LOUISIANA DEPARTMENT OF INSURANCE
STATEMENT OF COMPLIANCE
POLICY FORM / RATE / ADVERTISING FILING

Insurer Name:

NAIC #:

Company Tracking #:

Filing Submission Date:

Product Code: NG.HMO-IND
NG.MM-Ind

Product Name: Major Medical / HMO

Policy Holder Type: Non-Grandfathered Individual

The Certification of Compliance Form CANNOT BE FILED for any of these product types.

PLEASE NOTE:

1. The following Statement of Compliance consists of two (2) parts: (1) Policy Form/Rate/Advertising Filing and (2) EHB, both of which must be completed.

2. If applicable, a health insurance issuer should specifically identify any state requirements or requirements identified in the Statement of Compliance for Policy Form/Rate/Advertising and EHB that are unable to be met due to conflict with federal law(s), specifically listing which federal law(s) are applicable.

PART 1
POLICY FORM / RATE / ADVERTISING FILING

Form Filing Requirements		Form - Section / Page #
La. R.S. 22:1821 D(2)(d)	Every insurer or health maintenance organization shall inform its insureds, enrollees, patients, and affiliated providers about all applicable policies related to emergency care access, coverage, payment, and grievance procedures.	
La. R.S. 22:864 B(1)	A policy shall specify the names of the parties to the contract. The insurer's name and if not a life insurer, the type of organization shall be clearly shown in the policy.	
La. R.S. 22:864 B(2)	A policy shall specify the subject of the insurance.	
La. R.S. 22:864 B(3)	A policy shall specify the risks insured against.	
La. R.S. 22:864 B(4)	A policy shall specify the time at which the insurance thereunder takes effect and the period during which the insurance is to continue.	
La. R.S. 22:864 B(5)	A policy shall include a statement of the premium. If other than life, accident or health, or title insurance, the premium rate should also be specified.	
La. R.S. 22:864 B(6)	A policy shall specify the conditions pertaining to the insurance.	

La. R.S. 22:864 B(8) La. R.S. 22:973 (4)	Every printed portion of the text matter of the policy and of any endorsements or attached papers shall be printed in uniform, no less than ten-point type. The text matter shall include all printed matter except the name and address of the insurer, name or title of the policy, captions, sub-captions, and form numbers.	
La. R.S. 22:864 B(9)	Each policy form, including riders and endorsements, shall be identified by a form number in the lower left-hand corner of each page.	
La. R.S. 22:869	Every insurance contract shall be executed in the name of and on behalf of the insurer by its officer, employee, or representative duly authorized by the insurer. A facsimile signature of any such executing officer, employee, or representative may be used in lieu of an original signature.	
Form Filing Prohibitions		**Form - Section / Page #**
La. R.S. 22:1823 A	No policy of hospitalization insurance may exclude payment of benefits to an insured for services rendered by a medical facility owned or operated by the state of Louisiana or any of its political subdivisions, whether it be a general hospital, a mental hospital, a tubercular hospital, or a geriatric hospital. Any policy provision in violation of this Subsection shall be invalid.	
La. R.S. 22:1823 B	No policy of hospitalization insurance shall exclude payment of benefits to an insured or his assignee for services rendered by a provider of medical services, which services are considered reimbursable in whole or in part from federal or state medical assistance funds provided pursuant to Title XIX of the Social Security Act and R.S. 46:153. Any payment in excess of actual charges for such services shall be reimbursed to the appropriate federal or state medical assistance fund by the person or establishment receiving such excess payment.	
La. R.S. 22:868 A(2)	No insurance contract shall contain any condition, stipulation, or agreement depriving the courts of this state of the jurisdiction of action against the insurer.	

Cover / Face Page		**Form - Section / Page #**
La. R.S. 22:973 (2)	Time at which the insurance takes effect and terminates must be expressed in the policy.	
La. R.S. 22:973 (7)(a)	No health and accident policy or contract shall be delivered or issued for delivery on risks in this state unless there is prominently printed on or attached, a notice to the insured that ten days are allowed, from the date of his receipt of the policy, to examine its provisions. If such policy was solicited by deceptive advertising or negotiated by deceptive, misleading, or untrue statements of the insurer or any agent on behalf of the insurer, such policy may be surrendered within said ten-day period. Any premium advanced by the insured, upon such surrender, shall be immediately returned to him; however, the insurer shall have the option of printing or attaching the notice required by this Subparagraph or a notice of equal prominence which, in the opinion of the commissioner of insurance, is not less favorable to the policyholder. This Paragraph shall not apply to travel insurance policies which by their terms are not renewable.	

Schedule of Benefits		Form - Section / Page #
La. R.S. 22:1028 E	Mandated coverage for annual Pap test, minimum mammography examination and detection of prostate cancer shall not be subject to any policy or health coverage plan deductible amount.	
La. R.S. 22:1034 C	The benefits provided for coverage for diabetes shall be subject to the same annual deductibles or co-insurance established for all other covered benefits within a given policy.	

Definitions		Form - Section / Page #
La. R.S. 22:1005 A (6)	"Life-threatening illness" means a severe, serious, or acute condition for which death is probable.	
La. R.S. 22:1024 C(1)	Definition of "Newly Born" means infants from the time of birth until age one month or until such time as the infant is well enough to be discharged from a hospital or neonatal special care unit to his home, whichever period is longer.	
La. R.S. 22:1024 C(2)	Definition of "Temporarily Medically Disabled Mother" means a woman who has recently given birth and whose physician has advised that normal travel would be hazardous to her health.	
La. R.S. 22:1061 (4)	"Creditable coverage" means coverage of an individual under (a) A group health plan; (b) Health insurance coverage; (c) Medicare coverage; (d) Medicaid; (e) Medical insurance coverage under the General Military Law; (f) A medical care program of the Indian Health Service or of a tribal organization; (g) A state health benefits risk pool; (h) A health plan offered for federal employees; (i) A public health plan; or (j) A health benefit plan provided to members of the Peace Corps. Such term does not include coverage consisting solely of coverage of excepted benefits.	
La. R.S. 22:1061 (5)(a)	"Beneficiary" means a person designated by a participant, or by the terms of a health insurance benefit plan, who is or may become entitled to a benefit under the plan.	
La. R.S. 22:1061 (5)(k)	"Placement" or "being placed", for adoption, in connection with any placement for adoption of a child with any person, means the assumption and retention by such person of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's placement with such person terminates upon the termination of such legal obligation.	
La. R.S. 22:1821 D(2)(g)(i)	The following definitions shall apply - (i) "Emergency medical condition" is a medical condition of recent onset and severity, including severe pain, that would lead a prudent layperson, acting reasonably and possessing an average knowledge of health and medicine, to believe that the absence of immediate medical attention could reasonably be expected to result in: (aa) Placing the health of the individual, or with respect to a pregnant woman the health of the woman or her unborn child, in serious jeopardy; (bb) Serious impairment to bodily function; or (cc) Serious dysfunction of any bodily organ or part.	

La. R.S. 22:1821 D(2)(g)(ii)	The following definitions shall apply - (ii) "Emergency medical services" are those medical services necessary to screen, evaluate, and stabilize an emergency medical condition.	

Eligibility Provisions		**Form - Section / Page #**
La. R.S. 22:1000 A(2) La. R.S. 22:1003 A(1)	Eligible dependents includes spouse, children under 26 years of age, and grandchildren under 26 years of age who are in the legal custody of the grandparent, except that the policy may provide for continuing coverage for any child or grandchild in the legal custody of and residing with the grandparent who is incapable of self-sustaining employment by reason of mental retardation or physical handicap, who became so incapable prior to age twenty-six.	
La. R.S. 22:1000 C	New members becoming eligible for insurance in an existing group or class shall be added.	
La. R.S. 22:1004 A	Any unmarried child who is placed in the home of an insured pursuant to an adoption placement agreement executed with a licensed adoption agency shall be considered a dependent child of the insured from the date of placement in the home of the insured.	
La. R.S. 22:1004 B	Any unmarried child who is placed in the home of an insured following execution of an act of voluntary surrender in favor of the insured or the insured's legal representative shall be considered a dependent child of the insured effective on the date on which the act of voluntary surrender becomes irrevocable.	
La. R.S. 22:1072 E	Any individual policyholder or individual subscriber shall be authorized to add a newborn child to his individual policy or subscriber agreement at any time prior to birth, effective upon birth. Coverage for a newborn child added to a policy or subscriber agreement shall be subject to adjustment for the additional coverage provided.	

Benefit / Coverage Provisions		**Form - Section / Page #**
La. R.S. 22:1005 B	To provide for continuity of health care.	
La. R.S. 22:1005 B (1)	To provide for continuity of care in the event an enrollee or insured has been diagnosed as being a high-risk pregnancy.	
La. R.S. 22:1005 B (2)	To provide for continuity of care in the event an enrollee or insured has been diagnosed with a life-threatening illness.	

La. R.S. 22:1005 C	Certain reasons when continuity of care coverage is not required to be covered.	
La. R.S. 22:1024 A	Any policy issued under LRS 22:1024, which in addition to covering the insured also covers members of the insured's immediate family, shall provide coverage for illnesses and injuries of unmarried dependent children of the insured and unmarried grandchildren in the legal custody of the grandparent from the date of birth to the attainment of the limiting age. Such coverage shall include coverage for illness, injury, congenital defects, and premature birth, but need not include routine well baby care.	

