This is an amendment to 13.10.34 NMAC, adding new Section 23, effective 1/1/2025 and new Section 24, effective April 1, 2026

13.10.34.23 PLANS SOLD TO INDIVIDUALS COVERED UNDER MAJOR MEDICAL INSURANCE: Accident-only, specified disease or illness, hospital indemnity, and other fixed indemnity plans issued to individuals, employer groups, labor unions or group plans issued through bona fide associations, covered under a major medical plan shall comply with the provisions of this section.

A. Proof of coverage required. Carriers must obtain proof of major medical coverage prior to the issuance of a plan subject to this section. Proof shall be demonstrated through:

(1) Individual plans:

(a) A copy of the current insurance card; or

(b) the insurer name, group, and policy number.

(2) Employer-group, labor unions and group plans issued through a bona fide association:

(a) A copy of the current insurance card of each subject employee or group member;

(b) the insurer name, group, and policy number of each subject employee or group member; or

(c) the insurer name(s) and the group number(s) of the major medical plan(s) purchased by the group.

B. Disclosure required.

(1) Initial disclosure. Plans issued in accordance with this section must include the following prominently displayed disclosure statement on the application, and enrollment form, as well as on the policy or certificate of coverage issued to each covered person.

COMPANY NAME

[SPECIFIC EXCEPTED BENEFIT PLAN TYPE] INSURANCE

REQUIRED DISCLOSURE STATEMENT

This [policy] [certificate of coverage] provides [Specific Excepted Benefit Plan Type] ONLY. This [policy] [certificate of coverage] does NOT provide major medical insurance, as defined under New Mexico Law.

[Accurately list benefits, exclusions, reductions and limitations of the policy in a manner that does not encourage misrepresentation of the actual coverage provided.] OR provide a copy of the approved outline of coverage containing this information]

This disclosure statement is a very brief summary of your [policy] [certificate of coverage]. The [policy] [certificate of coverage] itself sets forth the rights and obligations of both you and the insurance company. It is therefore imperative that you READ YOUR [POLICY][CERTIFICATE OF COVERAGE] carefully.

The expected loss ratio for this policy is [___]%. This ratio is the portion of future premiums that the company expects to pay as benefits under this policy, when averaged over all individuals with this policy or certificate of coverage.

(2) Annual disclosure. Upon renewal, or if coverage is not renewed yearly then not less than annually, the insurer must provide each insured and policyholder the statement listed below. For insurance issued on a group basis, the statement may be provided to the policyholder for distribution to each person insured under the policy.

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. BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES.

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

C. Ancillary plans. Plans issued in accordance with this section shall be considered ancillary to the underlying major medical or comprehensive health plan.

(1) Exemptions. Ancillary plans shall not be required to comply with the following provisions of the rule:

(a) 13.10.34 10- ADDITIONAL REQUIREMENTS FOR ACCIDENT ONLY PLANS

(b) 13.10.34.11- ADDITIONAL REQUIREMENTS FOR HOSPITAL INDEMNITY PLANS

(c) 13.10.34.12- OTHER FIXED INDEMNITY BENEFITS

(d) 13.10.34.13- ADDITIONAL REQUIREMENTS FOR SPECIFIED DISEASE PLANS

(e) 13.10.34.14-ADDITIONAL REQUIREMENTS FOR HOSPICE CARE BENEFITS

(f) 13.10.34.18- REQUIRED DISCLOSURE AND NOTICES

(2) Requirements. Ancillary plans offered in accordance with this section are subject to these additional requirements:

(a) Treatment trigger. Benefits offered pursuant to this section may be conditioned upon a covered person receiving medical care given in a medically appropriate location. A carrier shall not condition payment for any such benefit on prior approval of treatment or on medical necessity.

(b) Basis of compensation. Plans offered pursuant to this section shall provide benefits only on a fixed indemnity basis.

(c) Benefit maximum. Other fixed indemnity benefits shall be limited to hospitalization, outpatient services, ambulance and other transportation services, behavioral health services, laboratory and imaging services, in-home care, durable medical equipment, home, work or vehicle modifications to accommodate disability, therapy services, treatment-related lost wages, health care related lodging, pet care and daycare services, or cosmetic services relating to a covered accident or illness. Other fixed indemnity benefits offered pursuant to this section shall not be in excess of $500,000.

D. MEWAs. MEWAs and non-employer groups subject to the provisions of 13.19.4 NMAC may not offer ancillary plans in accordance with this section, unless the coverage is offered through a bona fide association.

[13.10.34.23 NMAC - N, 1/1/2025]

13.10.34.24 CONTINUING EDUCATION

A. License required. All producers selling excepted benefits plans under this rule must maintain current licensure with the state in accordance with the New Mexico Insurance Code.

B. Continuing education. Producers transacting in excepted benefits must complete at least two hours in specialized training in excepted benefits in order to meet continuing education requirements found in 13.4.7 NMAC.

C. Course offering. Carriers offering excepted benefits for sale in New Mexico must offer two-hour specialized training courses for producers. Courses shall comply with all provisions of 13.4.7 NMAC.

D. Effective date. The requirements of this section shall go into effect on April 1, 2026 or upon the final adoption of the amended rule at 13.4.7 NMAC, whichever is later. Licensees, defined under 13.4.7.7 NMAC and subject to this rule, must comply with its requirements prior to the next compliance period.

[13.10.34.24 NMAC - N, 4/1/2026]