8 Enrollment and Termination Information

Term of Coverage

Your coverage starts on the Policy's effective date at 12:01 a.m. Standard Time where you live. It ends at 12:01 a.m., the same Standard time, or the first renewal date. Each time you renew your Policy by paying the premium within the 31-day grace period, the new term begins when the old term ends.

Who Is Eligible

To be eligible for the NM Medical Insurance Pool program, you must be and continue to be a **resident of the state of New Mexico** (a resident is any person who resides within the state of New Mexico in a place of permanent habitation). Unless otherwise indicated below, you must apply for Pool coverage **within the time frames indicated, if any,** after satisfying the condition that caused you to become eligible. An application is dated on the later of the requested effective date or the day of the postmark date affixed by the United States Post Office. (If the envelope containing the application is not postmarked by the United States Post Office or the postmark is not legible, the application date will be the later of the requested effective date or the date received by the Pool.)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that New Mexico residents are eligible for Pool coverage if:

- They have had an aggregate of 18 or more months of creditable coverage, the last of which must be group coverage; and
- They have received notice of termination of comprehensive medical/surgical group coverage (including COBRA continuation and meeting a general lifetime maximum benefit under prior coverage) that terminates within 63 days prior to the initial application date for Pool coverage; and
- Proof of such existing coverage must be included with the application for Pool coverage.

NOTE: If the most recent creditable coverage available to you under this provision was terminated as a result of nonpayment of premium or due to fraud, you are not eligible for Pool coverage.

In addition, if you are a New Mexico resident, you are eligible for Pool coverage if you have received one or more of the following:

1. A notice of rejection for comprehensive major medical coverage in the last 12 months.
2. A note or letter from a physician stating that you have been specifically diagnosed with one of the qualifying medical or health conditions (you may review the list of qualifying conditions on the NM Medical Insurance Pool Web site or request a copy of the list from the Administrator)
3. A notice of health insurance being available ONLY with a rider, waiver, or restrictive provision for a specific condition for a period of time of not less than 12 months.
4. Proof that your current premium rate for in-force coverage (or a quote received within last 31 days for applied-for health insurance coverage) exceeds 125 percent of the Pool's standard risk rate for similar deductible options for your age and sex.

5. A notice of current enrollment with the New Mexico Health Insurance Alliance (and you wish to switch enrollment to the Pool).
6. A notice stating that your most recent prior comprehensive major medical coverage has, or will terminate because the insurer stopped issuing coverage in New Mexico, or your coverage in another state's high risk pool ended due to non-residency, or you moved to New Mexico and your current coverage is not valid. In order to prevent a lapse in coverage, you must apply for Pool coverage within 31 days after termination of prior coverage and pay premiums for the entire coverage period; the pre-existing condition limitation may still apply.
7. A notice stating that you are on Medicare due to a disability and under the age of 65. (Note: Persons eligible due to this criterion will receive the NM Medical Insurance Pool Medicare Carve-Out Policy.)

Each member of a family covered under the Pool must meet the eligibility provisions of this Policy, except newborns up to 31 days old. There are no family rates; each family member who is enrolled will be charged the rate applicable to his/her age and sex.

Who is Not Eligible — You are not eligible to enroll if any of the following conditions apply to you:

