TITLE 13 INSURANCE
CHAPTER 10 HEALTH INSURANCE
PART 34 STANDARDS FOR ACCIDENT ONLY, SPECIFIED DISEASE OR ILLNESS, HOSPITAL INDEMNITY, AND RELATED EXCEPTED BENEFITS

13.10.34.1 ISSUING AGENCY: New Mexico Office of Superintendent of Insurance ("OSI").
[13.10.34.1 NMAC - N, 10/01/2020]

13.10.34.2 SCOPE:
A. This rule applies to the following individual and group excepted benefits insurance plans.
(1) coverage-only for accident insurance;
(2) coverage-only for a specified disease or illness;
(3) hospital indemnity or other fixed indemnity insurance;
(4) Champus/TRICARE supplement plans that provide one or more of the coverages specified in Sections 1 through 3 of this rule.
B. This rule applies to every such contract of insurance issued in this state, and to any such contract issued to a group located outside of this state, if any covered person resides in this state.
[13.10.34.2 NMAC - N, 10/01/2020]

13.10.34.3 STATUTORY AUTHORITY: Section 59A-23G-3 NMSA 1978.
[13.10.34.3 NMAC - N, 10/01/2020]

13.10.34.4 DURATION: Permanent.
[13.10.34.4 NMAC - N, 10/01/2020]

13.10.34.5 OBJECTIVE: The purpose of this rule is to establish regulatory requirements for the subject excepted benefit plans. The rule will standardize and simplify the terms and coverages; facilitate public understanding and comparison of coverage; eliminate provisions that may be misleading or confusing in connection with the purchase and renewal of the coverages or with the settlement of claims; and require disclosures in the marketing and sale of excepted benefit plans.
[13.10.34.5 NMAC - N, 10/01/2020]

13.10.34.6 EFFECTIVE DATE: October 1, 2020, unless a later date is cited at the end of a section. If the superintendent previously approved a subject excepted benefits plan for sale in this state, that plan shall be amended to comply with this rule no later than April 1, 2023, if issued on or after that date.
[13.10.34.6 NMAC – N, 10/01/2020; A/E, 09/15/2021; A, 3/8/2022].

13.10.34.7 DEFINITIONS: For definitions of terms contained in this rule, refer to 13.10.29 NMAC, unless otherwise noted below.
A. **"Accident only"** means a plan that provides benefits for death, dismemberment, disability, hospital, or medical care or injuries arising from an accident.
B. **"Certificate"** means a statement of the coverage and provisions of a group plan delivered to an individual insured.
C. **"Direct response insurer"** means a carrier who does not sell its insurance products through producers.
D. **"Domestic co-insured"** means a spouse or domestic partner insured under the same plan or certificate.
[13.10.34.7 NMAC - N, 10/01/2020]

13.10.34.8 PROHIBITED PLAN PROVISIONS:
A. **Probationary periods.** Except as otherwise expressly allowed by these rules, a plan shall not include a probationary or waiting period during which no coverage is provided for a covered benefit under the plan. A probationary period does not include an eligibility-waiting period during which no premium is paid.
B. **Riders and other supplements.** A plan that includes a rider, amendment, endorsement or other supplement shall explicitly state which benefits the carrier has amended or supplemented from the original plan.

C. Preexisting conditions. An individual plan or plan sold through an association or group described in Paragraph (2) or (4) of Subsection A of Section 59A-23-3 NMSA 1978 shall not exclude coverage for a loss due to a preexisting condition unless the application or enrollment form requires disclosure of prior illness, disease or physical conditions, or of prior medical care and treatment. A disclosure form shall not request family member health information unless the family member is also seeking coverage under the plan.

D. Return of premium. An excepted benefits plan may include a return of premium or cash value benefit if authorized by the superintendent following an evaluation of the potential impact on the carrier's reserves and ability to service policy obligations. Nothing in this rule requires a carrier to seek authorization from the superintendent to return premiums unearned through termination or suspension of coverage, retroactive waiver of premium paid during medical condition, payment of dividends on participating policies, or experience rating refunds.

