above quoted rule of the Fire Division will be regarded as a violation of that condition and companies guilty of such violation may expect that all applicable provisions of the Insurance Code will be invoked.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, April 4, 1955.

Chapter 57. Regulation 14—Limiting Exclusions in Industrial Policies, Restricting Payments for Death Caused in Specified Manner

§5701. Payment of Death or Funeral Benefits

A. All Domestic Insurance Companies

1. If your industrial life insurance or funeral benefit policies contain provisions which exclude or limit the payment of death or funeral benefits because death is caused in any specified manner, or occurs while the insured has a specified status, except those listed below, then it will be necessary that you amend such policies before they are issued.

2. Provisions excluding or restricting coverage in the event of death occurring:

a. as a result of war, declared or undeclared, under conditions specified in the policy;

b. while in:

i. the military, naval or air forces of any country at war, declared or undeclared;

ii. any ambulance, medical, hospital, or civilian non-combatants unit serving with such forces, either while serving with or within six months after termination of service in such forces or units;

c. as a result of self-destruction, while sane or insane, within two years from the date of issue of the policy;

d. as a result of aviation under conditions specified in the policy;

e. within two years from date of issue of the policy as a result of a specified hazardous occupation or occupations, or while the insured is residing in a specified foreign country or countries.

3. In the event of death to which there is an exclusion or restriction pursuant to §5701.A.2.a, b, c, d, or e of this provision, the insurer shall pay an amount not less than the reserve on the policy, together with the reserve for any paid-up additions thereto and any dividends standing to the credit of the policy, less any indebtedness to the insurer on the policy, including interest due or accrued.

4. In the event of death as to which there is an exclusion or restriction pursuant to Subparagraph (b) of Paragraph (3)(B), the insurer shall pay the greater of:

a. the amount specified in the preceding paragraph; or

b. the amount of the gross premiums charged on the policy less dividends paid in cash or used in the payment of premiums thereon and less any indebtedness to the insurer on the policy, including interest due or accrued.

5. None of the provisions of §5701.A.5 shall apply to policies issued under Sections 253 and 162.E, nor to any accidental benefits in the event such death by accident or accidental means included in a life policy.

B. Senate Committee Amendment Number 3

1. The Legislative intent of this Amendment, as evidenced by Industry and Committee hearings, was that it should apply only to the two immediately preceding unnumbered paragraphs so that a reduction not to exceed the percentages of the reserve, computed in accordance with Part 5 of the Code, could continue to be taken on funeral policies. Note reference to Sections 253 and 162.E.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:259.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, July 24, 1958.

§5703. Rider or Endorsement

A. We believe that these policies can be made acceptable more easily by the use of a rider or endorsement. For your guidance, we have reproduced below a form of rider or endorsement which will accomplish the purpose.

> NOTE: The language which we have suggested is not intended to preclude your substituting any appropriate language which is substantially similar in context.

B. If the language of the rider or endorsement which you intend to use is identical with that suggested, you may issue policies, already approved, containing such rider or endorsement, before sending them to this department for approval. Provided, however, that such rider or endorsement must be sent for approval within 30 days of the date of this Directive, and provided further, that if the language suggested is not used, then prior approval must be obtained before policies may be issued.

C. Suggested Rider

"Attached to and Made Part of Policy No. _____

Any provision in this policy which excludes or restricts coverage in the event of death for any reason, except death occurring:

1. as a result of war, declared or undeclared, under conditions specified in the policy;

2. while in:

a. the military, naval or air forces of any country at war, declared or undeclared; or

b. any ambulance, medical, hospital or civilian non-combatant unit serving with such forces, either while serving with or within six months after termination of service in such forces or units;

3. as a result of self-destruction, while sane or insane, within two years from the date of issue of the policy;

4. as a result of aviation under conditions specified in the policy;

5. within two years from date of issue of the policy as a result of a specified hazardous occupation or occupations, or while the insured is residing in a specified foreign country or countries, is null and void.

