Solvency Assessment Model Act);

b. actuarial function;

c. investment decision-making processes;

d. reinsurance decision-making processes;

e. business strategy/finance decision-making processes;

f. compliance function;

g. financial reporting/internal auditing; and

h. market conduct decision-making processes.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:11 and 22:691.31-691.38.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 41:2664 (December 2015).

§209. Severability Clause

A. If any Section or provision of Regulation 104 or the application to any person or circumstance is held invalid, such invalidity or determination shall not affect other Sections or provisions or the application of Regulation 104 to any persons or circumstances that can be given effect without the invalid section or provision or application, and for these purposes the Sections and provisions of Regulation 104 and the application to any persons or circumstances are severable.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:11 and 22:691.31-691.38.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 41:2665 (December 2015).

Chapter 3. Regulation 32—Coordination of Benefits

§301. Purpose and Applicability

A. The purpose of this regulation is to:

1. establish a uniform order of benefit determination under which plans pay claims;

2. reduce duplication of benefits by permitting a reduction of the benefits to be paid by plans that, pursuant to rules established by this regulation, do not have to pay their benefits first; and

3. provide greater efficiency in the processing of claims when a person is covered under more than one plan.

B. This regulation applies to all plans which includes all accident and health products and health maintenance organization products that are issued on or after the effective date of this regulation. The effective date of this regulation is upon final publication, January 20, 2018.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3.2014.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 17:67 (January 1991), amended LR 20:52 (January 1994), LR 23:415 (April 1997), LR 41:1095 (July 2016), LR 44:64 (January 2018).

§303. Definitions

A. As used in this regulation, these words and terms have the following meanings, unless the context clearly indicates otherwise.

Allowable Expense—a health care service or expense including deductibles, coinsurance, or copayments that are covered in full or in part by any of the plans covering the person, except as set forth below or where a statute requires a different definition. This means that an expense or service or a portion of an expense or service that is not covered by any of the plans is not an allowable expense.

a. The following are examples of expenses or services that are and are not an allowable expense.

i. If a covered person is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room, (unless the patient's stay in the private hospital room is medically necessary in terms of generally accepted medical practice, or one of the plans routinely provides coverage for private hospital rooms), is not an allowable expense.

ii. If a person is covered by two or more plans that compute their benefit payments on the basis of usual and customary fees, any amount in excess of the highest of the usual and customary fee for a specified benefit is not an allowable expense.

iii. If a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an allowable expense.

iv. If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary fees and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangement shall be the allowable expense for all plans.

b. The definition of *allowable expense* may exclude certain types of coverage or benefits such as dental care, vision care, prescription drug, or hearing aids. A plan that limits the application of COB to certain coverages or benefits may limit the definition of allowable expenses in its contract to services or expenses that are similar to the services or expenses that it provides. When COB is restricted to specific coverages or benefits in a contract, the definition of *allowable expense* shall include similar services or expenses to which COB applies.

c. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid.

d. The amount of the reduction may be excluded from allowable expense when a covered person's benefits are reduced under a primary plan:

i. because the covered person does not comply with the plan provisions concerning second surgical opinions or pre-certification of admissions or services; or

ii. because the covered person has a lower benefit

because he or she did not use a preferred provider.

e. If the primary plan is a closed panel plan and the secondary plan is not a closed panel plan, the secondary plan shall pay or provide benefits as if it were primary when a covered person uses a nonpanel provider, except for emergency services or authorized referrals that are paid or provided by the primary plan.

Birthday—refers only to month and day in a calendar year and does not include the year in which the individual is born.

Claim—a request that benefits of a plan be provided or paid. The benefits claimed may be in the form of:

a. services (including supplies);

b. payment for all or a portion of the expenses incurred;

c. a combination of Subparagraphs a and b of this Paragraph; or

d. an indemnification.

Claim Determination Period or *Plan Year*—a period of not less than 12 consecutive months over which allowable expenses shall be compared with total benefits payable in the absence of COB to determine whether overinsurance exists and how much each plan will pay or provide.

a. The claim determination period is usually a calendar year, but a plan may use some other period of time that fits the coverage of the group or individual contract. A person is covered by a plan during a portion of a claim determination period if that person's coverage starts or ends during the claim determination period.

b. As each claim is submitted, each plan determines its liability and pays or provides benefits based upon allowable expenses incurred to that point in the claim determination period. That determination is subject to adjustment as later allowable expenses are incurred in the same claim determination period.

Closed Panel Plan—a plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan, and that excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

Consolidated Omnibus Budget Reconciliation Act of 1985 or *COBRA*—coverage provided under a right of continuation pursuant to federal law.

Coordination of Benefits or *COB*—a provision establishing an order in which plans pay their claims, and permitting secondary plans to reduce their benefits so that the combined benefits of all plans do not exceed total allowable expenses.