Benefit / Coverage Provisions		**Form - Section / Page #**
La. R.S. 22:1024 B(1)	Transportation coverage for newly born children is required.	
La. R.S. 22:1024 B(2)	Transportation coverage for medically disabled mother of the ill newly born child is required.	
La. R.S. 22:1033 La. R.S. 22:272 D - HMO	Policies shall not prevent any individual insured from receiving direct access to an obstetrician or gynecologist or in-network obstetrician or gynecologist for routine gynecological care. For those enrollees in a plan that has made agreements with providers for the provision of health care or related services, the provisions of this Subsection may limit direct access to any in-network obstetrician or gynecologist for routine gynecological care.	
La. R.S. 22:1039	Any insurer of any policy of health and accident insurance shall pay any claim up to the limit of the policy for any service performed in a licensed ambulatory surgical center provided such service would have been covered if performed as an inpatient service.	
La. R.S. 22:1040	Policies shall provide benefits for anesthesia when rendered in a hospital setting and for associated hospital charges when the mental or physical condition of the insured requires dental treatment to be rendered in a hospital setting.	
La. R.S. 22:1060.2	A health insurance issuer of a health benefit plan that covers prescription drugs and uses one or more drug formularies to specify the prescription drugs covered under the plan shall: 1) Provide in plain language in the coverage documentation provided to each enrollee each of the following: a) Notice that the plan uses one or more drug formularies. b) An explanation of what a drug formulary is. c) A statement regarding the method the health insurance issuer uses to determine the prescription drugs to be included in or excluded from a drug formulary. d) A statement of how often the health insurance issuer reviews the contents of each drug formulary. e) Notice, on a form approved by the Department of Insurance, that an enrollee may contact the health insurance issuer to determine whether a specific drug is included in a particular drug formulary.	

La. R.S. 22:1060.3	A health insurance issuer of a health benefit plan that covers prescription drugs shall offer to each enrollee at the contracted benefit level and until the enrollee's plan renewal date any prescription drug that was approved or covered under the plan for a medical condition or illness, regardless of whether the drug has been removed from the health benefit plan's drug formulary before the plan renewal date.	
La. R.S. 22:1060.4	The refusal of a health insurance issuer to provide benefits to an enrollee for a prescription drug is an adverse determination for the purposes of medical necessity if the following conditions are met: (1) The drug is not included in a drug formulary used by the health benefit plan. (2) The enrollee's physician or other authorized prescriber has determined the drug is medically necessary.	
La. R.S. 22:1065 A	A group health plan may not: (a) Restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child, following a normal vaginal delivery, to less than forty-eight hours; (b) Restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child, following a cesarean section, to less than ninety-six hours; (c) Require that a provider obtain authorization from the plan or the issuer for prescribing any length of stay. An attending provider, in consultation with the mother, may discharge the mother or her newborn child prior to the expiration of the minimum length of stay.	
La. R.S. 22:1075	The standards relating to benefits for mothers and newborns set forth in LRS-22:1065 (A), (B), and (C) shall apply to health insurance coverage offered in the individual market in the same manner as it applies to health insurance coverage offered by a health insurance issuer in connection with a group health plan in the small or large group market.	
La. R.S. 22:1154 C	Any health insurance policy or employee benefit plan that provides benefits for dental care expenses, shall: (1) Disclose, if applicable, that the benefit offered is limited to the least costly treatment; (2)(a) Define and explain the standard upon which the payment of benefits or reimbursement for the cost of dental care services is based, such as "usual and customary or words of similar import, or shall specify in dollars and cents the amount of the payment or reimbursement for dental care services to be provided; and (b) The payment or reimbursement for a non-contracting provider dentist shall be the same as the payment or reimbursement for a contracting provider dentist.	

Benefit / Coverage Provisions		**Form - Section / Page #**
La. R.S. 22:1821 D(2)(b)	Every policy or contract which includes emergency medical services shall subsequently pay providers for emergency medical services provided to an insured, enrollee, or patient who presents himself with an emergency medical condition.	

La. R.S. 22:1821 D(2)(c)	An insurer or health maintenance organization shall not retrospectively deny or reduce payments to providers for emergency medical services even if it is determined that the emergency medical condition is later identified through screening not to be an actual emergency, except in the following cases: (i) Material misrepresentation, fraud, omission, or clerical error; (ii) Any payment reductions due to applicable co-payments, co-insurance, or deductibles which may be the responsibility of the insured; and (iii) Cases in which the insured does not meet the emergency medical condition definition, unless the insured has been referred to the emergency department by the insured's primary care physician or other agent acting on behalf of the insurer.	
La. R.S. 22:1821 F(1)	Health care services performed via transmitted electronic imaging or telemedicine shall not be denied if otherwise covered under the policy or contract. The payment, benefit, or reimbursement to a licensed physician at the originating facility or terminus shall not be less than seventy-five percent of the reasonable and customary amount of payment, benefit, or reimbursement which that licensed physician receives for an intermediate office visit.	
La. R.S. 47:337.11.1	All contracts executed by a health insurance issuer after January 1, 2009, which includes health insurance coverage for prescription drugs and pharmacist services shall clearly define the responsibility of the health insurance issuer or the health insurance issuer's member or insured for the payment of local taxes on the sale of prescription drugs and pharmacist services.	
La. R.S. 22:242 (3) - HMO	"Basic health care services" means emergency care, inpatient hospital and physician care, outpatient medical and chiropractic services, and laboratory and xray services. The term shall include optional coverage for mental health services for alcohol or drug abuse. With respect to chiropractic services, such services shall be provided on a referral basis at the request of the enrollee who presents a condition of an orthopedic or neurological nature necessitating referral, the treatment for which falls within the scope of a licensed chiropractor.	
La. R.S. 22:242 (6) - HMO	"Health care services" means any services rendered by providers which include but are not limited to medical and surgical care; psychological, optometric, optic, chiropractic, podiatric, nursing, and pharmaceutical services; health education, rehabilitative, and home health services; physical therapy; inpatient and outpatient hospital services; dietary and nutritional services; laboratory and ambulance services; and any other services for the purpose of preventing, alleviating, curing, or healing human illness, injury, or physical disability. Health care services shall also mean dental care, limited to oral and maxillofacial surgery as performed by board qualified oral and maxillofacial surgeons. The term shall also include an annual Pap test for cervical cancer and minimum mammography examination as defined in LA. R.S. 22:1028.	
Mandated Benefits / Provisions		**Form - Section / Page #**
La. R.S. 22: 1049	To provide coverage of prosthetic devices and prosthetic services.	

La. R.S. 22:1026	Policies shall include coverage for the treatment and correction of cleft lip and cleft palate. Such coverage shall also include benefits for secondary conditions and treatment attributable to that primary medical condition.	
La. R.S. 22:1027 La. R.S. 22:245 - HMO	Policies shall contain a provision or endorsement requiring payment for expenses incurred by the insured for services performed by a qualified interpreter/transliterator when such services are used by the insured in connection with medical treatment or diagnostic consultations performed by a physician, dentist, chiropractor, or podiatrist.	
La. R.S. 22:1028 A La. R.S. 22:242 - HMO	Any health coverage plan which is delivered or issued for delivery in this state shall include benefits payable for an annual Pap test and minimum mammography examination.	
La. R.S. 22:1028 B	Any health coverage plan which is delivered or issued for delivery in the state shall provide coverage for detection of prostate cancer, including digital rectal examination and prostate-specific antigen testing for men over the age of fifty years and as medically necessary and appropriate for men over the age of forty years. "Routine prostate preventative care" as used in this Subsection, shall mean a minimum of one routine annual visit, provided that a second visit shall be permitted based upon medical need and follow-up treatment within sixty days after either visit if related to a condition diagnosed or treated during the visits.	
La. R.S. 22:1029	Requirement for coverage of colorectal cancer screening	
La. R.S. 22:1030	Policies shall include benefits payable for immunizations for dependent children from birth to age six, under the same circumstances and conditions as benefits are paid for all other diagnoses, treatments, illnesses, or accidents and shall not be subject to any plan deductible.	
La. R.S. 22:1031	Policies shall include benefits payable for diagnosis and treatment of attention deficit/hyperactivity disorder, payable under the same circumstances and conditions as benefits are paid for all other diagnoses, illnesses, or accidents. The diagnosis and treatment for attention deficit/hyperactivity disorder shall be covered when rendered or prescribed by a physician or other appropriate health care provider licensed in this state and received in any physician's or other appropriate health care provider's office, any licensed hospital, or in any other licensed public or private facility, or portion thereof, including but not limited to clinics and mobil screening units. However, benefits for attention deficit/hyperactivity disorder provided for an initial diagnosis shall not exceed six hundred dollars. Services rendered on an out-patient basis shall not exceed fifty dollars per visit with a physician or other appropriate health care provider and total benefits shall be limited to ten thousand dollars during a person's lifetime, and shall not exceed twenty-five hundred dollars in any given year. The limitation on benefits payable for attention deficit/hyperactivity disorder shall be minimum levels of coverage and nothing in this Section shall prohibit insurers from offering benefits in excess of the coverage provided for in this Subsection.	
La. R.S. 22:1032	Policies shall include coverage for a qualified individual for scientifically proven bone mass measurement for the diagnosis and treatment of osteoporosis.	

