

Health Care Flexible Spending Arrangement

For

The State of Louisiana
An ERISA Exempt Employer

2002

Amended as of October 31, 2025

Office of Group Benefits
Division of Administration
State of Louisiana

Article 1

INTRODUCTION

1.1 Establishment of Health Care FSA

The Office of Group Benefits, Division of Administration, State of Louisiana, constructed the Health Care Flexible Spending Arrangement (“Health Care FSA”) as part of the Flexible Benefits Plan, which is an IRS-qualified cafeteria plan, established July 1, 1993. The purpose of this Health Care FSA is to permit a Participant to contribute to an Account for pre-tax reimbursement of certain Qualifying Medical Care Expenses. This Plan Document provides for two Health Care FSA coverage options – a General-Purpose Health Care FSA (GPFSA) and a Limited-Purpose (dental/vision) Health Care FSA (LPFSA).

Capitalized terms used in this Plan Document that are not otherwise defined in this Plan Document shall have the meanings set forth in Article 2.

1.2 Legal Status

This Health Care FSA is intended to: (1) qualify as a “self-insured medical reimbursement plan” under §105 of the Internal Revenue Code; (2) provide for the exclusion of Qualifying Medical Care Expenses reimbursed hereunder from each Participant’s gross income under Code §105(b); and (3) comply with the Internal Revenue Code and the regulations thereunder.

1.3 HIPAA Exception

This Health Care FSA satisfies the two conditions required for exception from the HIPAA portability rules.

Article 2

DEFINITIONS and CONSTRUCTION

2.1 Definitions

“Account(s)” means the Health Care Flexible Spending Arrangement accounts described in Section 5.3.

“Administrative Fee” means the required participation fee set by the Administrator to cover the cost of administering this Health Care Flexible Spending Arrangement. This fee is separate and in addition to amounts identified for Benefits. Failure to pay the Administrative Fee will result in the denial of the privilege to participate in this Health Care Flexible Spending Arrangement.

“Administrator” means the Office of Group Benefits, Division of Administration, State of Louisiana or other such person or entity that it appoints as its designee.

“Annual Enrollment Period” means the period designated by the Administrator which precedes the commencement of each Plan Year during which Eligible Employees can elect or modify the amount contributed for Benefits.

“Appeals Panel” means the panel of at least three (3) individuals appointed by the Administrator.

“Benefits” means any amounts available for reimbursement to a Participant in the Health Care FSA for Qualifying Medical Care Expenses incurred during a Plan Year and/or Grace Period by the Participant, his/her spouse, or his Dependent(s).

“COBRA” means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

“Code” means the Internal Revenue Code of 1986, as amended.

“Compensation” means the wages or salary paid to an Employee by the Employer, determined prior to (a) any Salary Reduction election under the Flex Plan; (b) any salary reduction election under any other cafeteria plan; and (c) any compensation reduction under any Code §132(f)(4) plan; but determined after salary deferral elections under any Code §§ 401(k), 403(b), 408(k) or 457(b) plan or arrangement.

“Contribution” means an amount that has not been actually or constructively received (after application of Section 125) by the Participant and has been designated by a Participant to become Employer contributions for the purpose of paying for reimbursements from the Health Care FSA.

“Dependent” means: (1) any individual who is a tax dependent of a Participant as defined in Code §152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof; (2) any child (as defined in Code §152(f)(1)(B)) of the participant who as of the end of the taxable year has not attained age 27; and, (3) any child of the Participant to whom IRS Revenue Procedure 2008-48 applies (regarding a child of divorced or separated parents where one or both parents have custody of the child for more than half of the calendar year and where the parents together provide more than half of the child’s support for the year). Notwithstanding the foregoing, the Health Care FSA will provide Benefits in accordance with the applicable requirements of any NMSN, even if the child does not meet the definition of “Dependent.”

“Effective Date” means the date that this Health Care FSA was effective, January 1, 2002, as amended October 31, 2025.

“Eligible Employee” means any active, full-time Employee of the State of Louisiana whose department or agency is participating in this Health Care FSA as provided in Section 3.1 of this Plan Document. Notwithstanding the foregoing, solely for purposes of determining eligibility to participate in the Health Care FSA, “Eligible Employee” shall include a FTE and any other Employee who is eligible to participate in an OGB-sponsored health plan.