Custodial Parent—

a. the parent awarded custody of a child by a court decree; or

b. in the absence of a court decree, the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

Group-Type Contract—a contract that is not available to the general public and is obtained and maintained only because of membership in or a connection with a particular organization or group, including blanket coverage. Group-type contract does not include an individually underwritten and issued guaranteed renewable policy even if the policy is purchased through payroll deduction at a premium savings to the insured since the insured would have the right to maintain or renew the policy independently of continued employment with the employer.

High-Deductible Health Plan—the meaning given the term under section 223 of the *Internal Revenue Code* of 1986, as amended by the Medicare Prescription Drug, Improvement and Modernization Act of 2003.

Hospital Indemnity Benefits—benefits not related to expenses incurred. Hospital indemnity benefits does not include reimbursement-type benefits even if they are designed or administered to give the insured the right to elect indemnity-type benefits at the time of claim.

Plan—a form of coverage with which coordination is allowed. Separate parts of a plan for members of a group that are provided through alternative contracts that are intended to be part of a coordinated package of benefits are considered one plan and there is no COB among the separate parts of the plan. If a plan coordinates benefits, its contract shall state the types of coverage that will be considered in applying the COB provision of that contract. Whether the contract uses the term "plan" or some other term such as "program," the contractual definition may be no broader than the definition of "plan" in this subsection. The definition of "plan" in the model COB provision in Appendix A of §321 of this Chapter is an example.

a. Plan includes:

i. group and nongroup insurance contracts and subscriber contracts;

ii. uninsured arrangements of group or group-type coverage;

iii. group and nongroup coverage through closed panel plans;

iv. group-type contracts;

v. the medical care components of long-term care contracts, such as skilled nursing care;

vi. the medical benefits coverage in automobile "no fault" and traditional automobile "fault" type contracts;

vii. Medicare or other governmental benefits, as permitted by law, except as provided in Subparagraph b of this Paragraph. That part of the definition of plan may be limited to the hospital, medical and surgical benefits of the governmental program; and

viii. group and nongroup insurance contracts and subscriber contracts that pay or reimburse for the cost of

dental care.

b. Plan does not include:

i. hospital indemnity coverage benefits or other fixed indemnity coverage;

ii. accident only coverage;

iii. specified disease or specified accident coverage;

iv. limited benefit health coverage as defined in R.S. 22:47(2)(c);

v. school accident-type coverages that cover students for accidents only, including athletic injuries, either on a 24-hour basis or on a "to and from school" basis;

vi. benefits provided in long-term care insurance policies for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services;

vii. Medicare supplement policies;

viii. a state plan under Medicaid; or

ix. a governmental plan, which, by law, provides benefits that are in excess of those of any private insurance plan or other non-governmental plan.

Policyholder or *Subscriber*—the primary insured named in a nongroup insurance policy.

Primary Plan—a plan whose benefits for a person's health care coverage must be determined without taking the existence of any other plan into consideration. A plan is a primary plan if:

a. the plan either has no order of benefit determination rules, or its rules differ from those permitted by this regulation; or

b. all plans that cover the person use the order of benefit determination rules required by this regulation, and under those rules the plan determines its benefits first.

Provider—a health care professional or health care facility.

Secondary Plan—a plan that is not a primary plan.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3.2014.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 17:67 (January 1991), amended LR 20:52 (January 1994), LR 23:415 (April 1997), LR 42:1095 (July 2016), LR 44:64 (January 2018).

§305. Use of Model COB Contract Provision

A. Appendix A and Appendix B contain model COB provisions that shall be used in group and individual contracts or subscriber agreements. That use is subject to the provisions of Subsections B, C, and D of this Section and to the provisions of §307.

B. Appendix B is a plain language description of the COB process that explains to the covered person how insurers will implement coordination of benefits. It is not intended to replace or change the provisions that are set forth in the contract. Its purpose is to explain the process by which the two (or more) plans will pay for or provide benefits, how the benefit reserve is accrued and how the covered person may use the benefit reserve.

C. The COB provision contained in Appendix A and the plain language explanation in Appendix B do not have to use the specific words and format shown in §321, Appendix A, or §323, Appendix B. Changes may be made to fit the language and style of the rest of the group contract or to reflect differences among plans that provide services, that pay benefits for expenses incurred and that indemnify. No substantive changes are permitted.

D. A COB provision may not be used that permits a plan to reduce its benefits on the basis that:

1. another plan exists and the covered person did not enroll in that plan;

2. a person is or could have been covered under another plan, except with respect to part B of Medicare; or

3. a person has elected an option under another plan providing a lower level of benefits than another option that could have been elected.

E. No plan may contain a provision that its benefits are "always excess" or "always secondary," except in accord with the rules permitted by this regulation.