La. R.S. 22:1034 A	Policies shall provide coverage for the equipment, supplies, and outpatient self-management training and education, including medical nutrition therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin using diabetes if prescribed by a physician or, if applicable, the patient's primary care physician.	
La. R.S. 22:1034 B	Coverage must be provided, not to exceed five hundred dollars, for a one time evaluation and training program per policy for diabetes self-management when medically necessary as determined by a physician. Additional diabetes self-management training shall be provided if a physician prescribes such additional training based upon its medical necessity because of a significant change in the insured's symptoms or conditions. This additional coverage shall be limited to one hundred dollars per year and a lifetime limit of two thousand dollars per insured.	
La. R.S. 22:1035 La. R.S. 22:246 - HMO	Policies shall provide coverage up to two hundred dollars per month, subject to applicable deductibles, coinsurance, and copayments, for low protein food products for treatment of inherited metabolic diseases, if the low protein food products are medically necessary and, if applicable, are obtained from a source approved by the health insurance issuer, provided coverage will not be denied if the health insurance issuer does not approve a source.	
La. R.S. 22:1038	Hearing aid coverage for minor child. Notwithstanding the provisions of R.S. 22:1047 to the contrary, an entity subject to this Section shall provide coverage for hearing aids for a child under the age of eighteen who is covered under a policy or contract of insurance if the hearing aids are fitted and dispensed by a licensed audiologist or licensed hearing aid specialist following medical clearance by a physician licensed to practice medicine and an audiological evaluation medically appropriate to the age of the child. An entity subject to this Section may limit the benefit payable under Paragraph (1) of this Subsection to one thousand and four hundred dollars per hearing aid for each hearing-impaired ear every thirty-six months. An insured or enrolled individual may choose a hearing aid that is priced higher than the benefit payable under this Subsection and may pay the difference between the price of the hearing aid and the benefit payable under this Subsection without financial or contractual penalty to the provider of the hearing aid. In the case of a health insurer or health maintenance organization that administers benefits according to contracts with health care providers, hearing aids covered pursuant to this Section shall be obtained from health care providers contracted with the health insurer or health maintenance organization. Such providers shall be subject to the same contracting and credentialing requirements that apply to other contracted health care providers.	
La. R.S. 22:1042	Each policy shall include as an option to be exercised by the policyholder, covered benefits for speech and language pathology therapy, physical therapy, rehabilitative services, and occupational therapy. As an alternative to offering optional coverage, including these benefits as standard benefits in such policies and programs shall be sufficient to comply with the law.	

La. R.S. 22:1044	Each policy or plan shall provide coverage for patient costs incurred as a result of a treatment being provided in accordance with a clinical trial for cancer except any applicable copayment, deductible, or coinsurance amounts. Such costs shall include coverage for costs incurred for health-related services not otherwise required under LRS- 22:999.	
La. R.S. 22:1077 A La. R.S. 22:272 E - HMO	A health insurance insurer that provides medical and surgical benefits with respect to a mastectomy shall provide coverage for reconstruction of the breast on which the mastectomy has been performed, coverage for surgery and reconstruction of the other breast to produce a symmetrical appearance, and coverage for prostheses and physical complications, all states of mastectomy, including lymphedemas. Written notice of the availability of coverage shall be delivered to the participant upon enrollment and annually thereafter as approved by the commissioner of insurance.	
La. R.S. 22:999.1	Parity for orally administered anti-cancer medications with intravenously administered or injected anti-cancer medications.	

Limitations / Exclusions		**Form - Section / Page #**
La. R.S. 22:1036	Policies shall not exclude coverage for diagnosis and treatment of a correctable medical condition otherwise covered by the policy, contract, or plan solely because the condition results in infertility.	
La. R.S. 22:1154 B	No health insurance policy or employee benefit plan shall: (a) Prevent any person from selecting the dentist of his choice to furnish the dental care services offered by the policy or plan, or interfere with such selection; (b) Deny any dentist the right to participate as a contracting provider for such policy or plan; (c) Authorize any person to regulate, interfere, or intervene in any manner in the diagnosis or treatment rendered by a dentist to his patient; or (d) Require that any dentist make or obtain dental x-rays or any other diagnostic aids.	
La. R.S. 22:973 (5)	Exceptions and Reductions of indemnity (Exclusions / Limitations) are clearly set forth in the policy, either with the applicable benefit or under an appropriate caption.	
La. R.S. 22:999	Every policy or plan which covers the treatment of cancer shall not exclude coverage for any drug prescribed for the treatment of cancer on the ground that the drug is not approved by the United States Food and Drug Administration for a particular indication if that drug is recognized for treatment of the covered indication in a standard reference compendia or in substantially accepted peer-reviewed medical literature. Coverage for a drug required by this Section shall also include all medically necessary services which are associated with the administration of the drug.	

Discrimination Prohibitions		Form - Section / Page #
LDI Dir 203:Dir 203 La. R.S. 22:995 La. R.S. 22:247	PAYMENT AND REIMBURSEMENT FOR HEALTH CARE SERVICES RENDERED BY A LICENSED CHIROPRACTOR AND THE CO-PAYMENT, COINSURANCE, DEDUCTIBLE OR BENEFIT LIMITATION IMPOSED ON AN ENROLLEE OR INSURED FOR HEALTH CARE SERVICES RENDERED BY A LICENSED CHIROPRACTOR.	
LDI Dir 73:Dir 73 La. R.S. 22:995 La. R.S. 22:247	Notice of insurers, medical service plan corporations, hospital service corporations, and medical service corporations - "Chiropractors".	
LDI Reg 63:Reg 63	Prohibitions on the Use of Medical Information and Genetic Test Results.	
La. R.S. 22:1037	On or after January 1, 2004, health insurance coverage shall not deny coverage of perioperative services rendered by a registered nurse first assistant if the insurer covers the same such first assistant perioperative services when they are rendered by an advanced practice nurse, a physician assistant, or a physician other than the operating surgeon.	
La. R.S. 22:1231	Organ transplant centers - No health insurance issuer authorized to transact business in this state shall refuse to consider an application to provide solid organ transplantation in any preferred or exclusive provider network by any transplant center located in the state provided certain conditions are met.	
La. R.S. 22:1232	Hematopoietic transplant centers - No health insurance issuer authorized to transact business in this state shall refuse to consider an application to provide hematopoietic cell transplantation in any preferred or exclusive provider network by any transplant center located in the state provided certain conditions are met.	
La. R.S. 22:995 La. R.S. 22:247	Policies or contracts providing payment or reimbursement for services that may be legally performed by a chiropractor licensed in this state, such payment or reimbursement shall not be denied when such service is rendered by a person so licensed. Terminology in such policy or contract deemed discriminatory against any such person or method of practice shall be void.	
La. R.S. 22:996	Any contract of insurance providing for reimbursement of services which are within the lawful scope of practice of a duly licensed podiatrist as defined in R.S. 37:611, shall not deny coverage when such service is rendered by a person so licensed.	
Discrimination Prohibitions		**Form - Section / Page #**
La. R.S. 22:997	Any contract of insurance providing for reimbursement of any visual services which are within the lawful scope of practice of a duly licensed optometrist as defined in R.S. 37:1041, shall not discriminate in the amount of reimbursement allowed for such visual services, whether performed by an optometrist or physician, in instances where the services performed are within the lawful scope of practice of both professions.	
La. R.S. 22:998	Any policy providing for the reimbursement of health related services that can lawfully be performed by a duly licensed psychologist as regulated under the provisions of R.S. 37:2351-2368, shall cover such services performed by a duly licensed psychologist.	

Coordination of Benefit Provisions		Form - Section / Page #
La. R.S. 22:1072 F	Individual health insurance coverage shall be subject to coordination of benefits with other health insurance coverage and treated as secondary to any group health insurance coverage in effect. In no instance shall a health insurance issuer be required to pay any amount in excess of the benefit amount that would have been paid under a policy or subscriber agreement if no other group health insurance coverage was in effect.	
La. R.S. 22:1836	Coordination of benefits.	
Subrogation / Right of Recovery		**Form - Section / Page #**
LDI Dir 175:Dir 175	Subrogation Provisions - The Commissioner will consider for approval language that clearly conveys to the insured that any right of recovery from third parties on the part of the insurer, whether by subrogation or reimbursement, is subordinate to the insured's right to be fully compensated for his damages; and that the insurer is obligated to share in the legal expenses incurred. The Commissioner will not approve policy language that excludes and/or reduces coverage for expenses incurred as a result of the treatment of injury or sickness caused by the fault of a third party.	
La. R.S. 22:882	Under any policy of insurance which authorizes the insured to waive the right of recovery of the insured against any party prior to loss without additional premium, the insured shall also be entitled to waive in writing after loss without invalidating the policy the right of recovery against any of the following: (1) Anyone insured under the same policy; (2) A corporation, partnership or other entity in which the insured owns stock or has a proprietary interest; (3) Anyone who owns stock or has a proprietary interest in the insured; (4) An employee or employer of the insured; (5) Anyone having an interest as owner, lessor or lessee of the insured premises or the premises on which the loss occurred and the employees, partners and stockholders of such owner, lessor or lessee; and (6) Any relative by blood or marriage of the insured. The insurer shall be entitled to recover from the insured any compensation received by the insured for such waiver after loss not to exceed the amount paid to the insured for such loss by the insurer.	
Cancellation / Termination Provisions		**Form - Section / Page #**
La. R.S. 22:1074 B(2)	A health insurance issuer may cancel the health insurance coverage of an individual in the individual market if individual has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact. Such health insurance coverage may not be cancelled except with 30-day prior notice to the enrollee or insured, and only as permitted by federal law or regulation pursuant to 42 U.S.C.A. Section 300gg-12, (Public Health Services Act); See also 45 CFR 147.128.	

La. R.S. 22:1074 C(1)	In any case in which an issuer decides to discontinue offering a particular type of health insurance coverage offered in the individual market, coverage of such type may be discontinued by the issuer only if: (a) The issuer provides at least ninety days notice of discontinuation to each covered individual; (b)The issuer extends the option to purchase any other individual health insurance coverage currently being offered; (c) The issuer acts uniformly without regard to any health status related factor of enrolled individuals or individuals who may become eligible for such coverage; and (d) The issuer files the notice and the insurance product being discontinued with the commissioner of insurance.	
La. R.S. 22:1074 C(2)(a)	A health insurance issuer may elect to discontinue offering all health insurance coverage in the individual market only if: (i) The issuer provides notice to the applicable state authority and to each individual of such discontinuation at least one hundred eighty days prior to the date of the expiration of such coverage; (ii) All health insurance issued or delivered for issuance in the state in such market are discontinued and coverage under such health insurance coverage in such market is not renewed; and (iii) Prior to providing the required notice, the issuer files such notice and the insurance product being discontinued with the commissioner of insurance.	
La. R.S. 22:1074 C(3)	No health insurance issuer shall not renew any policy or contract of coverage in the individual market prior to the end of the last period of coverage as stated in such policy or contract.	
La. R.S. 22:978 La. R.S. 22:272 A - HMO	The insurer shall notify the policyholder in writing at least sixty days before any cancellation or nonrenewal.	
La. R.S. 22:975 B(7)	OPTIONAL PROVISION for "Cancellation" by the insurer by written notice and with refund of the pro rata unearned portion of any premium paid. Such cancellation shall be without prejudice to any claim incurred prior to cancellation. The insured may likewise cancel this policy on the above terms. Upon cancellation by the insurer, the insurer shall only be liable for any claim for expenses incurred subsequent to the cancellation date if the subsequent claim is for an illness or condition which was the basis of any claim prior to cancellation and for which the insurer had notice and if the policy of insurance is cancelled for reasons other than failure of the policyholder to pay premiums or failure of the insured to maintain eligibility as provided in the policy.	
Renewal Provisions		**Form - Section / Page #**
La. R.S. 22:1074 A	A health insurance issuer that provides individual health insurance coverage to an individual shall renew or continue in force such coverage at the option of the individual.	

