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

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

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

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

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

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

13.10.35.6 OBJECTIVE: Establish minimum regulatory standards and sales practices relating to dental and vision plans; standardize and simplify the terms and coverages; facilitate public understanding and comparison of coverage; eliminate provisions that may be misleading or confusing in connection with the purchase and renewal of the coverages or with the settlement of claims; and require disclosures in the marketing and sale of the subject plans.
[13.10.35.6 NMAC - N, 01/01/2022]

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

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

B. "Preferred provider" means a dental or vision care provider, or group of providers, who contracts with a dental or vision insurance carrier to provide dental or vision services to a covered person.
[13.10.35.7 NMAC - N, 01/01/2022]

13.10.35.8 GENERAL PROHIBITED POLICY PROVISIONS:

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

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

C. Exclusions. A plan that includes a preexisting condition exclusion shall comply with these requirements:

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

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

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

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

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

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

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

G. Plan governance. A covered person's rights under any plan shall be governed by the terms of the plan approved by the superintendent, and by applicable state and federal law.

H. Discrimination. No plan shall discriminate in eligibility for coverage or benefits on the basis of sex, sexual orientation, gender, race, religion, or national origin

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

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

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

13.10.35.9 GENERAL STANDARDS FOR POLICIES AND BENEFITS:

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

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

(2) A "noncancellable," "guaranteed renewable," or "noncancellable and guaranteed renewable" individual plan shall not provide for termination of coverage of the domestic co-insured solely because of the occurrence of an event specified for termination of coverage of the covered person, other than nonpayment of premium. In addition, the plan shall provide that in the event of the covered person's death, the domestic co-insured of the covered person, if covered under the plan, shall become a covered person with the issuance of a new policy and completed agreement.

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

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

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

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

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

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

(iii) fraud or misrepresentation affecting coverage;

(iv) policyholder request for cancellation;

(v) policy term ends; or

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

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

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

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

(a) be in writing and dated;

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

(c) state that a covered person's plan cannot be terminated because of health status, need for services, race, gender, or sexual orientation of covered persons under the contract. Age may only be a factor in termination of coverage as outlined in Paragraph (4) of Subsection A and Paragraph (7) of Subsection B of this section;

(d) state that a covered person who alleges that an enrollment has been terminated or not renewed because of the covered person's health status, need for health care services, race, gender, age or sexual orientation may file a complaint with the superintendent of by phone or on the Office of Superintendent of Insurance website; and

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

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

(3) If a plan includes a conversion privilege, the provision shall be captioned, "Conversion Privilege." The provision shall specify who is eligible for conversion and the circumstances that govern conversion, or may state that the conversion coverage will be provided as an approved plan form used by the carrier for that purpose.

(4) If a carrier requires submission of a claim form as a condition of payment, the carrier, upon receipt of notice of a claim, shall furnish to the covered person a form to be delivered in the manner offered by the carrier that is preferred by the covered person. If the carrier does not furnish a claim form within 15 days after notice of a claim, the claimant shall be deemed to have complied with the requirement to provide proof of loss if the notice of claim contains written proof describing the claim, including the character and extent of the loss of which the claim is made. Adequate proof of loss must be in the possession of the insurance company at the time funds are disbursed in payment of claims.

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

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

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

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

(7) A plan may terminate the coverage of a dependent due to limiting age for a dependent per the plan's contracted age limits. However, a plan must offer coverage to dependents, regardless of age, who are physically or mentally disabled prior to reaching the limiting age and are incapable of self-sustaining employment. Coverage for a child who is physically or mentally disabled prior to reaching the limiting age and incapable of self-sustaining employment on the date the child would otherwise age out of coverage shall continue if the child depends on the covered person for support and maintenance. The plan may require that within 31 days of the date the company receives proof of the child's incapacity, the covered person may elect to continue the plan in force with respect to the child.

C. For group coverage. A group plan shall comply with Sections 8, 9, 11, and 12 of 13.10.5 NMAC, and Subsection D of 13.10.5.10 NMAC.

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

13.10.35.10 DENTAL PLANS:

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

B. Definitions. For purposes of this section:

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

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

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

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

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

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

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

(a) Bitewing x-rays at least once a year unless greater frequency is deemed medically necessary; and

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

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

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

(b) Fluoride treatment. A dental plan shall cover at least one fluoride treatment per calendar year furnished in a health care setting for children up to 14 years old or older as medically necessary.