F. Under the terms of a closed panel plan, benefits are not payable if the covered person does not use the services of a closed panel provider. In most instances, COB does not occur if a covered person is enrolled in two or more closed panel plans and obtains services from a provider in one of the closed panel plans because the other closed panel plan (the one whose providers were not used) has no liability. However, COB may occur during the claim determination period or plan year when the covered person receives emergency services that would have been covered by both plans. Then the secondary plan shall use the benefit reserve to pay any unpaid allowable expense.

G. A simple statement advising consumers that they can request a copy in either paper form or electronic form of Appendix C, that provides an explanation for secondary plans on the purpose and use of the benefit reserve and how secondary plans calculate claims, shall be added in the coordination of benefit section or provision found in group and individual policies.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3.2014.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 17:67 (January 1991), amended LR 20:52 (January 1994), LR 23:415 (April 1997), LR 42:1097 (July 2016), LR 44:64 (January 2018).

§307. Rules for Coordination of Benefits

A. When a person is covered by two or more plans, the rules for determining the order of benefit payments are as follows.

1. The primary plan shall pay or provide its benefits as if the secondary plan or plans did not exist.

2. If the primary plan is a closed panel plan and the secondary plan is not a closed panel plan, the secondary plan shall pay or provide benefits as if it were the primary plan when a covered person uses a non-panel provider, except for emergency services or authorized referrals that are paid or provided by the primary plan.

3. When multiple contracts providing coordinated coverage are treated as a single plan under this regulation, this section applies only to the plan as a whole, and coordination among the component contracts is governed by the terms of the contracts. if more than one carrier pays or provides benefits under the plan, the carrier designated as primary within the plan shall be responsible for the plan's compliance with this regulation.

4. If a person is covered by more than one secondary plan, the order of benefit determination rules of this regulation decide the order in which secondary plans benefits are determined in relation to each other. Each secondary plan shall take into consideration the benefits of the primary plan or plans and the benefits of any other plan, which, under the rules of this regulation, has its benefits determined before those of that secondary plan.

5. Except as provided in Paragraph 2 of this Subsection, a plan that does not contain order of benefit determination provisions that are consistent with this regulation is always the primary plan unless the provisions of both plans, regardless of the provisions of this Paragraph, state that the complying plan is primary.

6. Coverage that is obtained by virtue of membership in a group and designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

B. A plan may take into consideration the benefits paid or provided by another plan only when, under the rules of this regulation, it is secondary to that other plan.

C. Order of Benefit Determination. Each plan determines its order of benefits using the first of the following rules that applies:

1. Non-Dependent or Dependent

a. Subject to Subparagraph b of this Paragraph, the plan that covers the person other than as a dependent, for example as an employee, member, subscriber, policyholder or retiree, is the primary plan and the plan that covers the person as a dependent is the secondary plan.

b. If the person is a Medicare beneficiary, and, as a result of the provisions of title XVIII of the Social Security Act and implementing regulations, Medicare is:

i. secondary to the plan covering the person as a dependent; and

ii. primary to the plan covering the person as other than a dependent (e.g. a retired employee).

c. Then the order of benefits is reversed so that the plan covering the person as an employee, member, subscriber, policyholder or retiree is the secondary plan and the other plan covering the person as a dependent is the primary plan.

2. Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:

a. For a dependent child whose parents are married or are living together, whether or not they have ever been married:

i. the plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or

ii. if both parents have the same birthday, the plan that has covered the parent longest is the primary plan.

b. For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:

i. if a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the primary plan. This item shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision;

ii. if a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph a of this Paragraph shall determine the order of benefits;

iii. if a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph a of this Paragraph shall determine the order of benefits; or

iv. if there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

(a). the plan covering the custodial parent;

(b). the plan covering the custodial parent's spouse;

(c). the plan covering the non-custodial parent; and then

(d). the plan covering the non-custodial parent's spouse.

c. For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under Subparagraph a or b of this Paragraph as if those individuals were parents of the child.

d. For a dependent child covered under spouse‘s plan

i. For a dependent child who has coverage under either or both parents’ plans and also has his or her own coverage as a dependent under a spouse’s plan, the rule in Paragraph 5 of this Subsection applies.

ii. In the event the dependent child’s coverage under the spouse’s plan began on the same date as the dependent child’s coverage under either or both parents’ plans, the order of benefits shall be determined by applying the birthday rule in Subparagraph a of this Paragraph to the dependent child’s parent(s) and the dependent’s spouse.

3. Active Employee or Retired or Laid-Off Employee

a. The plan that covers a person as an active employee that is, an employee who is neither laid off nor retired or as a dependent of an active employee is the primary plan. The plan covering that same person as a retired or laid-off employee or as a dependent of a retired or laid-off employee is the secondary plan.

b. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored.

c. This rule does not apply if the rule in Paragraph 1 of this Subsection can determine the order of benefits.