La. R.S. 22:1074 B	A health insurance issuer may non-renew or discontinue health insurance coverage of an individual in the individual market based only on one or more of the following: (1) The individual has failed to pay premiums in accordance with the terms of the health insurance coverage or the issuer has not received timely premium payments; (2) The individual has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact. Such health insurance coverage may not be cancelled except with 30-day prior notice to the enrollee or insured, and only as permitted by federal law or regulation pursuant to 42 U.S.C.A. Section 300gg-12, (Public Health Services Act); (3) The issuer is ceasing to offer coverage in the individual market in accordance with La. R.S. 22:1074 C; (4) In the case of health insurance coverage through a network plan, the individual no longer resides, lives, or works in the service area, but only if such coverage is terminated uniformly without regard to any health status related factor of covered individuals; and (5) In the case of health insurance coverage available in the individual market only through one or more bona fide associations, the membership of the individual in the association, on the basis of which the coverage is provided, ceases but only if such coverage is terminated under this Paragraph uniformly without regard to any health status-related factor of covered individuals. See also 45 CFR 147.128(a)(1).	
La. R.S. 22:1074 D	A health insurance issuer may modify the health insurance coverage for a policy form offered to individuals in the individual market if each of the following conditions is met: (1) The modification occurs at the time of coverage renewal; (2) The modification is approved by the commissioner, is consistent with state law, and is effective on a uniform basis among all the individuals with that policy form. However, for purposes of this Section, modifications affecting drug coverage shall not require approval by the commissioner; (3) The issuer notifies, on a form approved by the Department of Insurance, each affected individual of the modification, including modification of coverage of a particular product or modification of drug coverage, not later than the sixtieth day before the date the modification is effective.	
La. R.S. 22:887 F	No insurer shall cancel or refuse to renew any policy of family group health and accident insurance except for nonpayment of premium or failure to meet the requirements for being a family group insurance policy until sixty days after the insurer has mailed written notice of such cancellation or nonrenewal by certified mail to the policyholder. The notice shall also include the reason the policy is being cancelled.	
La. R.S. 22:973 (8)	Policies subject to cancellation or renewal at the option of the insurer must include a statement prominently printed on face page so informing the policyholder.	

Reinstatement Provisions		**Form - Section / Page #**
La. R.S. 22:975 A(2)	REQUIRED PROVISION for reinstatement of a policy following default in payment of premium shall cover only loss resulting from accidental injury thereafter sustained or loss due to sickness beginning more than ten days after the date of such acceptance.	

Premium Rate Adjustment		Form - Section / Page #
La. R.S. 22:978 La. R.S. 22:272 A - HMO	The insurer shall notify the policyholder in writing at least forty-five days before any increase of twenty percent or more in the policy rates.	

Premium Payment / Grace Period Prov.		Form - Section / Page #
La. R.S. 22:977	Whenever an insurer does not receive a premium payment fifteen days prior to the end of the grace period, the insurer shall mail, by first class mail, a notice to the policyholder. The notice shall state that if the premium has not been paid by the end of the grace period, the policy will lapse as provided by the provisions of the policy. The notice shall also state that the policy will be reinstated with no penalties whatsoever to the insured if the full premium payment is received within the period allowed for reinstatement.	
La. R.S. 22:272 C (2) - HMO	Every health maintenance organization issuing a contract for health care services shall include in such contract a provision providing the subscriber or enrollee a grace period of thirty days from the date the prepaid charge was due. If the prepaid charge is paid during the grace period, then coverage shall remain in effect pursuant to the provisions of the contract.	
General / Standard Provisions		**Form - Section / Page #**
La. R.S. 22:973 (1)	Entire money and other consideration therefor must be expressed in the policy.	
La. R.S. 22:975 A(1)	REQUIRED PROVISION for what constitutes the "entire contract" of insurance. No change shall be valid until approved by an officer or endorsed on the policy.	
La. R.S. 22:975 A(10)	REQUIRED PROVISION for consent of beneficiary: Consent of the beneficiary shall not be requisite to surrender or assignment of this policy, nor to change of beneficiary, nor to any other changes in this policy.	
La. R.S. 22:975 A(11)	REQUIRED PROVISION for an insured's right to bring Legal Action: No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty days after proofs of loss have been filed in accordance with the requirements of this policy. No such action shall be brought after the expiration of one year after the time proofs of loss are required to be filed.	

La. R.S. 22:975 A(12)	REQUIRED PROVISION for Extension of time limitations: If any limitation of this policy with respect to giving notice of claim, furnishing proof of loss, or bringing any action on this policy is less than that permitted by law of the state, district or territory in which the insured resides at the time this policy is issued, such limitation is hereby extended to agree with the minimum period permitted by such law.	
La. R.S. 22:975 A(13)(a)	REQUIRED PROVISION for "Time Limit on Certain Defenses" / Incontestability is three years of the date of issue of the policy after which the policy becomes incontestable as to the statements contained in the application.	
General / Standard Provisions		**Form - Section / Page #**
La. R.S. 22:975 A(8)	REQUIRED PROVISION for the insurer's right and opportunity to require Physical Examinations: The insurer shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.	
La. R.S. 22:975 B(8)	OPTIONAL PROVISION for "Conformity with state statutes" stating that any provision of the policy which, on the date of issue, is in conflict with the statutes of the state in which the insured resides at the date of issue is understood to be amended to conform to such statutes.	
La. R.S. 22:975 B(10)	OPTIONAL PROVISION excluding coverage for any loss in consequence of the insured's involvement with "Intoxicants and narcotics", unless administered on the advice of a physician.	
La. R.S. 22:975 B(2)	OPTIONAL PROVISION for reduction in coverage or return of premiums paid due to a "Misstatement of age".	
La. R.S. 22:975 B(3)	OPTIONAL PROVISION for reduction in benefits payable due to "Other insurance in this insurer".	
La. R.S. 22:975 B(4)	OPTIONAL PROVISION for reduction in benefits payable due to the insured's failure to provide written notice of "Insurance with other insurers".	
La. R.S. 22:975 B(6)	OPTIONAL PROVISION for deduction of "Unpaid premium" from benefits payable.	
La. R.S. 22:975 B(9)	OPTIONAL PROVISION excluding coverage for any loss contributed by the insured's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an "Illegal occupation".	

Claim Filing Provisions		Form - Section / Page #
La. R.S. 22:1826 A	If a health care provider that does not contract with a health insurance issuer files a claim with a health insurance issuer for emergency services rendered, the health insurance issuer shall directly pay such a claim by a noncontracted provider as an amount for which the insured or enrollee is liable. Payment of such claim by the health insurance issuer shall in no circumstances be made directly to the patient, insured, or enrollee.	
La. R.S. 22:1832	Standards for payment of non-electronic claims submissions: A.(1) Any non-electronic claim by a health care provider under a contract with a health insurance issuer, for provision of health care services, submitted by the provider or its agent within forty-five days of the date of service, or date of discharge from a health care facility or institution, shall be paid, denied, or pended not more than forty-five days from the date upon which a non-electronic clean claim is received by the issuer or its agent, unless it is not payable under the terms of the applicable contract of health insurance coverage or unless just and reasonable grounds exist such as would put a reasonable and prudent businessman on his guard; (2) Any non-electronic claim by a health care provider under a contract with a health insurance issuer, for provision of health care services, submitted by the provider or its agent more than forty-five days after the date of service, or date of discharge from a health care facility or institution, or resubmitted because the original claim was not an accepted claim or not a clean claim shall be paid, denied, or pended not more than sixty days from the date upon which a non-electronic clean claim is received by the issuer or its agent, unless it is not payable under the terms of the applicable contract of insurance or unless just and reasonable grounds exist such as would put a reasonable and prudent businessman on his guard; (3) Any other non-electronic claim for health insurance coverage benefits submitted for payment by an enrollee or insured or by a non-contracted health care provider rendering covered health care services, or by the provider's agent, shall be paid, denied, or pended not more than forty-five days from the date upon which a non-electronic clean claim is received by the issuer or its agent, unless it is not payable under the terms of the applicable contract of insurance or unless just and reasonable grounds exist such as would put a reasonable and prudent businessman on his guard; (4) For purposes of this Subsection, the issuer shall either provide written notice to the provider that a claim is pended or allow the provider Internet access to such information; (5) Just and reasonable grounds, as used in this Subsection, shall include but not be limited to determination of whether the enrollee or insured was eligible for health insurance coverage on the date health care services were rendered.	
La. R.S. 22:1833	Standards for payment of electronic claims submissions: Any electronic claim shall be paid, denied, or pended not more than twenty-five days from the date upon which an electronic clean claim is electronically received by the health insurance issuer or its agent, unless it is not payable under the terms of the applicable contract of insurance or unless just and reasonable grounds exist such as would put a reasonable and prudent businessman on his guard.	