E. Type of illness, accident or medical condition. A plan shall not limit or exclude coverage by type of illness, accident, treatment or medical condition, except as follows:

(1) preexisting conditions or diseases;

(2) pregnancy and childbirth;

(3) illness, treatment or medical condition arising out of:

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

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

(c) aviation, other than travel on a commercial carrier; and

(d) incarceration;

(4) cosmetic surgery, other than reconstructive surgery when the service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child that has resulted in a functional defect;

(5) foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet;

(6) services for which benefits are provided under Medicare or other governmental program (except Medicaid), a state or federal workers' compensation program, employers liability or occupational disease law, or motor vehicle no-fault law;; services performed by a member of the covered person's immediate family; and services for which no charge is normally made in the absence of insurance;

(7) dental care or treatment with the exception of craniomandibular and temporomandibular joint disorders;

(8) eye glasses, hearing aids and examination for the prescription or fitting of them;

(9) illegal activities;

(10) injuries incurred as a result of intoxication;

(11) rest cures, custodial care, transportation and routine physical examinations;

(12) intoxication via drug, alcohol or ingestion or inhalation of unlawful chemicals;

(13) specifically named high -risk physical activities; and

(14) international territorial limitations.

F. Contracted providers. No excepted benefits plan shall contract with medical providers to provide benefits or services to its covered persons. Any reference in a plan document, advertisement or insurance card, to a provider network, a "multi-plan" or "PPO" arrangement is prohibited.

G. Pharmacy benefit plans. No carrier shall sell a plan or fixed indemnity benefit package that cover only prescription drug benefits. A plan design or fixed indemnity benefit package that covers prescription drugs plus a minimal number of additional benefits shall be considered a prohibited pharmacy benefit plan.

H. 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.

I. Arbitration provisions. A carrier shall not sell a plan that requires a covered person to submit a dispute to mediation or arbitration.

J. 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.

K. Telemedicine services. A plan shall pay a benefit to a covered person for eligible telemedicine or otherwise covered services, but shall not offer a benefit for a telemedicine service provided through a contracted provider.

L. **Conversion privileges**. No plan shall offer a conversion plan that is not approved by the superintendent.

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

N. **Insurance cards**. No plan or advisement language shall direct a covered person to submit their insurance card to a healthcare provider.

[13.10.34.8 NMAC - N, 10/01/2020]

13.10.34.9 GENERAL STANDARDS FOR PLANS AND BENEFITS:

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

B. **Consumer rights**. A plan shall protect consumer rights as follows:

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

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

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

D. **Death and dismemberment**. When accidental death and dismemberment coverage is part of an individual plan, the covered person shall have the option to include all covered persons under the coverage and not just the principal covered person. Hospital indemnity or specified disease or illness policies or certificates shall not include accidental death and dismemberment coverage.

E. **Military service exclusion or suspension.** If a plan contains a military service exclusion or a provision that suspends coverage during military service, the plan shall provide, upon receipt of written request, for refund of premiums as applicable to the person on a pro rata basis.

F. **Pregnancy.** A plan that provides pregnancy benefits shall extend those benefits for a pregnancy that begins while the plan is in force and for which benefits would have been payable if the plan had remained in force if the carrier cancels or refuses to renew coverage. A plan that provides pregnancy benefits shall provide for an extension of those benefits.

G. **Convalescent or extended care**. A plan that provides convalescent or extended care benefits following hospitalization shall provide such benefits if the admission to the convalescent or extended care facility is within 14 days after discharge from the hospital.

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

I. **Payment of benefits**. Accidental death and dismemberment benefits shall be payable if the loss occurs within 90 days from the date of the accident, except where the plan has terminated during this 90-day period due to non-payment of premium.

J. **Continuous loss.** The termination of a plan, except for termination of the plan due to non-payment of premium, shall not terminate benefits for a continuous loss that commences while the plan or certificate was in force unless expressly limited by the duration of the benefit period, if any, or any maximum benefit limitation.