4. COBRA or State Continuation Coverage

a. If a person whose coverage is provided pursuant to COBRA or under a right of continuation pursuant to state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the primary plan and the plan covering that same person pursuant to COBRA or under a right of continuation pursuant to state or other federal law is the secondary plan.

b. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

c. This rule does not apply if the rule in Paragraph 1 of this Subsection can determine the order of benefits

5. Longer or Shorter Length of Coverage

a. If the preceding rules do not determine the order of benefits, the plan that covered the person for the longer period of time is the primary plan and the plan that covered the person for the shorter period of time is the secondary plan.

b. To determine the length of time a person has been covered under a plan, two successive plans shall be treated as one if the covered person was eligible under the second plan within 24 hours after coverage under the first plan ended.

c. The start of a new plan does not include:

i. a change in the amount or scope of a plan’s benefits;

ii. a change in the entity that pays, provides or administers the plan’s benefits; or

iii. a change from one type of plan to another, such as, from a single employer plan to a multiple employer plan.

d. The person’s length of time covered under a plan is measured from the person’s first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a member of the group shall be used as the date from which to determine the length of time the person’s coverage under the present plan has been in force.

6. If none of the preceding rules determines the order of benefits, the allowable expenses shall be shared equally between the plans.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 17:67 (January 1991), amended LR 20:52 (January 1994), LR 23:415 (April 1997), LR 42:1098 (July 2016).

§309. Procedure to be Followed by Secondary Plan

A. When a plan is secondary, it shall reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period or plan year are not more than 100 percent of total allowable expenses as provided for in §303.A, *Allowable Expense,* a-e. The secondary plan shall calculate its savings by subtracting the allowable expense amount as provided for in §303.A, *Allowable Expense,* a-e that it paid as a secondary plan from the allowable expense amount provided for §303.A, *Allowable Expense,* a-e that it would have paid had it been primary. These savings shall be recorded as a benefit reserve for the covered person and shall be used by the secondary plan to pay any allowable expenses, not otherwise paid, that are incurred by the covered person during the claim determination period. (See Appendix C, Explanation for Secondary Plans on the Purpose and Use of the Benefit Reserve.) As each claim is submitted, the secondary plan must:

1. determine its obligation, pursuant to its contract;

2. determine whether a benefit reserve has been recorded for the covered person; and

3. determine whether there are any unpaid allowable expenses during that claims determination period.

B. If there is a benefit reserve, the secondary plan shall use the covered person's recorded benefit reserve to pay up to 100 percent of total allowable expenses as provided for in §303.A, *Allowable Expense,* a-e incurred during the claim determination period. At the end of the claim determination period the benefit reserve returns to zero. A new benefit reserve must be created for each new claim determination period.

C. The benefits of the secondary plan shall be reduced when the sum of the benefits that would be payable for the allowable expenses as provided for in §303.A, *Allowable Expense,* a-e under the secondary plan in the absence of this COB provision and the benefits that would be payable for the allowable expenses as provided for in §303.A, *Allowable Expense,* a-e under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not a claim is made, exceeds the allowable expenses in a claim determination period. In that case, the benefits of the secondary plan shall be reduced so that they and the benefits payable under the other plans do not total more than the allowable expenses as provided for in §303.A, *Allowable Expense,* a-e.

1. When the benefits of a plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of the plan.

2. The requirements of Paragraph 1 of this Subsection do not apply if the plan provides only one benefit, or may be altered to suit the coverage provided.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3.2014.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 17:67 (January 1991), amended LR 20:52 (January 1994), LR 23:415 (April 1997), LR 42:1099 (July 2016), LR 44:65 (January 2018).

§311. Notice to Covered Persons

A. Plan shall in its explanation of benefits provided to covered persons, include the following language. "If you are covered by more than one health benefit plan, you should file all your claims with each plan." Additionally, notice to obtain a copy of Appendix C, as provided for in LAC 37:XIII.305.G, shall be added as part of the coordination of benefit section or provision found in an insurance contract or subscriber agreement. Appendix C will also be available on the Louisiana Department of Insurance's website.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 17:67 (January 1991), amended LR 20:52 (January 1994), LR 23:415 (April 1997), LR 42:1100 (July 2016), LR 44:65 (January 2018).

§315. Miscellaneous Provisions (Formerly §313)

A. A secondary plan that provides benefits in the form of services may recover the reasonable cash value of the services from the primary plan, to the extent that benefits for the services are covered by the primary plan and have not already been paid or provided by the primary plan. Nothing in this provision shall be interpreted to require a plan to reimburse a covered person in cash for the value of services provided by a plan that provides benefits in the form of services.