If this policy contains a provision for additional benefit in event of death by accidental means, the conditions and exceptions contained therein shall not be affected by this rider.

In witness whereof, the Company has issued this policy rider effective with the date thereof."

D. It is directed that when present supplies of policies to which this rider is attached have been exhausted, that complete policies, containing all the provisions of the contract, including those provisions contained in the rider, will be sent to this department for approval.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2 and 22:259.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, July 24, 1958.

Chapter 60. Regulation 74—Payment of Health Coverage Claims

§6001. Purpose

A. The purpose of this regulation is to implement the statutory requirements of health insurance issuers under Title 22 of the Louisiana Revised Statutes of 1950. Title 22 of the Louisiana Revised Statutes of 1950 establishes the statutory requirements for payment of claims by health insurance issuers serving residents of Louisiana. The statutory requirements establish the intent of the legislature to assure that residents with health care coverage are not billed for liabilities of health insurance.

B. To carry out the intent of the legislature and assure full compliance with the provisions of applicable statutory requirements, this regulation sets forth the standards for payment of claims by health insurance issuers and supercedes current regulations on uniform claim forms.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 22:250.35, to implement and enforce the following provisions R.S. 22:230.4(A)(4), Part VI-D of Chapter 1 of the Louisiana Revised Statutes of 1950, and R.S. 40:2203.1).

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 26:2006 (September 2000).

§6003. Applicability and Scope

A. Except as otherwise specifically provided, the requirements of this regulation apply to all health insurance coverage issued for delivery in the state of Louisiana that is otherwise subject to the statutory requirements of Part VI-D of Chapter 1 of Title 22 of the Louisiana Revised Statutes of 1950. The requirements of this regulation apply to all preferred provider organization contracts as required under the provisions of R.S. 40:2203.1(E) of the Louisiana Revised Statutes of 1950. The requirements of this regulation shall also apply to the State Employees Group Benefits Program as required under R.S. 22:230.4(A)(4).

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 22:250.35, to implement and enforce the following provisions R.S. 22:230.4(A)(4), Part VI-D of Chapter 1 of the Louisiana Revised Statutes of 1950, and R.S. 40:2203.1).

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 26:2006 (September 2000).

§6005. Claim Payments—Definitions

Claim—a request that covered benefits of a health insurance issuer be provided or paid for services that have been provided. The benefits claimed may be in the form of covered services, supplies, payment for all or a portion, of expenses incurred a combination of covered services, supplies and expenses incurred, or indemnification for all or a portion of actual losses.

Claimant—covered person, an authorized representative, or other entity filing a clean claim that is entitled to receive reimbursement from a health insurance issuer for covered benefits.

Clean Claim—a correctly completed standardized claim form as required under the Department of Insurance, Regulation 48.

Commissioner—the Commissioner of Insurance.

Contracted Medical Services—services provided by a state licensed, certified, or state registered provider of health care services, treatment, or supplies, including but not limited to those entities defined in R.S. 40:2203.1 that have entered into a contract or agreement with a health insurance issuer to provide such services, treatment or supplies to an individual enrollee or insured.

Covered Benefits—benefits available to a member, subscriber or insured under an insurance policy, benefit plan, or other contract for coverage of health care benefits. The term also includes any medical services or equipment that is provided to a covered person under an assignment of benefits, when such assignment is authorized by law and the terms of an insurance policy or contract of coverage issued by a health insurance issuer.

Covered Person—an insured, enrollee, member, or subscriber. In the case of a minor, the term includes an insured or legal guardian authorized to act in the best interest of such minor and therefore is acting on behalf of such covered person.

Date Upon Which a Clean Claim is Received—the date the uniform claim form is received by the health insurance issuer or its legal agent. For health insurance issuer examinations, the department will use the postmark date of claims to determine if the date of receipt reasonably reflects the date claims are actually received by health insurance issuers.

Department—the Department of Insurance.

Electronic Claim—the transmission of data for purposes of payment of covered medical services in an electronic data format specified by a health insurance issuer and approved by the department.