K. Wellness benefits. Any plan offering wellness benefits shall exclude preventive care coverages mandated by the Affordable Care Act. Wellness benefits shall be rated separately in rate filings. Wellness benefits shall not be offered as a stand-alone fixed-indemnity benefit.

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

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

N. Review authority. These rules do not limit the superintendent's authority to approve or disapprove a plan or plan provision as authorized by any other state or federal law.

O. Termination of coverage. A carrier shall not terminate an excepted benefits plan except for "good cause," which, for purposes of this subparagraph means:

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

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

(3) fraud or misrepresentation affecting coverage;

(4) policyholder request for cancellation;

(5) policy term ends; and

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

P. Notice required upon termination of coverage for individual plans. Except in the case of termination for "good cause" as described in Subsection O of Section 9 of this rule, a carrier shall not terminate an excepted benefits plan unless it provides written notice to a covered person 60 days prior to the intended termination date. Notice of termination shall:

(1) be in writing and dated;

(2) state the reason(s) for termination, with specific references to the clauses of the excepted benefits plan giving rise to the termination;

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

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

(5) 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.

Q. Notice required upon termination of coverage for group plans. Except in the case of termination for "good cause" as described in Subsection O of Section 9 of this rule, a carrier shall not terminate an excepted benefits plan unless it provides written notice to a group plan subscriber 60 days prior to the subscriber's intended termination date. Notice of termination shall:

(1) be in writing and dated;

(2) state the reason(s) for termination, with specific references to the clauses of the excepted benefits plan giving rise to the termination;

(3) identify the individuals currently covered under the master plan; and

(4) state that in the event of termination by either the group policyholder or the plan, except in the case of fraud or deception, the plan shall, within 30 calendar days, return to the group policyholder 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 compensation practices.

R. Proof of loss. If a carrier requires submission of a claims form as a condition of payment, the carrier, upon receipt of notice of a claim, shall furnish to the covered person a claim form to be delivered in the manner offered by the carrier that is preferred by the covered person. If claim forms are not furnished 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

for 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. If a benefit requires proof of permanent loss, a carrier may institute a waiting period to ensure the loss is permanent.

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

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

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

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

T. Grace Periods. A carrier shall grant a grace period of at least 10 days for monthly premium plans and at least 31 days for all plans billed less frequently for the payment of each premium due after the first premium.
[13.10.34.9 NMAC - N, 10/01/2020]

13.10.34.10 ACCIDENT ONLY COVERAGE:

A. General rule. No plan providing benefits conditioned on the occurrence of an accident shall be sold or offered for sale except as an accident only plan.

B. Definitions. An accident only plan:

(1) shall not establish an accidental means test or use words such as “external, violent, visible wounds” or similar words of description or characterization;

(2) shall define “injury” to mean accidental bodily injury sustained by the covered person, independent of any other cause, that occurs while the coverage is in effect.

(a) The definition may provide that a covered disability must occur within a specified period of time (no greater than 30 days) of the accident, otherwise the condition shall be considered a sickness.

(b) The definition may provide that “injury” shall not include an injury for which benefits are provided under workers’ compensation, employers’ liability or similar law; or under a motor vehicle no-fault plan, unless prohibited by law; or injuries occurring while the covered person is engaged in any activity pertaining to a trade, business, employment or occupation for wage or profit.

C. Coverage requirements. An accidental death benefit in an accident-only plan shall be no less than $10,000 with a minimum of $5,000 for any dependent coverage. The death benefit amount may vary for each life insured under the policy or certificate. A dismemberment benefit shall be at least $5,000, for a limb. The benefit amounts for partial dismemberment and loss of a non-limb body part shall be no less than $250 for each covered loss. The benefit amount provided for each type of dismemberment benefit covered by the plan must be specified in the product filing and approved by the OSI.

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

E. Specified accident. Specified accident insurance coverage shall only be sold as blanket coverage pursuant to Section 59A-23-2 NMSA 1978, or as nonrenewable individual coverage with a term not to exceed 14 days.