La. R.S. 22:1834 B	Thirty day payment standard: A health insurance issuer may elect to utilize a thirty-day payment standard for compliance with R.S. 22:1832 and 1833 by providing written notice to the commissioner. Such notice shall be in a form prescribed by the commissioner and shall remain in effect until withdrawn in writing as may be required by the commissioner. Any health insurance issuer electing to utilize a thirty-day payment standard shall continue to comply with all other requirements of this Subpart	
La. R.S. 22:1834 C	Limitations on claim filing and audits: A health insurance issuer that prescribes the period of time that a health care provider under contract for provision of health care services has to submit a claim for payment under R.S. 22:1832 or 1833 shall have the same prescribed period of time following payment of such claim to perform any review or audit for purposes of reconsidering the validity of such claim.	
La. R.S. 22:1838	Recoupment of health insurance claim payments.	
La. R.S. 22:975 A(14)	REQUIRED PROVISION for processing of claims in conformity with the "Uniform claim forms" issued by the Department of Insurance pursuant LA. R.S. 22:1824.	
La. R.S. 22:975 A(3)	REQUIRED PROVISION for providing Notice of Claim: Written notice of claim for injury or for sickness must be given to the insurer within twenty days after the date of the accident causing such injury or the commencement of the disability from such sickness, except that in case of industrial policies such notice of claim must be given to the insurer within ten days in such cases. In the event of accidental death, immediate notice thereof must be given to the insurer. Such notice given by or on behalf of the insured or the beneficiary to the insurer at (insert the location of such office as the insurer may designate for that purpose), or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer. Failure to give such notice within such time shall not invalidate nor reduce any claim if it was not reasonably possible to give such notice within the time required, provided written notice of claim is given as soon as reasonably possible. (In this paragraph the requirement relating to immediate notice of claim in event of accidental death may be omitted at the option of the insurer.)	
La. R.S. 22:975 A(4)	REQUIRED PROVISION for the insurer to provide Claim Forms: The insurer, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within fifteen days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, affirmative written proof covering the occurrence, the character and the extent of the loss for which claim is made.	

La. R.S. 22:975 A(5)	REQUIRED PROVISION for a claimant to submit written Proofs of Loss: Affirmative written proof of loss must be furnished to the insurer at its said office in case of claim for loss of time from disability within ninety days after the termination of the period for which the insurer is liable and in case of claim for any other loss within ninety days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event later than one year from the time proof is otherwise required. Any such policy may also provide, at the insurer's option that written notice or proof of continuance of disability must be furnished not less frequently than each ninety days during the continuance of disability.	
La. R.S. 22:975 A(6)	REQUIRED PROVISION for Time of payment of claims: Indemnity claims payable under this policy for any loss other than loss of time on account of disability will be paid immediately upon receipt of written proof of such loss. Subject to written proof of loss, accrued indemnity claims for loss of time on account of disability will be paid (insert period of payment which must not be less frequently than monthly) and any balance remaining unpaid upon the termination of liability will be paid immediately.	
La. R.S. 22:975 A(7)	REQUIRED PROVISION for payment of claims: Indemnity for loss of life and any other accrued indemnity claims unpaid at the insured's death will be paid to the beneficiary, if surviving the insured, and otherwise to the estate of the insured. All other indemnity claims will be paid to the insured. The policy may, at the insurer's option, provide that if there is no beneficiary, or the beneficiary is the estate of the insured, or the insured or beneficiary is a minor or not competent to give a valid release, the insurer may pay any amount not exceeding one thousand dollars, otherwise payable to the insured or his estate to any relative by blood or connection by marriage of the insured appearing to the insurer to which they may be equitably entitled, and may make payment of any amount not exceeding one thousand dollars, otherwise payable to the beneficiary to any relative by blood or connection by marriage of such beneficiary appearing to the insurer to which they may be equitably entitled. The policy may, at the insurer's option, also provide that all or a portion of any indemnities provided by any such policy on account of hospital, nursing, medical, or surgical services may be paid directly to the hospital or person rendering such services; however, the policy may not require that the services be rendered by a particular hospital or person.	

Application / Enrollment Form		**Form - Section / Page #**
La. R.S. 22:1023 B(2)	No insurer shall require an applicant for coverage or an individual or family member who is presently covered under a policy or plan, to be the subject of a genetic test or to be subjected to questions relating to genetic information.	

La. R.S. 22:1023 B(3)	All insurers shall, in the application or enrollment information provided by the insurer concerning a policy or plan, provide an applicant or enrollee with a written statement disclosing the rights of the applicant or enrollee under this Section. Such statement shall be in a form and manner that is noticeable to and understandable by an average applicant or enrollee.	
La. R.S. 22:856	Written application for individual life, health and accident insurance and legal capacity to contract is required.	
La. R.S. 22:271 A - HMO	Every application for enrollment in a health maintenance organization shall contain the following statement conspicuously displayed on the front of such application in at least ten point bold-face capital letters: "NOTICE - YOU MUST PERSONALLY BEAR ALL COSTS IF YOU UTILIZE HEALTH CARE NOT AUTHORIZED BY THIS PLAN OR PURCHASE DRUGS WHICH ARE NOT AUTHORIZED BY THIS PLAN."	
La. R.S. 22:871	Every duly licensed insurance agent who solicits information to be contained on any application for individual life or individual family group health and accident insurance shall affix his legal signature thereto. No such agent shall sign any application described above unless he personally obtained the information shown on such application. Such information may be obtained by the agent in person, by telephone, or by any other means of direct communication between the agent and the applicant.	
La. R.S. 40:1424(B)	Required Fraud Statement. "Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison."	
Identification Cards		**Form - Section / Page #**
La. R.S. 22:1873 B (1)	Health Care Consumer Billing and Disclosure Protection Act - Identification Card notice requirements, "NOTICE: YOUR SHARE OF THE PAYMENT FOR HEALTH CARE SERVICES MAY BE BASED ON THE AGREEMENT BETWEEN YOUR HEALTH PLAN AND YOUR PROVIDER. UNDER CERTAIN CIRCUMSTANCES, THIS AGREEMENT MAY ALLOW YOUR PROVIDER TO BILL YOU FOR AMOUNTS UP TO THE PROVIDER'S REGULAR BILLED CHARGES."	

Disclosure / Notice Requirements		**Form - Section / Page #**
La. R.S. 22:1023 C(2)	Requirements to assure valid authorization for disclosure of genetic information.	
La. R.S. 22:1023 C(4)	An individual may revoke or amend the authorization, in whole or in part, at any time.	

La. R.S. 22:1873 B (2)	Health Care Consumer Billing and Disclosure Protection Act - Policy and Certificate of insurance notice requirements. , "NOTICE: YOUR SHARE OF THE PAYMENT FOR HEALTH CARE SERVICES MAY BE BASED ON THE AGREEMENT BETWEEN YOUR HEALTH PLAN AND YOUR PROVIDER. UNDER CERTAIN CIRCUMSTANCES, THIS AGREEMENT MAY ALLOW YOUR PROVIDER TO BILL YOU FOR AMOUNTS UP TO THE PROVIDER'S REGULAR BILLED CHARGES."	
La. R.S. 22:1880	Balance billing disclosure health insurance issuer requirements. . "NOTICE: HEALTH CARE SERVICES MAY BE PROVIDED TO YOU AT A NETWORK HEALTH CARE FACILITY BY FACILITY-BASED PHYSICIANS WHO ARE NOT IN YOUR HEALTH PLAN. YOU MAY BE RESPONSIBLE FOR PAYMENT OF ALL OR PART OF THE FEES FOR THOSE OUT-OF-NETWORK SERVICES, IN ADDITION TO APPLICABLE AMOUNTS DUE FOR CO-PAYMENTS, COINSURANCE, DEDUCTIBLES, AND NON-COVERED SERVICES. SPECIFIC INFORMATION ABOUT IN-NETWORK AND OUT-OF-NETWORK FACILITY-BASED PHYSICIANS CAN BE FOUND AT THE WEBSITE ADDRESS OF YOUR HEALTH PLAN OR BY CALLING THE CUSTOMER SERVICE TELEPHONE NUMBER OF YOUR HEALTH PLAN."	
La. R.S. 22:2098 B	No insurer may deliver a policy or contact described in §2083 B(1) unless the LLHIGA Summary Document, as prescribed by Reg 40, is delivered to the policy or contract holder prior to or at the time of delivery, except if §2098 D applies.	
La. R.S. 22:260 C - HMO	Every health maintenance organization shall make available in writing to its potential enrollees a reasonable explanation of the services to be provided or arranged for. This explanation shall also identify those services excluded from coverage and shall set forth the methods of access to all forms of treatment or class of providers included in the plan.	
La. R.S. 22:267 - HMO	Every health maintenance organization shall inform its subscribers and enrollees upon enrollment in the health maintenance organization and annually thereafter of the procedure for processing and resolving grievances. Such information shall include the location and telephone number where grievances may be submitted.	
La. R.S. 22:271 C - HMO	Every subscriber and enrollee shall at the time of enrollment and annually thereafter be provided with a written notice which fully explains copayment and deduction amounts applicable to each covered service. Any separate deductible amounts shall be fully disclosed. The written notice shall be printed in ten-point or larger type and shall outline any limitations on the choice of primary care physicians, access to specialists, and application of preexisting medical condition exclusions from coverage.	