“Employee” means an individual that the Employer classifies as active, full-time, and who is on the Employer’s W-2 payroll, but does not include the following: (a) any leased employee (including, but not limited to those individuals defined as leased employees in Code §414(n)) or an individual classified by the Employer as a contract worker, independent contractor, temporary employee or casual employee for the period during which such individual is so classified, whether or not any such individuals are on the Employer’s W-2 payroll or are determined by the IRS or others to be common-law employees of the Employer; (b) any individual who performs services for the Employer but who is paid by a temporary or other employment or staffing agency for the period during which such individual is paid by such agency, whether or not such individuals are determined by the IRS or others to be common-law employees of the Employer; or (c) any employee covered under a collective bargaining agreement.

“Employer” means the State of Louisiana through the respective Department or Agency employing the Eligible Employee and/or Participant(s).

“Enrollment Form” means the form or forms provided by the Employer or Administrator for the purpose of allowing an Eligible Employee to participate in this Health Care FSA.

“Enrollment Period” means the first 30 days following each new Eligible Employee’s hire date when Employees may select Benefits for the current Plan Year, and an enrollment period required by Code Section 4980H for a FTE.

“ERISA” means the Employee Retirement Income Security Act of 1974, as amended.

“Flexible Benefits Plan (Flex Plan)” means the Internal Revenue Service qualified cafeteria plan administered by or on behalf of the Office of Group Benefits, Division of Administration, State of Louisiana in accordance with Louisiana Revised Statutes 42:802B(9).

“FMLA” means Family and Medical Leave Act of 1993, as amended.

“Full-Time Equivalent (FTE)” means an employee who is determined to be a “full-time equivalent” employee for purposes of IRS Code Section 4980H and the regulations promulgated thereunder, as established by the Patient Protection and Affordable Care Act of 2010, as amended.

“General-Purpose Health Care FSA” means the flexible spending arrangement option that permits a Participant to contribute to an Account for pre-tax reimbursement of certain Qualifying Medical Care Expenses.

“Grace Period” means:

- For Plan Year 2024 – the 12 months immediately following the end of a Plan Year when Participants may incur Qualifying Medical Care Expenses to be reimbursed from their respective unused Benefits remaining as of the immediately

preceding Plan Year in accordance with IRS Notice 2005-42, or any amendment thereof;

- For Plan Year 2025 – the 12 months immediately following the end of the Plan Year when Participants may incur Qualifying Medical Care Expenses to be reimbursed from their respective unused Benefits remaining as of the immediately preceding Plan Year in accordance with IRS Notice 2005-42, or any amendment thereof;
- For Plan Year 2026 – the 2 months plus 15 days immediately following the end of a Plan Year when Participants may incur Qualifying Medical Care Expenses to be reimbursed from their respective unused Benefits remaining at the end of the immediately preceding Plan Year in accordance with IRS Notice 2005-42, or any amendment thereof.

“Health Care FSA” means the health flexible spending arrangement, which consists of two options: the General-Purpose Health Care Flexible Spending Arrangement (GPFSA) or the Limited-Purpose (dental/vision) Health Care Flexible Spending Arrangement (LPFSA), as set forth herein as amended.

“Health Savings Account (HSA)” means a health savings account established under Code §223. Such arrangements are individual trusts or custodial accounts, each separately established and maintained by an Employee with a qualified trustee/custodian.

“High Deductible Health Plan (HDHP)” means the high deductible health plan offered by the Employer and the Office of Group Benefits that is intended to qualify as a high deductible health plan under the Code §223 (c)(2), as described in materials provided separately by the Employer.

“HIPAA” means the Health Insurance Portability and Accountability Act of 1996, as amended.

“HSA-Eligible Individual” means an individual who: (1) is eligible to contribute or have contributions made on his behalf to a HSA under Code §223; (2) has elected qualifying HDHP coverage offered by the Employer; and, (3) is not covered by any disqualifying non-HDHP coverage.

“Improper Payment” means a payment that is not properly substantiated as well as a reimbursement of an expense that is later identified as not a qualifying medical expense.