1. A plan with order of benefit determination rules that comply with this regulation (complying plan) may coordinate its benefits with a plan that is "excess" or "always secondary" or that uses order of benefit determination rules that are inconsistent with those contained in this regulation (non-complying plan) on the following basis:

a. if the complying plan is the primary plan, it shall pay or provide its benefits first;

b. if the complying plan is the secondary plan, it shall pay or provide its benefits first, but the amount of the benefits payable shall be determined as if the complying plan were the secondary plan. In such a situation, the payment shall be the limit of the complying plan's liability; and

c. if the non-complying plan does not provide the information needed by the complying plan to determine its benefits within a reasonable time after it is requested to do so, the complying plan shall assume that the benefits of the non-complying plan are identical to its own, and shall pay its benefits accordingly. If, within two years of payment, the complying plan receives information as to the actual benefits of the non-complying plan, it shall adjust payments accordingly.

2. If the non-complying plan reduces its benefits so that the covered person receives less in benefits than the covered person would have received had the complying plan paid or provided its benefits as the secondary plan and the non-complying plan paid or provided its benefits as the primary plan, and governing state law allows the right of subrogation set forth below, then the complying plan shall advance to the covered person or on behalf of the covered person an amount equal to the difference.

3. In no event shall the complying plan advance more than the complying plan would have paid had it been the primary plan less any amount it previously paid for the same expense or service. In consideration of the advance, the complying plan shall be subrogated to all rights of the covered person against the non-complying plan. The advance by the complying plan shall also be without prejudice to any claim it may have against a non-complying plan in the absence of subrogation.

B. COB differs from subrogation. Provisions for one may be included in health care benefits contracts without compelling the inclusion or exclusion of the other.

C. If the plans cannot agree on the order of benefits within 30 calendar days after the plans have received all of the information needed to pay the claim, the plans shall immediately pay the claim in equal shares and determine their relative liabilities following payment, except that no plan shall be required to pay more than it would have paid had it been the primary plan.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 17:67 (January 1991), amended LR 20:52 (January 1994), LR 23:415 (April 1997), LR 42:1100 (July 2016).

§317. Severability Provision

A. If any Section or provision of Regulation 32 or the application to any person or circumstance is held invalid, such invalidity or determination shall not affect other

Sections or provisions or the application of Regulation 32 to any persons or circumstances that can be given effect without the invalid section or provisions or application, and for these purposes the Sections and provisions of Regulation 32 and the applications to any persons or circumstances are severable.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 42:1100 (July 2016).

§319. Effective Date for Existing Contracts (Formerly §315)

A. A contract that provides health care benefits and that was issued before the effective date of this regulation shall be brought into compliance with this regulation, by January 2019.

B. This amended regulation is applicable to every group and individual contract or subscriber agreement that provides health care benefits and that is issued on or after the effective date of this regulation. The effective date of this regulation shall be upon final publication and all contracts that provide healthcare benefits issued after the effective date shall be brought into compliance by January 2019.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3.2014.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 17:67 (January 1991), amended LR 20:52 (January 1994), LR 23:415 (April 1997), LR 42:1100 (July 2016), LR 44:66 (January 2018).

§321. Appendix A—Model COB Contract Provisions (Formerly §317)

A. Model COB Contract Provisions

COORDINATION OF THIS CONTRACT'S BENEFITS WITH OTHER BENEFITS

The Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense as provided for in §303A.(a.-e.) of Regulation 32.

DEFINITIONS

A. A Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

(1) Plan includes: group and nongroup insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

(2) Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage except those enumerated in LSA-R.S. 22:1000 A.3C; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

B. This plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. The order of benefit determination rules determine whether This plan is a Primary plan or Secondary plan when the person has health care coverage under more than one Plan. When This plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

D. Allowable expense is a health care service or expense, including deductibles, coinsurance and copayments, that is covered in full or at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense or service that is not covered by any Plan covering the person is not an Allowable expense.

The following are examples of expenses that are and are not an Allowable expenses:

(1) The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.

(2) If a person is covered by 2 or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.

(3) If a person is covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.

(4) If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary plan's payment arrangement shall be the Allowable expense for all Plans.

(5) The amount of any benefit reduction by the Primary plan because a covered person has failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

E. Closed panel plan is a Plan that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

F. Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

A. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.

(1) Except as provided in Paragraph (2), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying plan is primary.

(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide out-of-network benefits.

B. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

C. Each Plan determines its order of benefits using the first of the following rules that apply:

(1) Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary plan and the Plan that covers the person as a dependent is the Secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.

(2) Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:

(a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

The Plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or

If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.

(b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;

(ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;

(iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or

(iv) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

(a.) The Plan covering the Custodial parent;

(b.) The Plan covering the spouse of the Custodial parent;

(c.) The Plan covering the non-custodial parent; and then

(d.) The Plan covering the spouse of the non-custodial parent.