F. Occupational accident. An occupational accident plan shall not be sold through an association or employer-sponsored group. An occupational accident plan shall only be sold as blanket coverage pursuant to Section 59A-23-2 NMSA 1978 or on an individual basis to cover on-the-job injuries to persons who are not legally required to be covered by workers’ compensation insurance.

(1) Upon the sale of any occupational accident plan, the carrier or its designated agent shall file a disclosure form with the New Mexico Workers’ Compensation Administration.

(a) The carrier shall submit the form to the Workers’ Compensation Administration, Employer Compliance Bureau, 2410 Centre Ave SE, Albuquerque, NM 87106;

(b) The form shall contain the following information:

(i) Name of covered person;

(ii) Covered person’s occupation;

(iii) Name, address, and telephone number of any company for whom the covered person performs contracted work; and

(iv) Effective dates of the plan.

(2) An application for occupational accident coverage shall contain the following notice:

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

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

(3) An occupational accident plan shall not exclude activities and accidents inherent to the occupation of the individual seeking coverage.

(4) An occupational accident plan shall not require a covered person to waive his or her rights to workers' compensation coverage or benefits.

G. An accident only plan shall not contain a probationary or waiting period.

H. An accident only plan shall not offer sickness benefits unless such benefits are limited to covering an illness resulting from an accident. Sickness benefits shall be limited to illness that arises within 90 days of the accident. Sickness benefits may include coverage for mental health care or nervous disorders that result from an accident.

I. An accident only plan shall not include disability benefits unless offered as an optional rider.

J. An accident only plan that provides benefits that vary depending on the accidental cause shall prominently set forth in the outline of coverage the circumstances under which benefits are payable that are less than the maximum amount payable under the plan.

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

[13.10.34.10 NMAC - N, 10/01/2020]

13.10.34.11 HOSPITAL INDEMNITY:

A. General rule. No plan providing indemnity benefits conditioned on the occurrence of a hospital confinement or hospital-based treatment shall be sold or offered for sale except as a hospital indemnity plan.

B. Application. This section applies to every hospital indemnity plan that provides benefits on a fixed indemnity basis.

C. Benefit minimums for hospital confinement benefits. The following benefit minimums shall apply to the confinement benefit in a hospital indemnity plan:

(1) a hospital indemnity plan shall provide for a lump sum payment upon confinement of no less than $2,500; or

(2) a hospital indemnity plan shall provide benefits for hospital confinement on an indemnity basis in an amount not less than $100 per day after an initial payment of not less than $500 upon the first confinement in a 30 day-period, and for no less than five days during each period of confinement for each covered person under the plan.

D. Continuous hospital confinement. A hospital indemnity plan shall treat consecutive days of in-hospital service received as an inpatient, and successive inpatient confinement for treatment of the same condition within 30 days of prior discharge, as a single period of confinement. A carrier shall not combine confinement for an accident with another confinement for an illness in determining continuous hospital confinement.

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

F. Hospital indemnity benefit limitations. The benefits under hospital indemnity coverage shall be limited to hospitalizations and hospital-treatment related ambulatory surgical center services, outpatient services, facility fees, anesthesia, surgery, emergency care, imaging and diagnostic testing, lodging, caretaker and pet care, lost wages or travel coverages. These benefits shall not be offered as a separate rider.

G. Hospital indemnity outpatient visits. A hospital indemnity plan shall cover no more than five outpatient or physician office visits per incidence of hospitalization or visit to the emergency room. Outpatient or physician office visits shall be limited to:

(1) preoperative examinations and preparatory services;

(2) follow-up care directly related to the hospitalization; and

(3) must be delivered during a period no longer than six months from the hospitalization.

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

[13.10.34.11 NMAC - N, 10/01/2020]

13.10.34.12 OTHER FIXED INDEMNITY:

A. Prohibitions. A carrier may offer or provide other fixed-indemnity coverages as a benefit rider to a specified disease or hospital indemnity plan, but not to accident-only coverages.