“Limited-Purpose (dental/vision) Health Care FSA” means the flexible spending arrangement option available under the Flex Plan that permits a Participant to contribute to an Account for pre-tax reimbursement of certain Qualifying Medical Care Expenses and to maintain his HSA-Eligible Individual status.

“National Medical Support Notice (NMSN)” means the standardized form used by state child support enforcement agencies to obtain group health coverage for children, deemed to be a QMCSO when appropriately completed.

“Participant” means an Eligible Employee who is participating in this Health Care FSA in accordance with the provisions of Article 3.

“Plan-Recognized Qualified Life Event” means one or more of the Plan-Recognized Qualified Life Events recognized by OGB from time to time. The 2024 OGB Plan-Recognized Qualified Life Events are attached hereto as Exhibit “1.”

“Plan Year” means the period of coverage under the Health Care FSA from January 1 through December 31 of each year, except in the case of a Short Plan Year or where the Plan Year is being changed, in which case the Plan Year shall be the entire Short Plan Year.

“Prescription” means a written or electronic order for a medicine or drug that meets the legal requirements of a prescription in the state of the United States of America in which the medical expense is incurred and that is issued by an individual who is legally authorized to issue a prescription in that state. See IRS Notice 2010-59.

“QMCSO” means a Qualified Medical Child Support Order, as defined in ERISA §609(a).

“Qualifying Medical Care Expenses” means expenses incurred by a Participant, or by the spouse or Dependent of such Participant, for medical care as defined in Code §213(d) and Treasury Regulations §1.213-1(e), except amounts paid for insurance premiums and amounts paid for qualified long-term care services as defined in Code §7702B(c), but only to the extent that the Participant or other person incurring the expense is not reimbursed for the expense through insurance or otherwise. Qualifying Medical Care Expenses include over-the-counter (OTC) medications and menstrual care products purchased without a doctor’s prescription and prescribed medicines or drugs, other than insulin. These Qualifying Medical Care Expenses must be purchased within the United States. Amounts paid for OTC medications, menstrual care products, and prescribed medicines or drugs, other than insulin, purchased outside the United States are **NOT** Qualifying Medical Care Expenses. For Participants in the Limited-Purpose (dental/vision) Health Care FSA, Qualifying Medical Care Expenses are **further limited to** expenses for vision care or dental care **ONLY**.

“Qualified Reservist Distribution (QRD)” means a distribution of all or a portion of the balance of the Participant’s unused amount in his Health Care Flexible Spending Arrangement Account to a participant if: (1) the individual is a member of a reserve component (as defined in 37 U.S.C. §101) ordered or called to active duty for a period of at least one hundred eighty (180) days or for an indefinite period; (2) the request for distribution is made during the period beginning with the order or call to active duty and ending on the last day of the grace period for the Health Care FSA Plan Year in which the order/call was made; and, (3) the distribution is made on or after January 1, 2009.

“Run-out Period” means the time period immediately following the Grace Period, ending on April 30, when Participants may submit Qualifying Medical Care Expenses incurred during the preceding Plan Year and/or Grace Period for reimbursement from their respective unused Benefits remaining at the end of the immediately preceding Plan Year,

- For Plan Year 2024 – run out period is April 30, 2025
- For Plan Year 2025 – run out period is April 30, 2026
- For Plan Year 2026 – run out period is April 30, 2027

“Salary Reduction” means the amount by which the Participant’s Compensation is reduced and applied by the Employer under this Health Care FSA to pay for Benefits and the Administrative Fee, before any applicable state and federal taxes have been deducted from the Participant’s Compensation.

“Substantiation” means the written statement, explanation of benefits, itemized receipt, or bill from the health care provider that provides supporting details of the expense incurred and the amount.

“Short Plan Year” means the period of coverage under the Health Care FSA designated by the

Administrator that is less than one year.

2.2 Gender and Number

Except when otherwise indicated by the context, any masculine terminology used herein shall also include the feminine and the definition of any term herein in the singular shall also include the plural.

2.3 Headings

The headings of the various Articles and subsections are inserted for convenience of reference and are not to be regarded as part of the Health Care FSA Plan Document or as indicating or controlling the meaning or construction of any provision.

