ITEM 1. ENTERPRISE RISK

The Registrant/Applicant, to the best of its knowledge and belief, shall provide information regarding the following areas that could produce enterprise risk as defined in R.S. 22:691.2(4), provided such information is not disclosed in the Insurance Holding Company System Annual Registration Statement filed on behalf of itself or another insurer for which it is the ultimate controlling person:

(a) Any material developments regarding strategy, internal audit findings, compliance or risk management affecting the insurance holding company system;

(b) Acquisition or disposal of insurance entities and reallocating of existing financial or insurance entities within the insurance holding company system;

(c) Any changes of shareholders of the insurance holding company system exceeding ten percent or more of voting securities;

(d) Developments in various investigations, regulatory activities or litigation that may have a significant bearing or impact on the insurance holding company system;

(e) Business plan of the insurance holding company system and summarized strategies for next 12 months;

(f) Identification of material concerns of the insurance holding company system raised by supervisory college, if any, in last year;

(g) Identification of insurance holding company system capital resources and material distribution patterns;

(h) Identification of any negative movement, or discussions with rating agencies which may have caused, or may cause, potential negative movement in the credit ratings and individual insurer financial strength ratings assessment of the insurance holding company system (including both the rating score and outlook);

(i) Information on corporate or parental guarantees throughout the holding company and the expected source of liquidity should such guarantees be called upon; and

(j) Identification of any material activity or development of the insurance holding company system that, in the opinion of senior management, could adversely affect the insurance holding company system.

The Registrant/Applicant may attach the appropriate form most recently filed with the U.S. Securities and Exchange Commission, provided the Registrant/Applicant includes specific references to those areas listed in Item 1 for which the form provides responsive information. If the Registrant/Applicant is not domiciled in the U.S., it may attach its most recent public audited financial statement filed in its country of domicile, provided the Registrant/Applicant includes specific references to those areas listed in Item 1 for which the financial statement provides responsive information.

ITEM 2: OBLIGATION TO REPORT.

If the Registrant/Applicant has not disclosed any information pursuant to Item 1, the Registrant/Applicant shall include a statement affirming that, to the best of its knowledge and belief, it has not identified enterprise risk subject to disclosure pursuant to Item 1.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:691.6 and 22:691.11.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 41:1306 (July 2015).

Chapter 2. Regulation 104—Corporate Governance Annual Disclosure

Editor' Note: The Louisiana Revised Statutes cited in both the text and the authority notes of §§201, 203, 205, 207 and 209 were changed by the Louisiana Law Institute subsequent to the original citations herein. The below table shows those newly-designated citations.

Original Citations	Redesignated Citations
La. R.S. 22:691.31 – 22:691.38	La. R.S. 22:691.51 – 22:691.58
La. R.S. 22:691.33	La. R.S. 22:691.53
La. R.S. 22:691.34	La. R.S. 22:691.54
La. R.S. 22:691.35.B	La. R.S. 22:691.55.B

§201. Purpose

A. The purpose of this regulation is to set forth rules and procedural requirements which the commissioner deems necessary to carry out the provisions of R.S. 22:691.51-691.58 of the Insurance Code. The information called for by this regulation is hereby declared to be necessary and appropriate in the public interest and for the protection of the policyholders in this state.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:11 and 22:691.51-691.58.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 41:2663 (December 2015), amended LR 50:397 (March 2024).

§203. Definitions

Commissioner—commissioner of insurance for the state of Louisiana.

Corporate Governance Annual Disclosure or *CGAD*—a confidential report filed by the insurer or insurance group compiled in accordance with the requirements of R.S. 22:691.51-691.58 and Regulation 104.

Insurance Group—those insurers and affiliates included within an insurance holding company system as defined in R.S. 22:691.2(8).