(c) For a dependent child covered under more than one Plan of individuals who are the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

(d) For a dependent child covered under spouse's plan

(i) For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in Paragraph (5) applies.

(ii) In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in Subparagraph (a) to the dependent child's parent(s) and the dependent's spouse.

(3) Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same person as a retired or laid-off employee is the Secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(4) COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(5) Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary plan and the Plan that covered the person the shorter period of time is the Secondary plan.

(6) If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This plan will not pay more than it would have paid had it been the Primary plan.

EFFECT ON THE BENEFITS OF THIS PLAN

A. When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary plan. The Secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim. In addition, the Secondary plan shall credit to its plan deductible, coinsurance, copayments and any amounts it would have credited to its deductible in the absence of other health care coverage.

B. If a covered person is enrolled in two or more Closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed panel plan, COB shall not apply between that Plan and other Closed panel plans.

C. Effect on the Benefits of This Plan

(1) When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a plan year or claim determination period are not more than 100 percent of total allowable expenses. The difference between the benefit payments that this plan would have paid had it been the primary plan, and the benefit payments that it actually paid or provided shall be recorded as a benefit reserve for the covered person and used by this plan to pay any allowable expenses, not otherwise paid during the claim determination period. As each claim is submitted, this plan will:

(a) determine its obligation to pay or provide benefits under its contract;

(b) determine whether a benefit reserve has been recorded for the covered person; and

(c) determine whether there are any unpaid allowable expenses during that claims determination period.

(2) If there is a benefit reserve, the secondary plan will use the covered person's benefit reserve to pay up to 100 percent of total allowable expenses incurred during the claim determination period. At the end of the claims determination period, the benefit reserve returns to zero. A new benefit reserve must be created for each new claim determination period.

(3) If a covered person is enrolled in two or more closed panel plans, and if for any reason, including the provision of service by a nonpanel provider, benefits are not payable by one closed panel plan, COB shall not apply between that plan and other closed panel plans.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This plan and other Plans. [Organization responsibility for COB administration] may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This plan and other Plans covering the person claiming benefits. [Organization responsibility for COB administration] need not tell, or get the consent of, any person to do this. Each person claiming benefits under This plan must give [Organization responsibility for COB administration] any facts it needs to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another Plan may include an amount that should have been paid under This plan. If it does, [Organization responsibility for COB administration] may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This plan. [Organization responsibility for COB administration] will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by [Organization responsible for COB administration] is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3.2014.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 17:67 (January 1991), amended LR 20:52 (January 1994), LR 23:415 (April 1997), LR 42:1101 (July 2016), LR 44:66 (January 2018).

§323. Appendix B—Consumer Explanatory Booklet Coordination of Benefits (Formerly §319)

A. Consumer Explanatory Booklet Coordination of Benefits

COORDINATION OF BENEFITS

IMPORTANT NOTICE

This is a summary of only a few of the provisions of your health plan to help you understand coordination of benefits, which can be very complicated. This is not a complete description of all of the coordination rules and procedures, and does not change or replace the language contained in your insurance contract, which determines your benefits.

Double Coverage

It is common for family members to be covered by more than one health care plan. This happens, for example, when a husband and wife both work and choose to have family coverage through both employers.

When you are covered by more than one health plan, state law permits your insurers to follow a procedure called "coordination of benefits" to determine how much each should pay when you have a claim. The goal is to make sure that the combined payments of all plans do not add up to more than your covered health care expenses.

Coordination of benefits (COB) is complicated, and covers a wide variety of circumstances. This is only an outline of some of the most common ones. If your situation is not described, read your evidence of coverage or contact your state insurance department.

Primary or Secondary?

You will be asked to identify all the plans that cover members of your family. We need this information to determine whether we are the "primary" or "secondary" benefit payer. The primary plan always pays first when you have a claim.

Any plan that does not contain your state's COB rules will always be primary.

When This Plan is Primary

If you or a family member are covered under another plan in addition to this one, we will be primary when:

Your Own Expenses

- The claim is for your own health care expenses, unless you are covered by Medicare and both you and your spouse are retired.

Your Spouse's Expenses

- The claim is for your spouse, who is covered by Medicare, and you are not both retired.

Your Child's Expenses

- The claim is for the health care expenses of your child who is covered by this plan and
- You are married and your birthday is earlier in the year than your spouse's or you are living with another individual, regardless of whether or not you have ever been married to that individual, and your birthday is earlier than that other individual's birthday. This is known as the "birthday rule";

  or

- You are separated or divorced and you have informed us of a court decree that makes you responsible for the child's health care expenses;

  or

- There is no court decree, but you have custody of the child.

Other Situations

We will be primary when any other provisions of state or federal law require us to be.