B. Benefits. A carrier who offers or provides other fixed indemnity coverage shall provide benefits on an indemnity basis in an amount not less than $50 per diagnostic or imaging test or visit to an outpatient health care provider or physician office. No plan shall include more than five fixed indemnity benefits unless the carrier satisfies the superintendent that the plan that includes the additional fixed indemnity benefits will not be ambiguous, deceptive, or misleading, and is otherwise fair to a prospective insured.

C. Basis of compensation. Other fixed indemnity coverage shall only provide benefits on a fixed indemnity basis.

D. Other fixed indemnity benefit limitations. The other fixed indemnity benefits shall be limited to outpatient services, physician office visits not related to a hospitalization, ambulance and other transportation services, behavioral health services, laboratory and imaging services, in-home care, durable medical equipment, therapy services, and treatment-related lost wages and pet and daycare services. Fixed indemnity benefits shall not cover hospitalizations or services covered by the hospital indemnity plan for which the other fixed indemnity plan is a rider. Fixed indemnity plans may pay benefits arising from a prescription drug or wellness claim only if the benefits are not coordinated with other coverage, are supplemental, and do not pay directly for medical claims.

[13.10.34.12 NMAC - N, 10/01/2020]

13.10.34.13 SPECIFIED DISEASE OR CRITICAL ILLNESS COVERAGE:

A. Application. This rule applies to any plan that provides benefits for the diagnosis and treatment of a specifically named disease or diseases that are life threatening in nature and could cause a person to incur substantial financial out of pocket expenses. All critical illness plans are subject to specified disease regulations.

B. General rules for coverage.

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

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

(3) A specified disease plan that does not pay a lump sum upon diagnosis shall provide benefits for the specified disease, and for any other disease or condition directly caused or aggravated by the specified disease. Coverage shall also apply to all forms of the disease.

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

(5) A specified disease plan shall not contain a waiting or probationary period longer than 30 days.

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

(7) Payments under a specified disease plan may be conditioned upon a covered person receiving medically necessary care, given in a medically appropriate location, under a medically accepted course of diagnosis or treatment. A carrier shall not condition payments on prior approval of benefits or use of specified providers. For purposes of this regulation only, medically necessary care shall be defined as health care services as determined by a provider to be appropriate or necessary according to any applicable generally accepted principles and practices of good medical care.

(8) After the effective date of the coverage (or applicable waiting period, if any) benefits that are paid on a per event basis shall begin with the first day of care or confinement if the care or confinement is for a covered disease or illness even though the diagnosis is made at some later date.

(9) With respect to payment of benefits, a specified disease plan shall not use the terms "actual amount" or "usual and customary rate."

(10) Specified disease benefits shall only be paid on a fixed indemnity basis.

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

(1) Benefits must be provided only on a fixed indemnity basis, at no less than an aggregate amount of $5,000 per triggering diagnosis. The OSI may approve product filings that allow a lower aggregate amount for certain types of diseases that require minimally invasive treatment or are non-life-threatening. OSI may also approve riders that allow plan designs for more extensive coverage for dependents.

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

(3) Where coverage is advertised or otherwise represented to offer generic coverage of a disease or diseases, the same dollar amounts shall be payable regardless of the particular subtype of the disease.

D. **Exclusions.** The definition of disease or sickness may be modified to exclude sickness or disease for which benefits are provided under a workers' compensation or employers' liability or other similar law.

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

F. **Overinsurance**. No carrier shall sell a covered person more than four individual specified disease plans, and no two plans shall provide benefits for the same disease.

[13.10.34.13 NMAC - N, 10/01/2020]

13.10.34.14 HOSPICE CARE COVERAGE.

A. **Application.** This rule applies to any accident only or hospital indemnity plan that provides, alone or in conjunction with other coverage, a hospice benefit that applies to care received in a facility or through an in-home program, licensed, certified or registered in accordance with state law that provides a formal program of care that is:

(1) for terminally ill patients whose life expectancy is less than six months;

(2) provided on an inpatient or outpatient basis; and

(3) directed by a physician.

B. **Benefits trigger.** Hospice benefits shall be payable when the attending physician of the covered person provides a written statement that the covered person has a life expectancy of six months or less.

