	May 13
Issue Number 10	May 16	May 31
Issue Number 11	June 1	June 15
Issue Number 12	June 16	June 30
Issue Number 13	July 1	July 15
Issue Number 14	July 18	July 29
Issue Number 15	August 1	August 15
Issue Number 16	August 16	August 31
Issue Number 17	September 1	September 15
Issue Number 18	September 16	September 30
Issue Number 19	October 3	October 17
Issue Number 20	October 18	October 31
Issue Number 21	November 1	November 15
Issue Number 22	November 16	November 30
Issue Number 23	December 1	December 15
Issue Number 24	December 16	December 30

The *New Mexico Register* is the official publication for all material relating to administrative law, such as notices of rule making, proposed rules, adopted rules, emergency rules, and other similar material. The Commission of Public Records, Administrative Law Division publishes the *New Mexico Register* twice a month pursuant to Section 14-4-7.1 NMSA 1978. For further subscription information, call 505-476-7907.