How We Pay Claims When We Are Primary

When we are the primary plan, we will pay the benefits in accordance with the terms of your contract, just as if you had no

other health care coverage under any other plan.

How We Pay Claims When We Are Secondary

We will be secondary whenever the rules do not require us to be primary.

How We Pay Claims When We Are Secondary

When we are the secondary plan, we do not pay until after the primary plan has paid its benefits. We will then pay part or all of the allowable expenses left unpaid, as explained below. An "allowable expense" is a health care service or expense covered by one of the plans, including copayments, coinsurance and deductibles.

- If there is a difference between the amount the plans allow, we will base our payment on the higher amount. However, if the primary plan has a contract with the provider, our combined payments will not be more than the contract calls for. Health maintenance organizations (HMOs) and preferred provider organizations (PPOs) usually have contracts with their providers.
- We will determine our payment by subtracting the amount the primary plan paid from the amount we would have paid if we had been primary. We will use any savings to pay the balance of any unpaid allowable expenses covered by either plan.
- If the primary plan covers similar kinds of health care expenses, but allows expenses that we do not cover, we will pay for those items as long as there is a balance in your benefit reserve, as explained below.
- We will not pay an amount the primary plan did not cover because you did not follow its rules and procedures. For example, if your plan has reduced its benefit because you did not obtain pre-certification, as required by that plan, we will not pay the amount of the reduction, because it is not an allowable expense.
- Benefit Reserve
- When we are secondary we often will pay less than we would have paid if we had been primary. Each time we "save" by paying less, we will put that savings into a benefit reserve. Each family member covered by this plan has a separate benefit reserve. We use the benefit reserve to pay allowable expenses that are covered only partially by both plans. To obtain a reimbursement, you must show us what the primary plan has paid so we can calculate the savings. To make sure you receive the full benefit or coordination, you should submit all claims to each of your plans. Savings can build up in your reserve for one year. At the end of the year any balance is erased, and a fresh benefit reserve begins for each person the next year as soon as there are savings on their claims.

Questions about Coordination of Benefits?
Contact Your State Insurance Department

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3.2014.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 17:67 (January 1991), amended LR 20:52 (January 1994), LR 23:415 (April 1997), LR 42:1103 (July 2016), LR 44:66 (January 2018).

§325. Appendix C—Explanation for Secondary Plans on the Purpose and Use of the Benefit Reserve

A. Explanation for Secondary Plans on the Purpose and Use of the Benefit Reserve

COORDINATION OF BENEFITS

The purpose of coordination of benefits is to ensure that a covered person does not receive more than 100% of the total allowable expenses. Any plan that has been determined to be the secondary plan in accordance with this model regulation is

permitted to reduce its benefits so that the total benefits paid by all plans during a claim determination period (a period of time not less than 12 months, usually a calendar year or contract year) are not more than the total allowable expenses.

The secondary plan usually saves money on claims due to the other plan paying first. The amount saved by the secondary plan must be used to pay allowable expenses which would not otherwise have been paid. To do this, secondary plans must establish a benefit reserve account for each covered person. The secondary plan puts the money saved on claims for the covered person into the benefit reserve account. This money is to be used to pay any portion of an allowable expense incurred by the covered person during a claim determination period by using the following procedure:

- **First,** as each claim is received, the secondary plan determines how much it would have paid if it had been the primary plan.
- **Second,** the secondary plan subtracts this amount from what it paid on the claim.
- **Third,** the difference (or savings) between what the secondary plan paid and what it would have paid if it had been the primary plan is then placed in the benefit reserve account established for the covered person.
- **Lastly,** as subsequent claims are submitted for the covered person, the secondary plan reviews previous claims and determines its obligation to pay for allowable expenses on those claims and pays on those claims to the extent savings are available in the covered person's benefit reserve account. This includes claims that were previously applied to either plan's deductible, coinsurance or copayment. For example, if the first claim incurred by the covered person was applied to both plans' deductibles and the second claim incurred by a covered person was payable at 100% by both plans, the secondary plan must use the savings realized from the second claim to pay toward the first claim.

The procedure outlined above is illustrated in the various claim examples that follow. For all of the examples, Plan A is the primary plan and Plan B is the secondary plan. Both plans have an 80 percent/20 percent coinsurance requirement. For illustrative purposes, Plan A has a $25 deductible and Plan B has a $100 deductible. Claims are assumed to have occurred in the same claim determination period and in consecutive order.