La. R.S. 22:271 D - HMO	Every subscriber, enrollee, and participating provider shall be provided with an annual plan notification statement which provides: (1) A listing of compensation mechanisms utilized to pay providers including incentive arrangements; (2) A description of the services or treatments which will be covered under the plan; (3) A statement regarding the coverage of experimental treatments; and (4) A statement regarding the coverage of prescription drugs. Such statement shall include the procedure used for adding or deleting coverage of specific prescribed drugs.	
La. R.S. 22:272 C (3) - HMO	Whenever a health maintenance organization does not receive a prepaid charge payment fifteen days prior to the end of the grace period, the health maintenance organization shall mail, by first class mail, a notice to the subscriber or enrollee. The notice shall state that if the prepaid charge has not been paid by the end of the grace period, the contract will lapse as provided by the provisions of the contract. The notice shall also state that the contract will be reinstated with no penalties whatsoever to the subscriber or enrollee if the full payment is received within the period allowed for reinstatement.	

Advertising		**Form - Section / Page #**
LDI Rule 3:Rule 3	Advertisements of Accident and Sickness Insurance	

Marketing Requirements		**Form - Section / Page #**
La. R.S. 22:1964 (10)(b)	Unfair Trade Practice: Tying the purchase of a health and life insurance policy or policies to another insurance product. "Tying" is the requirement by any small employer or individual health insurance carrier, as a condition to the offer or sale of a health benefit plan, health maintenance organization, or prepaid limited health care service plan to a small employer or to an individual, that such employer or individual purchase any other insurance product.	

Administration		**Form - Section / Page #**
La. R.S. 22:249 (8) - HMO	A health maintenance organization has the power to issue point of service policies that have been approved by the commissioner to groups and individuals. The indemnity exposure of such policies shall conform to the same solvency requirements for claim reserves that are required of accident and health insurance companies licensed to operate in this state.	

2014 Legislation		Form - Section / Page #
La. R.S. 22:1260.31 - .38 as enacted by 2014 La. Acts No. 174 has been signed by the Governor and is effective August 1, 2014.		
La. R.S. 22:1260.33.A	When a physician or other healthcare provider or his representative requests information regarding an enrollee from a qualified health plan issuer about eligibility, coverage, or health plan benefits, or the status of a claim or claims for services provided, and the request or service is for a date within the second or third month of a grace period, the qualified health plan issuer shall clearly identify that the applicable enrollee is in the grace period and provide additional information as required by this Subpart. Unless the qualified health plan issuer makes the notice available on its website or by other electronic means, the qualified health plan issuer shall provide the notice through the same medium through which the physician or other healthcare provider or his representative sought the information from the qualified health plan issuer pursuant to Paragraph (1) of this Subsection. The information provided about the enrollee's grace period status shall be binding on the qualified health plan pursuant to this Subpart.	
La. R.S. 22:1260.33.B	If the qualified health plan issuer informs the physician or other healthcare provider or his representative that the enrollee is eligible for services but not that the enrollee is in the grace period, the determination shall be binding on the qualified health plan issuer and it shall pay the claims for covered services in accordance with the qualified health plan. The binding determination shall preclude the qualified health plan issuer from seeking to recoup payment from the physician or other healthcare provider for services rendered during the grace period. If the qualified health plan issuer informs the physician or other healthcare provider that the enrollee is in a grace period, he shall then provide further notification pursuant to Subsection C of this Section.	
La. R.S. 22:1260.33.D	In a conspicuous location on a qualified health plan website, the qualified health plan issuer shall provide the following information: Whether the qualified health plan issuer will hold any claims of the physician or other healthcare provider for services that the physician or other healthcare provider furnishes to the enrollee during the grace period. A statement indicating that should the qualified health plan issuer indicate that it will pay some or all of the claims for services provided to an enrollee during the grace period, whether and how it will seek to recoup claims payments made to physicians or healthcare providers for services furnished during the grace period.	

2014 Legislation		Form - Section / Page #
These laws have not yet been signed by the Governor or otherwise become law after the requisite passage of time without the signature of the Governor. Therefore, you should monitor their progress and enactment by review using http://www.legis.la.gov/ and consultation with your counsel.		
La. R.S. 22:1054 as enacted by HB 1254 shall become effective upon signature of the Governor or on August 1, 2014, whether signed by the Governor before that date or upon expiration of the time for bills to become law without the signature of the Governor. If vetoed by the Governor and subsequently approved by the legislature, this provision shall become effective on the day following such approval.	Notwithstanding any other provision of the law to the contrary and particularly the provisions of R.S. 22:1047, no health care coverage plan shall deny coverage for medically necessary treatment prescribed by a physician and agreed to by a fully informed insured or, if the insured lacks legal capacity to consent, by a person who has legal authority to consent on the insured's behalf, based solely on an insured's life expectancy or the fact that the insured is diagnosed with a terminal condition.	
La. R.S. 22:1025.1.A as enacted by SB 57 shall become effective upon signature of the Governor or on August 1, 2014, whether signed by the Governor before that date or upon expiration of the time for bills to become law without the signature of the Governor. If vetoed by the Governor and subsequently approved by the legislature, this provision shall become effective on the day following such approval.	Any health insurance policy issued or issued for delivery in this state shall include as an option to be exercised by the policyholder, as defined therein, covered benefits for the treatment of lymphedema, rendered or prescribed by a physician licensed in this state or received in any licensed hospital or in any other public or private facility authorized to provide lymphedema treatment, including multilayer compression bandaging systems and customor standard fit gradient compression garments.	
La. R.S. 22:1025.1.B as enacted by SB 57 shall become effective upon signature of the Governor or on August 1, 2014, whether signed by the Governor before that date or upon expiration of the time for bills to become law without the signature of the Governor. If vetoed by the Governor and subsequently approved by the legislature, this provision shall become effective on the day following such approval.	Any insurer who, on August 1, 2014, has health insurance policies in force in this state shall convert such existing policies to conform to the provisions of this Section on or before the renewal dates.	

La. R.S. 22: 1060.5.A., as enacted by SB 165 shall become effective upon signature by the Governor on January 1, 2015, whether signed by the Governor before that date or upon expiration of the time for bills to become law without the signature of the Governor. If vetoed by the Governor and subsequently approved by the legislature, this provision shall become effective on the day following such approval.	A health insurance issuer of a health benefit plan that covers prescription drugs, as defined in R.S. 22:1060.1(8), and utilizes a formulary tier that is higher than a preferred or non-preferred brand drug tier, sometimes known as a specialty drug tier, shall limit any required co-payment or coinsurance applicable to drugs on such tier to an amount not to exceed one hundred and fifty dollars per month for each drug up to a thirty-day supply of any single drug. This limit shall be inclusive of any co-payment or coinsurance. This limit shall be applicable after any deductible is reached and until the individual's maximum out-of-pocket limit has been reached.	
La. R.S. 22: 1060.5.B., as enacted by SB 165 shall become effective upon signature by the Governor on January 1, 2015, whether signed by the Governor before that date or upon expiration of the time for bills to become law without the signature of the Governor. If vetoed by the Governor and subsequently approved by the legislature, this provision shall become effective on the day following such approval.	A health care issuer of a health benefit plan that covers prescription drugs, as defined in R.S. 22:1060.1(8), and utilizes specialty tiers shall be required to implement an exceptions process that allows enrollees to request an exception to the formulary. Under such an exception, a non-formulary specialty drug could be deemed covered under the formulary if the prescribing physician determines that the formulary drug for treatment of the same condition either would not be as effective for the individual, would have adverse effects for the individual, or both. In the event an enrollee is denied an exception, such denial shall be considered an adverse event and shall be subject to the health plan internal review process and the state external review process.	
La. R.S. 44:1.1(B)(11) as amended and La. R.S. 22:972(D) as enacted by SB 244 shall become effective upon signature of the Governor or on August 1, 2014, whether signed by the Governor before that date or upon expiration of the time for bills to become law without the signature of the Governor. If vetoed by the Governor and subsequently approved by the legislature, this provision shall become effective on the day following such approval.	Policy forms and premium rates for major medical health and accident and dental policies, including but not limited to policies subject to the requirements of Title I of Public Law 111-148, shall be exempt from disclosure under R.S. 44:1 et seq., the Public Records Law, until the commencement of the open enrollment period of the policy year during which the forms and rates are to be utilized. A health insurance issuer, including a health maintenance organization, shall mark such filings as confidential or proprietary in order to utilize the exemption authorized in this Subsection. The exemption authorized in this Subsection shall not prevent the commissioner from publishing a summary or description of rate filings in the operation of an effective rate review program pursuant to Section 2794 of the Public Health Service Act.	

La. R.S. 22:1080 as enacted by SB 403 shall become effective upon signature of the Governor or on August 1, 2014, whether signed by the Governor before that date or upon expiration of the time for bills to become law without the signature of the Governor. If vetoed by the Governor and subsequently approved by the legislature, this provision shall become effective on the day following such approval.	No health insurance issuer or health maintenance organization shall refuse the receipt of a premium payment when such payment is made by a third party to the insurance contract, provided that the payment is made from or pursuant to a fund or grant established by any one of the following: The RyanWhite HIV/AIDS Program pursuant to Title XXVI of the Public Health Service Act. Indian tribes, tribal organizations, or urban Indian organizations. State or federal government programs. The American Kidney Fund.	
La. R.S. 22:972.A. as amended by SB 554 shall become effective upon signature of the Governor or on August 1, 2014, whether signed by the Governor before that date or upon expiration of the time for bills to become law without the signature of the Governor. If vetoed by the Governor and subsequently approved by the legislature, this provision shall become effective on the day following such approval.	No policy or subscriber agreement of a health insurance issuer, hereafter including a health maintenance organization, shall be delivered or issued for delivery in this state, nor shall any endorsement, rider, or application which becomes a part of any such policy, which may include a certificate, be used in connection therewith until a copy of the form and of the rates and of the classifications of risks pertaining thereto have been filed with the department. No policy, subscriber agreement, endorsement, rider, or application, hereinafter referred to as a policy or subscriber agreement, shall be used until the expiration of sixty days 25 after the form has been filed unless the department gives its written approval prior thereto. Written notification shall be provided to the health insurance issuer specifying the reasons a policy form or subscriber agreement does not comply with the provisions of this Subpart. It shall be unlawful for any health insurance issuer to issue any form in this state not previously submitted to and approved by the department. An aggrieved party affected by the department's decision, act, or order in reference to a policy form or subscriber agreement may demand a hearing in accordance with Chapter 12 of this Title, R.S. 22:2191 et seq.	
La. R.S. 22:972.B. as amended by SB 554 shall become effective upon signature of the Governor or on August 1, 2014, whether signed by the Governor before that date or upon expiration of the time for bills to become law without the signature of the Governor. If vetoed by the Governor and subsequently approved by the legislature, this provision shall become effective on the day following such approval.	After providing twenty days' notice, to the health insurance issuer, the department may withdraw its approval of any such policy form or subscriber agreement on any of the grounds stated in R.S. 22:862. It shall be unlawful for the health insurance issuer to issue such policy form or subscriber agreement or use it in connection with any policy or subscriber agreement after the effective date of such withdrawal of approval. An aggrieved party affected by the department's decision, act, or order in reference to a policy form or subscriber agreement may demand a hearing in 19 accordance with Chapter 12 of this Title, R.S. 22:2191 et seq.	