- You have or are eligible for **Medicare** (unless you are under age 65) or **Medicaid,** unless such coverage is limited to coverage for amounts in excess of limited policies such as dread disease, cancer policies, or hospital indemnity policies. In such instances Medicare or Medicaid coverage will be the primary payer and the Pool will be the secondary payer. (If you are under age 65 and become eligible for both Parts of Medicare after enrollment in the Pool, you are eligible to enroll in the Pool's Carveout Plan or you may retain coverage under this Policy until you reach age 65. If you reach age 65 and become eligible for Medicare after January 1, 2006, you may **not** continue coverage under any Pool Policy. If you are age 65 or older and enrolled for coverage under this Policy before January 1, 2006, you may continue coverage under this Policy, whether or not you are eligible for Medicare.)
- You are eligible for coverage under a group health plan or have other comprehensive major medical health insurance coverage, including benefits consisting of medical care, items, or services provided directly, through insurance or reimbursement, or otherwise under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract. (You may continue coverage under the Pool while satisfying a pre-existing condition waiting period under the other group health plan or health insurance policy. You may also continue other coverage if you qualify for Pool coverage due to premium rate or a condition rider. The Pool Policy is secondary to all other coverage.)
- You were offered the option of continuing coverage under a federal COBRA provision or similar state program, but the coverage meets the conditions for eligibility described under numbers 3, 4, or 5 starting on the previous page.
- You have voluntarily terminated a Pool Policy within the past 12 months. However, if you terminated Pool coverage because you became eligible for and covered by a health plan and such coverage was then involuntarily terminated in less than 12 months, you may re-apply for a Pool Policy. Persons who are HIPAA-eligible individuals at the time of re-application are also eligible to re-apply for Pool coverage within a 12-month period.
- You are an inmate of a public institution or eligible for public programs for which medical care is provided.

Family Provision

While the Pool does not offer a "Family" Policy, if you have three or more qualified family members on Pool Policies with the same deductible you may receive reduced deductible and out-of-pocket limits as indicated on the chart below.

Plan Variable (printed on ID card)	Individual Deductible Choice and Family Amount	Out-of-Pocket Limit (annual deductible plus coinsurance)
500	Individual = $500 Family = $1,000	Individual = $2,500 Family = $5,000
1000	Individual = $1,000 Family = $2,000	Individual = $3,500 Family = $7,000
2000	Individual = $2,000 Family = $4,000	Individual = $5,000 Family = $10,000
5000	Individual = $5,000 Family = $10,000	NA - The Pool pays 100% after deductible is met
7500	Individual = $7,500 Family = $15,000	NA - The Pool pays 100% after deductible is met
10,000	Individual = $10,000 Family = $20,000	NA - The Pool pays 100% after deductible is met

Family Members — In order to qualify as a member of a family, the members must be related to you in one of the following ways:

- your legal **spouse**
- your unmarried **child** through the end of the billing period in which the child becomes age **25** (At that time, the child is automatically removed from the Family provision.)
- your unmarried child over age 25 who was enrolled as a dependent at the time of reaching the age limit, and who is medically certified as **disabled** and chiefly dependent upon you for support and maintenance (Such condition must be certified by a physician and the Administrator. Also, a child may continue to be eligible for coverage under a "Family" Policy beyond the dependent age limit only if the condition began before or during the month in which the child would lose coverage due to his/her age status. Proof of incapacity and dependency must be furnished to the Administrator within 120 days of the dependent's 25th birthday. The Administrator may request subsequent proof of incapacity and dependency but no more often than on an annual basis after a two-year period following attainment of the limiting age. (A child who is no longer your eligible dependent and therefore not able to continue coverage under your "Family" policy, but who meets the criteria for continued coverage under the Pool, may apply for his/her own Pool Policy.)

Children — A child is considered to be a specific age on the first day of the month following his/her birthday, and includes your unmarried:

- natural or legally adopted child
- child under age 18 placed in your home for purposes of adoption
- stepchild who depends upon you for support and maintenance and resides with you in a parent-child relationship

Note: If three or more children family members, as defined above, are members of the Pool program, they can qualify as a family even if you or your spouse are not covered. However, if a child qualifying as part of a family has his or her own child, the newborn child may not qualify as part of the same family. The newborn, if

eligible, must switch to his/her own Policy and the additional premium for the newborn must be paid.

Family members covered under the Pool program must each meet the eligibility provisions of this Policy. The Administrator may require acceptable proof (such as copies of income tax forms, legal adoption or legal guardianship papers, or court orders) that an individual qualifies as a family member. Unless listed as an eligible family member, no other relative or person is eligible for coverage as a family.

If a child is under the age of 15, his/her parent, legal guardian, or other responsible party must submit the application for coverage on the child's behalf. Also, for any child covered under a Pool Policy, any obligations of the policyholder set forth in this benefit booklet, any endorsements, addenda, or riders will be the obligations of the parent, legal guardian, or other responsible party applying for coverage on the child's behalf.