Examples:

Claim Number 1 **Actual Charge = $100**	
Plan A $100 -25 Deductible $75 80 percent $60 Payable	Plan B $100 -100 Deductible $0 Payable
Plan A must pay $60. Plan B makes no payment because it would have no liability under the terms of the policy if it had been primary. No money is available from the benefit reserve account.	
Claim Number 2 **Actual Charge = $5300**	
Plan A $5300 -0 Deductible $5300 80 percent $4240 Payable	Plan B $5300 -0 Deductible $5300 80 percent $4240 Payable
The deductible on both plans was calculated in Claim #1. Deductibles will not apply from this claim forward. Plan A must pay $4240. Plan B must pay the difference between the actual charge and the amount paid by Plan A ($1060). Plan B must now establish a benefit reserve account. This amount, the savings, is calculated by subtracting the amount it paid from the amount it would have paid if primary ($4240-$1060=$3180). Now Plan B must go back to Claim #1 and pay the $40 balance of that claim out of the benefit reserve account, leaving a balance in that account of $3140.	

Claim Number 3 Actual Charge = $110	
Plan A $110 80 percent $88 Payable	Plan B $110 80 percent $88 Payable
Plan A pays $88. Plan B pays the difference of the actual charge and the amount paid by Plan A ($22). Plan B would have paid $88 if primary, but only paid $22, so the balance of the savings of $66 goes into the benefit reserve account, which now totals $3206. Plan B does not have to go back to any other prior claims to pay any incurred, but unpaid, allowable expenses, because there are none outstanding. So, the balance in the benefit reserve account remains unchanged at $3206.	
Claim Number 4 Actual Charge = $1500	
Plan A $1300 RVS 80 percent $1040 Payable	Plan B $1100 RVS 80 percent $880 Payable
The insured is liable for the difference between the actual charge and the highest amount under the relative value schedule (RSV) reimbursement methodology ($200). Plan A pays $1040. Plan B pays the difference between the highest RSV amount and the amount paid by Plan A ($1300-$1040=$260). The benefit reserve account is increased by the difference between what Plan B would have paid if primary and the amount actually paid by Plan B ($880-$260=$620), for a new balance of $3826.	
Claim Number 5 Actual Charge = $2295 for 51 visits	
This claim involves spinal manipulation. Plan A provides up to 26 visits per year on an 80 percent/20 percent basis. Total actual charge of $45 per visit is within RSV limits.	
Plan A $1170 RSV for 26 visits 80 percent $936 Payable	Plan B has no coverage for spinal manipulation. However, because Plan A has coverage under its policy, the claim is considered an allowable expense for the 26 visits. Plan B must pay the 20% coinsurance ($234) amount for the 26 visits from the benefit reserve account, leaving a final balance of $3592. The remaining amount of $1125 for the additional 25 visits is not payable by either Plan A or Plan B because it is not considered an allowable expense under Plan A. Plan A pays benefits for only 26 visits per year. Again, Plan B has no coverage for spinal manipulation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3.2014.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 44:67 (January 2018).

Chapter 5. Regulation 33—Medicare Supplement Insurance Minimum Standards

§501. Purpose

A. The purpose of this regulation is:

1. to provide for the reasonable standardization of coverage and simplification of terms and benefits of Medicare supplement policies;

2. to facilitate public understanding and comparison of such policies;

3. to eliminate provisions contained in such policies which may be misleading or confusing in connection with the purchase of such policies or with the settlement of claims; and

4. to provide for full disclosures in the sale of accident and sickness insurance coverages to persons eligible for Medicare.

5. to incorporated Medigap policies that cover Part B deductibles to "newly eligible" Medicare beneficiaries defined as those individuals who:

a. have attained age 65 on or after January 1, 2020; or

b. first become eligible for Medicare due to age, disability or end-stage renal disease, on or after January 1, 2020.

AUTHORITY NOTE: Promulgated in accordance with R.S.22:224 and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1101 (June 1999), repromulgated LR 25:1481 (August 1999), LR 29:2434 (November 2003), LR 31:2902 (November 2005), amended LR 44:2189 (December 2018).

§502. Applicability and Scope

A. Except as otherwise specifically provided in §§510, 540, 545, 560 and 585, this regulation shall apply to:

1. all Medicare supplement policies delivered or issued for delivery in this state on or after the effective date of this regulation; and

2. all certificates issued under group Medicare supplement policies which certificates have been delivered or issued for delivery in this state.

B. This regulation shall not apply to a policy or contract of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees, or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations.

C. Updating Regulation 33 to comply with Medicare Access and CHIP Reauthorization Act.

AUTHORITY NOTE: Promulgated in accordance with R.S.22:224 and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1101 (June 1999), repromulgated LR 25:1481 (August 1999), LR 29:2434 (November 2003), LR 31:2902 (November 2005), amended LR 44:2189 (December 2018).

§503. Definitions

A. For purpose of this regulation:

1990 Standardized Medicare Supplement Benefit Plan, 1990 Standardized Benefit Plan or 1990 Plan—a group or individual policy of Medicare supplement insurance issued on or after July 20, 1992 and with an effective date for coverage prior to June 1, 2010 and includes Medicare