PART 2
EHB STATEMENT OF COMPLIANCE

Requirement (Description)	Legal Reference	Location of Evidence of Compliance by Reference to Form No., Page No., & Section If N/A selected, provide an explanation to support the inapplicability of the requirement
Product is designed to allow for issuance of plans that meet the requisite Actuarial Values (AV) or Metal Levels.	ACA §1302 ACA §1302(d)(3) 45 CFR §156.135 45 CFR §156.140	
Elimination of Pre-Existing Condition Exclusions	PHSA §2704 PHSA §1255 ACA §1201 & 10103(e) 45 CFR §147.108	
No rescissions except in cases of fraud or intentional misrepresentation of material fact. ▪ Coverage may not be cancelled except with 30 days prior notice to each person who would be affected.	PHSA §2712 ACA §1001 45 CFR §147.128 La. R.S. 22:1074	
Complies with Cost-Sharing Limited to Maximum Out-of-Pocket ▪ Cost-sharing includes deductibles, coinsurance, copayments, or similar charges; and any other expenditure required of an insured individual which is a qualified medical expense for EHB covered under the plan. ▪ Maximum Out-of-Pocket for 2015 • $ 6,600.00 self only • $13,200.00 for other than self-only (family)	ACA §1302 45 CFR §156.20 45 CFR §156.125 45 CFR §156.130 42 USC §18022 26 USC §223(c)(2)(A)(ii)	

<table>
<tr><th>Requirement (Description)</th><th>Legal Reference</th><th>Location of Evidence of Compliance by Reference to Form No., Page No., & Section
If N/A selected, provide an explanation to support the inapplicability of the requirement</th></tr>
<tr><td>Complies with Reduced Cost-Sharing Limited to Maximum Out-of-Pocket for Eligible Insured
▪ Eligible insured means an individual who enrolls in a silver plan, and whose house hold income is between 100-250% FPL.
▪ The insurer must reduce out-of-pocket (OOP) limits as follows:
<table>
<tr><th>Household Income</th><th>Self-Only OOP</th><th>Other Than Self-Only OOP</th><th>Actuarial Value Rating</th></tr>
<tr><td>100 -150% FPL</td><td>$2250</td><td>$4500</td><td>94%</td></tr>
<tr><td>150 -200% FPL</td><td>$2250</td><td>$4500</td><td>87%</td></tr>
<tr><td>200 -250% FPL</td><td>$5200</td><td>$10,400</td><td>73%</td></tr>
</table>
</td><td>ACA §1402</td><td></td></tr>
<tr><td>Cost-Sharing Exemptions for American Indians and Alaska Natives
▪ A member of a federally recognized tribe with a household income at or below 300% of the FPL, will have no cost sharing for services covered by a Marketplace QHP.</td><td>ACA §1402</td><td></td></tr>
<tr><td>Provide 60 days advance notice to enrollees before the effective date of any material modification including changes in preventive benefits.</td><td>PHSA §2715</td><td></td></tr>
<tr><td>Dependent Coverage
▪ Coverage for dependents must be available up to age 26 if policy offers dependent coverage.
▪ Eligible children are defined based on their relationship with the participant. Limiting eligibility is prohibited based on:
• Financial dependency on primary subscriber;
• Residency;
• Student status;
• Employment;
• Eligibility for other coverage; and
• Marital status.</td><td>PHSA §2714
45 CFR §147.120
La. R.S. 22:1000
La. R.S. 22:1003.1</td><td></td></tr>
<tr><td>Prohibition on Lifetime Limits on EHBs
▪ There can be no lifetime limits on the dollar value of EHBs.</td><td>PHSA §2711
ACA §1001
45 CFR §147.126</td><td></td></tr>
</table>

Requirement (Description)	Legal Reference	Location of Evidence of Compliance by Reference to Form No., Page No., & Section If N/A selected, provide an explanation to support the inapplicability of the requirement
Prohibition on Annual Limits on EHBs ▪ There can be no annual limits on the dollar value of EHBs.	PHSA §2711 ACA §1001 45 CFR §147.126	
EHB Benefit Substitution Identify which of the ten (10) categories and which specific benefits within each of the ten (10) categories of EHBs for which a benefit substitution has been made using the format provided below. (Add additional sheets to the Statement of Compliance as necessary). Also, identify by Reference Page the location of the Actuarial Certification supporting the EHB Benefit Substitution(s). Category Name: Benefit Substituted: Reference Page: Actuarial Certification: The EHB – Substituted Benefit (Actuarial Equivalent) Supporting Documentation and Justification must be attached in the Supporting Documentation tab of SERFF.	45 CFR §156.115	
EHB CATEGORY 1- AMBULATORY PATIENT SERVICES		
Coverage for Ambulatory Patient Services as Established in the EHB Benchmark Plan for Louisiana		
Primary Care Visit to Treat An Injury or Illness	PHSA §2719A ACA §1001 45 CFR §147.138	
Designation of primary care provider	PHSA §2719A ACA §1001 45 CFR §147.138	
Identify the location of the following notices: A. Notice of Right to Designate a Primary Care Provider	PHSA §2719A ACA §1001	A.

Requirement (Description)	Legal Reference	Location of Evidence of Compliance by Reference to Form No., Page No., & Section If N/A selected, provide an explanation to support the inapplicability of the requirement
B. Notice of Right to Designate a Primary Care Provider (addition for pediatrician) C. Notice of Right to Receive Services from an OB/GYN without a referral	45 CFR §147.138	B. C.
Specialist Visit		
Other Practitioner Office Visit (Nurse, Physician Assistant)		
Outpatient Surgery Physician/Surgical Services		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)		
Home Health Care Services Covered if provided in lieu of an Inpatient Hospital Admission.		
Skilled Nursing Facility		
EHB CATEGORY 2- EMERGENCY SERVICES		
Coverage for Emergency Services as Established in the EHB Benchmark Plan for Louisiana		
Emergency Services A. No prior authorization B. No limitation on coverage can be more restrictive than the requirements or limitations that apply to emergency department services received from network providers. C. Compliance with cost-sharing requirements for out-of-network providers. D. Utilizes appropriate definition of “emergency medical condition”. E. Direct payment for non-contracted providers. ▪ Must pay for out-of-network emergency services the greatest of: • The median in-network rate	PHSA §2719A ACA §1001 45 CFR §147.138 45 CFR §156.130(h) SSA §1395dd La. R.S. 22:242 La. R.S. 22:272 La. R.S. 22:1033 La. R.S. 22:1821 La. R.S. 22:1826	A. B. C. D. E.

Requirement (Description)	Legal Reference	Location of Evidence of Compliance by Reference to Form No., Page No., & Section If N/A selected, provide an explanation to support the inapplicability of the requirement
• The usual customary and reasonable rate (or similar rate determined by using the plans or issuer's general formula for determining payments for out-of-network services) • The Medicare rate		
Emergency Room Services A. Includes hospital facility charge and Professional/Physician charges. B. Charges are the same for Preferred Provider, Participating Provider, and Non-Participating Provider.		A. B.
Emergency Transportation/Ambulance	*See also*, La. R.S. 22:1024	
Urgent Care Centers or Facilities		
EHB CATEGORY 3- HOSPITALIZATION		
Coverage for Inpatient Hospital Services as Established in the EHB Benchmark Plan for Louisiana		
Coverage for Inpatient Physician and Surgical Services as Established in the EHB Benchmark Plan for Louisiana		

Requirement (Description)	Legal Reference	Location of Evidence of Compliance by Reference to Form No., Page No., & Section If N/A selected, provide an explanation to support the inapplicability of the requirement
EHB CATEGORY 4- MATERNITY AND NEWBORN CARE		
Coverage for Prenatal and Postnatal Care as Established in the EHB Benchmark Plan for Louisiana A. Surgical and Medical Services B. Facility Services/Hospital Services		A. B.
Coverage for Delivery and All Inpatient Services for Maternity Care as Established in the EHB Benchmark Plan for Louisiana A. Surgical and Medical Services B. Facility Services/Hospital Services		A. B.
Coverage for Required Benefits for Hospital Stays in Connection with Childbirth and for Coverage of Newborn Child A. Not less than 48 hours following a vaginal delivery//96 hours following a cesarean section. B. No prior authorization required for 48/96 hour hospital stay. C. Identify Location of Newborns' Act Disclosure Notice	PHSA §2725 45 CFR §148.170 La. R.S. 22:1065 La. R.S. 22:1075	A. B. C.
EHB CATEGORY 5- MENTAL HEALTH SERVICES AND SUBSTANCE USE DISORDER SERVICES		
Coverage for Mental Health Services and Substance Use Disorder Services Mental health services (MH) and substance use disorder (SUD) services, including behavioral health treatment services, must be provided in a manner that complies with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).	ACA §1302 45 CFR §146.136 45 CFR §156.110 45 CFR §156.115	
Mental/Behavioral Health Inpatient Services		
Mental/Behavioral Health Outpatient Services In Physician's Office		