C. **Hospice benefit.** A hospice care benefit shall pay a minimum of $100 per day or a lump sum of no less than $1,000.

[13.10.34.14 NMAC - N, 10/01/2020]

13.10.34.15 FORM AND RATE FILING AND APPROVAL REQUIRED:

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

B. **Prior approval of rates required**. A carrier shall not use rates or modified rates for an excepted benefit plan unless and until such rates are filed with and approved by the superintendent with the exception of rates for an excepted benefit plan issued to an out-of-state group policyholder. A carrier shall not issue an out-of-state, group excepted benefits plan to New Mexico residents unless it complies with Subsections D and G of this section.

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

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

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

Type of Coverage:	OR	CR	GR	NC
Medical Expense	65%	60%	60%	55%

Loss of Income and Other	65%	60%	55%	50%

(a) **OR- Optionally Renewable:** renewal is at the option of the insurance company;
(b) **CR- Conditionally Renewable:** renewal can be declined by class; by geographic area or for stated reasons other than deterioration of health;
(c) **GR- Guaranteed Renewable:** renewal cannot be declined by the insurance company for any reason, but the insurance company can revise rates on a class basis;
(d) **NC- Non-Cancelable:** renewal cannot be declined nor can rates be revised by the insurance company.

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

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

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

The factor I is determined as follows:

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

where:

(a) (N-1) is the calendar year immediately preceding the calendar year (N) in which the rate filing is submitted in the state;
(b) CPI-U is the consumer price index for all urban consumers, for all items, and for all regions of the U.S. combined, as determined by the U.S. Department of Labor, Bureau of Labor Statistics based on the 1982=100 basis;
(c) the CPI-U for any year (N-1) is taken as the value of September. For 1982, this value was 97.9;
(d) hence, for rate filings submitted during calendar year 1983, the value of I is 1.00.
(e) Low Average Annual Premium is defined as average annual premium less than or equal to I x .250.
(f) High Average Annual Premium is defined as average annual premium more than or equal to I x 1500.

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

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

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

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

(4) **Determination of average premium.** A carrier shall determine the average annual premium per form based on distribution of business by all significant criteria having a price difference, such as age,

sex, amount, dependent status, rider frequency, etc., except assuming an annual mode for all certificates (i.e., the fractional premium loading shall not affect the average annual premium or anticipated loss ratio calculation).

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

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

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

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

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

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

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

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

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

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

The factor I is determined as follows:

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

where:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) Measurement period. Compliance with the minimum loss ratio shall be measured over all years of issue combined and for each calendar year of experience utilized in the rate determination process (but never less than the last three years). A filing for a new pool will not be required until three years of experience has been accumulated for the pool. Separate filings shall be made for separate rating pools.

(4) Frequency. Loss ratios shall be calculated annually by carriers that issue excepted benefits products specified in this rule, beginning in 2021.

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

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

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

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

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

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

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

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

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

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

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

(3) that uses any false or misleading statements;

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

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

[13.10.34.15 NMAC - N, 10/01/2020]

13.10.34.16 REQUIRED DISCLOSURES AND NOTICES:

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

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

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

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

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

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

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

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

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

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

I. Medicare supplement notice.

(1) The outline of coverage delivered with a plan subject to this rule shall contain the following notice in bold 14-point type:

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

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

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

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

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

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

K. Insurance cards.

(1) Insurance card requirements. If a carrier provides an insurance card at the time of a plan's issuance, the card shall include the phone number and website of the insurance company. The carrier shall receive and process questions concerning benefits or claims at the number specified on the card. The card shall also include contact information for the OSI consumer assistance bureau.

(2) Notice requirements. An insurance card issued for an excepted benefits plan shall state in bold 12-point type, "This is a limited benefit plan. This is not major medical health insurance coverage."

(3) Provider network prohibition. No insurance card for an excepted benefits plan shall refer to a provider network.

L. Delivery of plan documents. A producer or carrier shall not bind coverage for any subject excepted benefits plan without delivering all plan documents to a prospective insured and allowing the prospective insured 10 calendar days to review those materials. Nothing in this subsection precludes a carrier from making coverage retroactive to the date that the plan documents were delivered to the prospective insured. The carrier shall maintain for five years proof of compliance with this requirement for each product sale.