You may not apply for a Pool Policy on behalf of a non-disabled adult child without obtaining authorization from the child to enter into a health insurance contract; therefore, an application for any such coverage of an adult child, whether as a dependent or as the subscriber, must be signed by the child. If the adult child is disabled and unable to sign the application, his/her legal guardian may apply for coverage on his/her behalf and, by doing so, accepts any obligations of the subscriber set forth in the Policy, including any endorsements, addenda, or riders. You may be required to provide a copy of a power of attorney for an adult child.

Medicare/Medicaid-Eligible Members

Shortly before you turn age 65 or qualify for Medicare benefits for other reasons, you are responsible for contacting the local Social Security office to establish Medicare eligibility.

Members with both Parts of Medicare may also choose to apply for an individual Medicare Supplemental Policy, which may require a health statement and/or a pre-existing conditions waiting period. (The options available to members under age 65 and eligible for Medicare may differ from those available to members age 65 and older.)

A person is eligible to enroll if he/she has Medicaid coverage that provides benefits only for limited conditions.

Newborn and Adopted Children

If you are a member of the pool, your newborn child, a child physically placed in your home for the purpose of adoption, or your newly adopted child is automatically eligible for 31 consecutive calendar days of coverage **for an additional premium.** (This provision applies only to children of adult policyholders. If a Pool member is the dependent child of another policyholder and has his/her own child, the child of the dependent may qualify for automatic coverage but the dependent must switch to his/her own Policy and pay the additional premium for the newborn.)

You must complete an application for coverage and submit it to the Administrator **within 31 days** of the birth, placement in the home, or legal adoption. In such cases, the child does not have to establish eligibility for Pool coverage, this Policy's pre-existing conditions limitation does not apply, and the newborn is covered

at birth (or, in the case of a child who has been placed in your home or adopted, for 31 days following placement or adoption).

Eligibility must be established for the child to remain on the Policy beyond 31 days.

Note: A child under age 18 who is physically placed in your home for the purposes of adoption may acquire Pool coverage as soon as the child is physically placed in the home or upon completion of the legal adoption (or any time in between). They must still establish continued eligibility to be covered beyond the 31-day period.

When Coverage Begins

Your Pool coverage begins on the first of the month following the date your application is accepted and the premium is paid. This date is your effective date. The Pool pays for covered services that you receive after the effective date of coverage. In some instances, coverage may begin on the first of the month during which your prior coverage terminated; in such cases, retroactive premium may be required.

This Policy does not cover any service received or any admission that begins before your effective date of coverage. Also, if your prior coverage has an extension of benefits provision, this Policy will not cover those charges incurred after your effective date that are covered under the prior plan.

Pre-Existing Conditions Limitation

A pre-existing condition is a physical or mental condition for which medical advice, medication, diagnosis, care, or treatment was recommended for or received by an applicant within the **six-month** period before his/her effective date of coverage. (No pre-existing condition limitation or exclusion may be imposed on a HIPAA-eligible individual regardless of when the medical condition occurred.) Complication of pregnancy is **not** considered a pre-existing condition. (However, if you selected the optional routine maternity services coverage, this Policy does not cover routine maternity care or elective abortion for pregnancies conceived before the optional coverage became effective, unless the pre-existing condition limitation was waived upon enrollment, as described under "Exceptions," below. See *Section 4* for details.)

No benefits are available for any pre-existing condition for **six months** after the member's effective date of coverage under this Policy, except as described below.

Exceptions — The following members are **not** subject to this pre-existing conditions limitation:

- Any member who enrolled as a HIPAA-eligible individual.
- Newborn child acquiring Pool coverage within 31 days of birth.
- Adopted child under age 18 (or child under age 18 physically placed in your home for the purpose of adoption) and acquiring Pool coverage prior to or within 31 days of adoption.
- Members who had satisfied the pre-existing conditions limitation, if any, under their prior creditable coverage and who applied timely (within 31 days) for Pool coverage.