(c) Molar sealants. A dental plan shall cover one treatment of molar sealant per tooth every five consecutive years as medically necessary. A dental plan may exclude coverage where an occlusal restoration has been completed on the tooth. A dental plan may apply a waiting period of six consecutive months for medically necessary sealants.

(4) Cavities. A dental plan shall cover necessary fillings for cavities.

(5) Craniomandibular and temporomandibular joint disorders. A dental plan sold in conjunction with a qualified health plan shall cover the diagnosis and treatment of craniomandibular and temporomandibular joint disorders, if such coverage is not offered by the qualified health plan.

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

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

13.10.35.11 VISION PLANS:

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

B. Definitions. For purposes of this section:

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

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

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

(a) lenses;

(b) frames;

(c) contact lenses; and

(d) spectacle or contact lens treatments and coatings;

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

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

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

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

(8) "vision care provider" means an individual licensed under state law as an optometrist or ophthalmologist.

C. Required minimum benefits. A vision plan shall provide each covered person benefits for the following vision services and vision materials. A pediatric vision plan sold in conjunction with a qualified health plan shall provide vision coverage mandated by law for the qualified health plan, or the benefits mandated by this rule, whichever are most favorable to the member.

(1) Examinations. At least once every consecutive two-year period for adults and once every 12-month consecutive period for children under the age of 19, a comprehensive vision examination. The comprehensive vision examination shall include a complete analysis of the eyes and related structures, as appropriate, to determine the presence of vision problems or other abnormalities.

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

(3) Contact lenses shall be covered as follows:

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

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

(c) This benefit may be limited to once each 12-month consecutive period, and may be subject to a maximum one month waiting period.

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

(1) any that are not medically necessary;

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

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

(4) vision therapy; and

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

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

13.10.35.12 COORDINATION AND COMBINATION OF BENEFITS:

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

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

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

13.10.35.13 COVERAGE DOCUMENTATION:

A. Coverage forms and benefits disclosures.

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

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

(a) the covered services, supplies and materials;

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

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

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

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

(f) procedures for filing claims;

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

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

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

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

B. Notice required. The following language shall be provided in a summary of benefits: READ YOUR PLAN CAREFULLY - THIS BENEFITS SUMMARY PROVIDES A VERY BRIEF DESCRIPTION OF THE IMPORTANT FEATURES OF YOUR PLAN. THIS IS NOT THE INSURANCE CONTRACT. YOUR FULL RIGHTS AND BENEFITS ARE EXPRESSED IN THE ACTUAL PLAN DOCUMENTS THAT ARE AVAILABLE TO YOU UPON YOUR REQUEST TO US.

C. Contact information. The policy, certificate or summary of benefits shall state the plan's contact information and the website and phone number of the office of superintendent of insurance.

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

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

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

(1) That, in population areas of 50,000 or more residents, two dental or vision care providers are available in any county within no more than 20 miles or 20 minutes' average driving time for ninety percent of the enrolled population, or, in population areas of less than 50,000, whether two dental or vision care providers are available in any county or service area within no more than 60 miles or 60 minutes' average driving time for ninety percent of the enrolled population. For remote rural areas, the superintendent shall consider on a case by case basis whether the dental or vision plan has made sufficient providers available given the number of residents in the county or service area and given the community's standard of care.

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

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

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

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

(a) include specialty providers;

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

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

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

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

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

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

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

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

13.10.35.15 UTILIZATION MANAGEMENT DETERMINATIONS:

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

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

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

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

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

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

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

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

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

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

(5) another payer is responsible for the payment;

(6) another payer has already paid the claim;

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

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

E. Notice of denial. If a carrier denies a request for prior authorization, it shall deliver to the covered persons a written explanation of the basis for the denial within 24 hours of the determination for emergency care and within 10 calendar days for all other care.

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

13.10.35.16 CONSUMER COMPLAINTS: A carrier shall state in all plan documents that a covered person who cannot resolve a complaint with the plan may contact the office of the superintendent of insurance.

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

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

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

13.10.35.18 SEVERABILITY: If any section of this rule, or the applicability of any section to any person or circumstance, is for any reason held invalid by a court of competent jurisdiction, the remainder of the rule, or the applicability of such provisions to other persons or circumstances, shall not be affected.

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

History of 13.10.35 NMAC: [RESERVED]