[13.10.34.16 NMAC - N, 10/01/2020]

13.10.34.17 REQUIREMENTS FOR REPLACEMENT OF INDIVIDUAL EXCEPTED BENEFITS PLAN COVERAGE

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

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

C. Non-direct response carrier notice:

NOTICE TO APPLICANT REGARDING REPLACEMENT
OF LIMITED BENEFIT HEALTH INSURANCE

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

(1) Health conditions that you may presently have, (preexisting conditions) may not be immediately or fully covered under the new plan. This could result in denial or delay of a

claim for benefits under the new plan, whereas a similar claim might have been payable under your present plan.

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

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

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

____
(Date)

____
(Applicant's Signature)

D. Direct response carrier notice:

NOTICE TO APPLICANT REGARDING REPLACEMENT
OF LIMITED BENEFIT HEALTH INSURANCE

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

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

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

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

[COMPANY NAME]

[13.10.34.17 NMAC - N, 10/01/2020]

13.10.34.18 COORDINATION OF BENEFITS, BUNDLING AND VARIABILITY:

A. Noncoordination of benefits. Accident only, specified disease and critical illness, hospital indemnity and other fixed indemnity coverages shall not be coordinated with other benefits. These coverages shall:

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

(2) have no coordination between the benefits offered by the plan and exclusions under a health plan offered by the same plan sponsor; and

(3) pay benefits regardless of any benefits provided under another health plan, excepting Champus/TRICARE supplement coverage.

B. **No bundling.** No carrier or affiliated producer shall market or sell a bundled combination of accident only, specified disease or, hospital indemnity plans. No one plan sold shall contain coverage for hospital indemnity, specified disease, and accident only benefits or any combination thereof. Fixed indemnity benefits shall have the limitations stated in Section 12 of this rule. Additional memberships or discount services that purport to provide other health care benefits shall not be sold or offered in combination with plans governed by this rule. The provisions of the subsection shall not apply to a plan sold through a group identified in Paragraphs (1) or (3) of Subsection A of 59A-23-3 NMSA 1978.

C. **Major medical coverage requirement.** Accident only, hospital indemnity and specified disease coverage, excluding blanket coverage compliant with Section 59A-23-2 NMSA 1978, shall only be issued to persons who acknowledge that such coverages are not major medical or comprehensive health insurance as defined in Paragraph (1) of Subsection M of 13.10.29.7 NMAC. For purposes of this requirement, short-term, limited duration insurance shall not be considered major medical coverage.

(1) An application for an excepted benefits plan subject to this rule shall include an attestation by the applicant affirming that the applicant understands that the individual is not purchasing major medical insurance at the time of application. The attestation shall be a written attestation that must be signed by the applicant before coverage becomes effective. The carrier may retroactively apply coverage to the date of application.

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

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

(4) If a carrier or the carrier through its agent learns that a covered person's major medical coverage has lapsed or was cancelled, the carrier shall send the person the following notice:

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

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

D. **VARIABILITY**. An excepted benefits plan subject to this rule shall not include variable options for plan scope or benefit levels unless each possible combination of benefits under the plan form meets the MLR requirements specified in this rule. The superintendent reserves the right to reject a plan that has no meaningful difference from another plan offered by the same carrier.

E. **MATRIX FORMS**. The coverages governed by this rule are subject to the prohibitions on matrix forms set out in 13.6.2 NMAC.

[13.10.34.18 NMAC - N, 10/01/2020]

13.10.34.19 **PENALTIES:** The sale of any plan that does not comply with this rule is unlawful. In addition to any applicable suspension, revocation or refusal to continue any certificate of authority or license under the 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. The actions of any producer or third party administrator relating to the sale of a plan subject to this rule, or a claim under any such plan, shall be deemed the actions of the plan issuer.

[13.10.34.19 NMAC - N, 10/01/2020]

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

[13.10.34.20 NMAC - N, 10/01/2020]