- A newborn or adopted child who was enrolled in any group health plan or other creditable coverage within 31 days of birth or adoption who has not experienced any significant lapse of coverage (i.e., 63 or more days) prior to enrolling in this Pool program.

If you do not qualify for a full waiver of the pre-existing conditions limitation, the six-month waiting period will be reduced to the extent similar waiting periods were satisfied under previous creditable coverage. To obtain the waiting period reduction, your application for Pool coverage must be received by the Administrator within 31 days of termination of prior coverage (or the notification date of involuntary termination, if later, or receipt of information indicating you have met your lifetime maximum benefit under creditable coverage).

You can add up any creditable coverage you had prior to enrollment under this Policy, but if you went for 63 days or more without any creditable coverage (excluding any excepted time periods outlined below), the coverage you had before the break will not be counted. Proof of such prior creditable coverage (e.g., Certificate of Creditable Coverage) is required before credit will be given. For persons enrolling as HIPAA-eligible applicants, proof of prior coverage must be included **with** the application for Pool coverage.

Premiums must be paid for the entire coverage period.

Note: The waiver and/or reduction in the pre-existing conditions limitation may not apply to services covered under the optional routine maternity services coverage. See *Section 4* for details.

What is Not Considered a Break in Coverage — For purposes of determining any significant break in coverage (i.e., 63 or more days), lapses in coverage due to any of the following situations will not be considered as part of a break:

- a waiting period imposed by a group health plan before it allowed you to become eligible for enrollment
- the amount of time between the date you submitted a substantially complete application for individual plan coverage and either the date the coverage began (if you were accepted), or the date on which the application was denied or on which the offer of coverage lapsed (if you were not accepted)
- the period of time between loss of coverage and COBRA election for certain workers whose employment was adversely affected by international trade and who were entitled to a second COBRA election period as a result

Premium

Your Policy will be renewed each time the required premium payment is made. The premium is due and payable to the Administrator in advance of each period for which the coverage is to be in effect. A grace period of 31 days is granted following the premium due date. No benefits are available for care for services received during the grace period unless the premium is remitted to the Administrator's office before the grace period's expiration date.

Failure to receive premium due notices does not relieve the applicant from responsibility for paying the premium when due.

Rates are re-evaluated on January 1 and July 1 of each year and may be adjusted based on various factors, including your age (e.g., your premium may increase on the first of the month following your birthday). The Administrator will notify you at least 60 days before an increase in premium occurs due to a re-evaluation of rates. (You will not be notified of a rate increase that occurs due to age.)

Policy Termination

Unless stated otherwise, coverage ends at the end of the last-paid billing period during which one of the following events occurs:

- When the Administrator does not receive the premium payment on time. If the month's premium is not received within 31 days after the premium due date (known as the "grace period"), your coverage will be terminated at the end of the last period for which premium was paid.
- When you become covered by a group plan. Such termination may be made retroactively upon disclosure of the group coverage. If you are subject to a pre-existing conditions period under the group coverage, the Pool coverage will terminate on the date the period ends.
- When you are no longer eligible for coverage under the New Mexico Medical Insurance Pool program.
- When you are no longer a New Mexico resident.
- When you do not reply within 30 days after the date that the Administrator makes an inquiry concerning your place of residence.
- When you request this Policy to end.
- When New Mexico statutes require cancellation of this Policy.

If you knowingly gave false material information in connection with your or a family member's eligibility or enrollment, the Administrator may terminate the coverage of you and all family members retroactively to the date of initial enrollment. You are liable for any benefit payments made as a result of such improper actions.

Re-Entering the Pool After Termination

If you fail to pay the premium in accordance with the terms of this Policy, or if you voluntarily leave the Pool, you will not be eligible to re-apply until 365 days have passed from the date of termination of coverage. However, if you terminated Pool coverage because you became covered by a health plan that was then involuntarily terminated in less than 12 months OR if you qualified as a HIPAA-eligible individual or were enrolled in a federally eligible plan, you may re-apply for Pool coverage.