Insurer—shall have the same meaning as set forth in R.S. 22:46(14). For the purposes of this Subpart, a health maintenance organization as defined R.S. 22:242(6) shall also be considered an insurer. The term "insurer" shall not include agencies, authorities, or instrumentalities of the United States, its possessions and territories, the Commonwealth of Puerto Rico, the District of Columbia, or a state or political subdivision of a state.

Senior Management—any corporate officer responsible for reporting information to the board of directors at regular intervals or providing this information to shareholders or regulators and shall include, for example and without limitation, the chief executive officer (CEO), chief financial officer (CFO), chief operations officer (COO), chief procurement officer (CPO), Chief Legal Officer (CFO), chief information officer (CIO), chief technology officer (CTO), chief revenue officer (CRO), chief visionary officer (CVO), or any other "C" level executive.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:11 and 22:691.51-691.58.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 41:2663 (December 2015), amended LR 50:397 (March 2024).

§205. Filing Procedures

A. An insurer, or the insurance group of which the insurer is a member, required to file a CGAD by R.S. 22:691.53 shall, no later than June 1 of each calendar year, submit to the commission a CGAD that contains the information described in §207 of this regulation.

B. The CGAD shall include a signature of the insurer's or insurance group's chief executive officer or corporate secretary attesting to the best of that individual's belief and knowledge that the insurer or insurance group has implemented the corporate governance practices and that a copy of the CGAD has been provided to the insurer's or insurance group's board of directors (hereafter "board") or the appropriate committee thereof.

C. The insurer or insurance group shall have discretion regarding the appropriate format for providing the information required by these regulations and is permitted to customize the CGAD to provide the most relevant information necessary to permit the commission to gain an understanding of the corporate governance structure, policies and practices utilized by the insurer or insurance group.

D. For purposes of completing the CGAD, the insurer or insurance group may choose to provide information on governance activities that occur at the ultimate controlling parent level, an intermediate holding company level and/or the individual legal entity level, depending upon how the insurer or insurance group has structured its system of corporate governance. The insurer or insurance group is encouraged to make the CGAD disclosures at the level at which the insurer's or insurance group's risk appetite is determined, or at which the earnings, capital, liquidity, operations, and reputation of the insurer are overseen collectively and at which the supervision of those factors are coordinated and exercised, or the level at which legal liability for failure of general corporate governance duties would be placed. If the insurer or insurance group determines the level of reporting based on these criteria, it shall indicate which of the three criteria was used to determine the level of reporting and explain any subsequent changes in level of reporting.

E. Notwithstanding Subsection A of this Section, and as outlined in R.S. 22:691.53, if the CGAD is completed at the insurance group level, then it shall be filed with the lead state of the group as determined by the procedures outlined in the most recent Financial Analysis Handbook adopted by the NAIC. In these instances, a copy of the CGAD shall also be provided to the chief regulatory official of any state in which the insurance group has a domestic insurer, upon request.

F. An insurer or insurance group may comply with this section by referencing other existing documents (e.g., ORSA Summary Report, Holding Company Form B or F Filings, Securities and Exchange Commission (SEC) Proxy Statements, foreign regulatory reporting requirements, etc.) if the documents provide information that is comparable to the information described in §207. The insurer or insurance group shall clearly reference the location of the relevant information within the CGAD and attach the referenced document if it is not already filed or available to the regulator.

G. Each year following the initial filing of the CGAD, the insurer or insurance group shall file an amended version of the previously filed CGAD indicating where changes have been made. If no changes were made in the information or activities reported by the insurer or insurance group, the filing shall so state.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:11 and 22:691.51-691.58.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, LR 41:2663 (December 2015), amended LR 50:397 (March 2024).

§207. Contents of Corporate Governance Annual Disclosure

A. The insurer or insurance group shall be as descriptive as possible in completing the CGAD, with inclusion of attachments or example documents that are used in the governance process, since these may provide a means to demonstrate the strengths of their governance framework and practices.