Requirement (Description)	Legal Reference	Location of Evidence of Compliance by Reference to Form No., Page No., & Section If N/A selected, provide an explanation to support the inapplicability of the requirement
Mental/Behavioral Health Outpatient Services Not In Physician's Office		
Substance Abuse Disorder Inpatient Services		
Substance Abuse Disorder Outpatient Services: In Physician's Office		
Substance Abuse Disorder Outpatient Services: Not In Physician's Office		
Where plans offer benefits for specific MH condition or a SUD in one of the following classifications, the plan must also provide benefits for the MH condition or SUD in every other classification in which M/S benefits are offered: A. Inpatient, in-network services B. Inpatient, out-of-network services C. Outpatient, in-network services D. Outpatient, out-of-network services E. Emergency care F. Prescription drug benefits		A. B. C. D. E. F.
Equivalence is required for treatment of the following items for benefits for mental health services/substance use disorder services and medical surgical benefits: A. annual and lifetime dollar limits B. cost-sharing C. treatment limitations		A. B. C.
EHB CATEGORY 6- PRESCRIPTION DRUGS		
Coverage of at least the greater of one drug in every category and class; or the same number of drugs in each category and class as the EHB-benchmark plan using the United States Pharmacopeia's (USP) classification system.	45 CFR §156.115 45 CFR §156.122 45 CFR §156.125 45 CFR §156.200	

Requirement (Description)	Legal Reference	Location of Evidence of Compliance by Reference to Form No., Page No., & Section If N/A selected, provide an explanation to support the inapplicability of the requirement
List and identify the location of the descriptions or definitions of the different tiers or types of prescription drugs covered: (add additional pages as necessary). [Ex: Tier 1, Tier 2, Tier 3, Tier 4, Tier 5, Specialty Drugs]		
EHB CATEGORY 7- REHABILITATIVE AND HABILITATIVE SERVICES		
Rehabilitative Services	45 CFR §156.110	
Habilitative Services	45 CFR §156.110 45 CFR §156.115	
Durable Medical Equipment (DME)	45 CFR §156.110	
EHB CATEGORY 8- LABORATORY SERVICES		
Diagnostic Tests (X-Rays and Laboratory Tests)	45 CFR §156.110	
Imaging (CTs, PET Scans, and MRIs)	45 CFR §156.110	

Requirement (Description)	Legal Reference	Location of Evidence of Compliance by Reference to Form No., Page No., & Section If N/A selected, provide an explanation to support the inapplicability of the requirement
EHB CATEGORY 9- PREVENTIVE SERVICES		
Preventive Care Services, Screenings, Immunizations ▪ Covers preventive services without cost-sharing requirements including deductibles, co-payments, and co-insurance. ▪ Covered preventive services include: • Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the USPSTF; • Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices (CDC); • Evidence-informed preventive care and screenings provided for in HRSA guidelines for infants, children, adolescents, and women; and • Current recommendations of the USPSTF regarding breast cancer screening, mammography, and prevention.	45 CFR §156.110 PHSA §2713 45 CFR §§147.130; and 156.155(b) CCIIO ACA Implementation FAQs – Set 18	
EHB CATEGORY 10- PEDIATRIC SERVICES (including Dental and Vision)		
Pediatric Services means services for individuals under the age of 19 years.	45 CFR §156.110	
Pediatric Dental Coverage	45 CFR §156.110	
Dental Check-Up for Children	45 CFR §156.110	
Pediatric Vision Coverage	45 CFR §156.110	

Requirement (Description)	Legal Reference	Location of Evidence of Compliance by Reference to Form No., Page No., & Section If N/A selected, provide an explanation to support the inapplicability of the requirement
Vision Screening for Children	45 CFR §156.110	
Eye Glasses for Children	45 CFR §156.110	
ADDITIONAL BENEFITS REQUIRED BY INCLUSION OF BENEFITS IN LOUISIANA EHB BENCHMARK PLAN		
Oral Surgery Benefits		
Second Surgical Opinion		
Organ, Tissue and Bone Marrow Transplant Benefits		
Outpatient Registered Dietician Visits		
Hospice Care		
Outpatient Private Duty Nursing		
Sleep Studies		
Chiropractic Services		
Disposable Medical Equipment or Supplies		

Requirement (Description)	Legal Reference	Location of Evidence of Compliance by Reference to Form No., Page No., & Section If N/A selected, provide an explanation to support the inapplicability of the requirement
Pre-Admission Testing		
Routine Wellness Physical Examination		
Autism Spectrum Disorder		
Routine Foot Care Coverage for persons who have been diagnosed with diabetes; cutting or removal of corns and calluses, nail trimming or debriding, or supportive devices of the foot.		
ADDITIONAL FEDERAL REQUIREMENTS		
Coverage for reconstructive surgery after mastectomy - Women's Health and Cancer Rights Act (WHCRA) ▪ Identify the location of the WHCRA Enrollment Notice and WHCRA Annual Notice	PHSA §2727 *See also*, La. R.S. 22:1077 and La. R.S. 22:272	
Coverage for dependent student on <u>medically necessary leave of</u> <u>absence</u> ("Michelle's Law") ▪ Identify the location of the Notice required to be provided to enrollees.	PHSA §2728 45 CFR §147.145	

Requirement (Description)	Legal Reference	Location of Evidence of Compliance by Reference to Form No., Page No., & Section If N/A selected, provide an explanation to support the inapplicability of the requirement
Guaranteed Availability	45 CFR 147.104 La. R.S. 22:1073	
Enrollment Periods	45 CFR 147.104 La. R.S. 22:1072(E)	
Special Enrollment Periods ▪ IN MARKETPLACE available for 60 days from the date of the following: • Birth, adoption, or placement for adoption • Marriage • Loss of minimum essential coverage • Individual becomes a citizen, a national, or lawfully present • Unintentional enrollment or non-enrollment in a QHP • Violation by QHP of a material contract provision • New eligibility determination, access to a new QHP through a permanent move • Native Americans may change one time per month • Other exceptional circumstances as defined by the Exchange ▪ OFF MARKETPLACE available for 60 days from the date of the following: • Birth, adoption, or placement for adoption • Marriage • Loss of minimum essential coverage ▪ Effective dates of coverage for Special Enrollment periods: • For birth, adoption, or placement for adoption, coverage is effective ON the date of the event • For marriage or loss of minimum essential coverage, coverage is effective on the first day of the following month	26 CFR §54.9801-6(a)(3)(i)-(iii) 45 CFR §§147.104, 155.410 and 155.420	
Child-Only Option provided ▪ An issuer offering any metal level of coverage in the individual market must offer coverage in that same metal level as a plan in which the only enrollees are individuals who have not yet attained the age of 21 (child-only plans). ▪ An issuer can satisfy this standard by offering the same product to applicants seeking child-only coverage that it offers to applicants seeking coverage solely for adults or for families including both adults and children.	45 CFR 147.150(c)	
Guaranteed Renewability	PHSA §2702 45 CFR §148.122 45 CFR § 147.106 La. R.S. 22:1074	

Requirement (Description)	Legal Reference	Location of Evidence of Compliance by Reference to Form No., Page No., & Section If N/A selected, provide an explanation to support the inapplicability of the requirement
Termination ▪ An Enrollee may terminate coverage with 14 days prior notice to QHP ▪ An Issuer is permitted to terminate coverage if: • Enrollee is no longer eligible for coverage through the Exchange • Enrollee obtains other minimum essential coverage • Payment of premiums cease • Enrollee's coverage is rescinded for a non-prohibited reason • QHP is terminated or decertified • Enrollee changes from one plan to another through open/special enrollment ▪ Effective dates of termination • If terminated during the 3-month grace period, the last day of coverage will be the last day of the first month of the 3-month grace period. • If coverage is terminated by the issuer, 30 days prior notice is required and must include the reason for termination. • The issuer must provide a three-month grace period for recipients of advance payments of premium tax credit. • Issuers must pay appropriate claims for the first month of the grace period. Issuers may pend claims in second and third months. ▪ Issuer must provide the enrollee with notice of payment delinquency.	45 CFR §155.430 and §156.270	
Genetic Information Nondiscrimination Act of 2008- GINA ▪ Identify the location of the disclosure required by La. R.S. 22:1023(B)(3)	PHSA §2753 45 CFR §148.180 La. R.S. 22:1023	
Providers operating within their scope of practice cannot be discriminated against	PHSA§2706 CCIIO ACA Implementation FAQs – Set 15	

Requirement (Description)	Legal Reference	Location of Evidence of Compliance by Reference to Form No., Page No., & Section If N/A selected, provide an explanation to support the inapplicability of the requirement
Discrimination ▪ QHP does not use benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs in QHPs. ▪ Does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation. ▪ Coverage decisions, determination of reimbursement rates, establishment of incentive programs or benefits designs cannot be made in ways that discriminate against individuals because of their age, disability, or expected length of life. ▪ An issuer does not provide EHBs if its benefit design or the implementation of its benefit design discriminates based upon an individual's age, expected length of life, present or predicted disability, degree of medical dependency, or other health conditions.	45 CFR §156.225 and §156.200(e) ACA §1557 PHSA §1302(b)(4) 45 CFR §156.125	
Benefit Specific Waiting Periods ▪ Issuers may not impose benefit-specific waiting periods for an EHB ▪ Issuers may impose a reasonable waiting period when covering pediatric orthodontia	45 CFR §156.125 CCIIO FAQs on Health Insurance Market Reforms and Marketplace Standards, dated May 16, 2014	
Coverage for individuals participating in approved clinical trials	PHSA §2709	
Appeals Procedure A. Internal Appeals B. External Appeals	La. R.S. 22:2391-2453	A. B.