B. The CGAD shall describe the insurer's or insurance group's corporate governance framework and structure including consideration of the following.

1. The board and various committees thereof ultimately responsible for overseeing the insurer or insurance group and the level(s) at which that oversight occurs (e.g., ultimate control level, intermediate holding company, legal entity, etc.). The insurer or insurance group shall describe and discuss the rationale for the current board size and structure; and

2. The duties of the board and each of its significant committees and how they are governed (e.g., bylaws, charters, informal mandates, etc.), as well as how the board's leadership is structured, including a discussion of the roles of chief executive officer (CEO) and chairman of the board within the organization.

C. The insurer or insurance group shall describe the policies and practices of the most senior governing entity and significant committees thereof, including a discussion of the following factors:

1. How the qualifications, expertise and experience of each board member meet the needs of the insurer or insurance group.

2. How an appropriate amount of independence is maintained on the board and its significant committees.

3. The number of meetings held by the board and its significant committees over the past year as well as information on director attendance.

4. How the insurer or insurance group identifies, nominates and elects members to the board and its committees. The discussion should include, for example:

a. whether a nomination committee is in place to identify and select individuals for consideration.

b. whether term limits are placed on directors.

c. how the election and re-election processes function.

d. whether a board diversity policy is in place and if so, how it functions.

5. The processes in place for the board to evaluate its performance and the performance of its committees, as well as any recent measures taken to improve performance (including any board or committee training programs that have been put in place).

D. The insurer or insurance group shall describe the policies and practices for directing senior management, including a description of the following factors:

1. Any processes or practices (i.e., suitability standards) to determine whether officers and key persons in control functions have the appropriate background, experience and integrity to fulfill their prospective roles, including:

a. identification of the specific positions for which suitability standards have been developed and a description of the standards employed.

b. any changes in an officer's or key person's suitability as outlined by the insurer's or insurance group's standards and procedures to monitor and evaluate such changes.

2. The insurer's or insurance group's code of business conduct and ethics, the discussion of which considers, for example:

a. compliance with laws, rules, and regulations; and

b. proactive reporting of any illegal or unethical behavior.

3. The insurer's or insurance group's processes for performance evaluation, compensation and corrective action to ensure effective senior management throughout the organization, including a description of the general objectives of significant compensation programs and what the programs are designed to reward. The description shall include sufficient detail to allow the commissioner to understand how the organization ensures that compensation programs do not encourage and/or reward excessive risk taking. Elements to be discussed may include, for example:

a. the board's role in overseeing management compensation programs and practices.

b. the various elements of compensation awarded in the insurer's or insurance group's compensation programs and how the insurer or insurance group determines and calculates the amount of each element of compensation paid;

c. how compensation programs are related to both company and individual performance over time;

d. whether compensation programs include risk adjustments and how those adjustments are incorporated into the programs for employees at different levels;

e. any clawback provisions built into the programs to recover awards or payments if the performance measures upon which they are based are restated or otherwise adjusted;

f. any other factors relevant in understanding how the insurer or insurance group monitors its compensation policies to determine whether its risk management objectives are met by incentivizing its employees.

4. The insurer's or insurance group's plans for CEO and senior management succession.

E. The insurer or insurance group shall describe the processes by which the board, its committees and senior management ensure an appropriate amount of oversight to the critical risk areas impacting the insurer's business activities, including a discussion of:

1. How oversight and management responsibilities are delegated between the board, its committees and senior management;

2. How the board is kept informed of the insurer's strategic plans, the associated risks, and steps that senior management is taking to monitor and manage those risks;

3. How reporting responsibilities are organized for each critical risk area. The description should allow the commission to understand the frequency at which information on each critical risk area is reported to and reviewed by senior management and the board. This description may include, for example, the following critical risk areas of the insurer:

a. Risk management processes (An ORSA Summary Report filer may refer to its ORSA Summary Report pursuant to the Risk Management and Own Risk and 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