Article 3

PARTICIPATION

3.1 Eligibility to Participate

An Employee is eligible to participate in this Health Care FSA if the Employee:

- (a) is an active, full-time Employee or a FTE as defined herein or is otherwise eligible for health insurance under an OGB-sponsored health plan or for whom OGB, in its sole discretion, determines should participate in this Health Care FSA to properly administer the requirements of applicable federal and state law; and
- (b) is employed by an Employer that utilizes the State of Louisiana Flexible Benefits Plan.

Retirees are not eligible to participate in this Health Care FSA, except for rehired retirees who otherwise meet the definition of Eligible Employee.

3.2 Participation for HSA-Eligible Individuals

- (a) *Limited-Purpose (dental/vision) Health Care FSA Option.* An Eligible Employee with qualifying HDHP coverage may participate in the Limited-Purpose (dental/vision) Health Care FSA option and remain a HSA-Eligible Individual.
- (b) *General-Purpose Health Care FSA Option.* An Eligible Employee with qualifying HDHP coverage may not participate in the General-Purpose Health Care FSA option and remain a HSA-Eligible Individual.
- (c) *Transition Rule.* A Participant who has an election for the General-Purpose Health Care FSA that is in effect on the day immediately preceding the first day of a Plan Year cannot make HSA Contributions for any of the first three calendar months of that same Plan Year, unless the balance in the Participant's General-Purpose Health Care FSA Account was \$0.00 on the day immediately preceding the first day of that same Plan Year. For this purpose, a Participant's General-Purpose Health Care FSA Account balance is determined on a cash basis – that is without regard to any claims that have been incurred but have not yet been reimbursed (whether or not such claims have been submitted).

3.3 Election to Participate; Commencement of Participation

- (a) *Elections During Enrollment Period.* New Eligible Employees who want to enroll in the Health Care FSA must submit the Enrollment Form and elect to pay any applicable Administrative Fee within the Enrollment Period. The applicant becomes a Participant effective the first of the month following the first full calendar month of eligibility.
- (b) *Elections During Annual Enrollment Period.* During each Annual Enrollment Period with respect to a Plan Year, the Administrator shall make available an Enrollment Form upon request. The Enrollment Form shall be completed and returned to the Employer on or before the last day of the Annual Enrollment Period. If an Eligible Employee elects to participate during an Annual Enrollment Period, he becomes a Participant on the first day of the applicable Plan Year.
- (c) *Eligible Employee Who Fails to File an Enrollment Form.* If an Eligible Employee fails to file (or fails to timely file) an Enrollment Form with respect to a Plan Year with his Employer

during the Annual Enrollment Period, he will not be considered a Participant in this Health Care FSA with respect to the Plan Year and he may not elect to participate in this Health Care FSA until the next Annual Enrollment Period, unless he experiences a Plan-Recognized Qualified Life Event as outlined in Section 4.5, and makes an election change on account of and consistent with the Plan-Recognized Qualified Life Event pursuant to Section 4.5.

3.4 Participation Agreement

An election by an Eligible Employee to participate in this Health Care FSA is an agreement to the following:

- (a) Agreement to pay the Administrative Fee (Failure to pay the Administrative Fee will result in the denial of the privilege to participate in the Health Care FSA);
- (b) Agreement to authorize his Employer to reduce his Compensation by his Salary Reduction before federal and state income and Social Security taxes are calculated;
- (c) Agreement to forfeit any amount remaining in his Health Care FSA Account after 45 days following the end of the Grace Period for the Plan Year;
- (d) Agreement to not request reimbursement for expenses covered by another health care FSA account;
- (e) Agreement to not deduct expenses, for which he is reimbursed by this Health Care FSA, on his income tax return;
- (f) Agreement to request reimbursement only for Qualifying Medical Care Expenses incurred during the same Plan Year and/or Grace Period as the Plan Year in which the funds were deposited into the Health Care FSA Account;
- (g) Agreement to repay improper payment amounts; and
- (h) Agreement that his Employer and Administrator will not incur any liability resulting from either his participation in the Health Care FSA or his failure to sign or accurately complete an Enrollment Form.

3.5 Termination of Participation

An Eligible Employee will cease to be a Participant in this Health Care FSA upon the earlier of:

- (a) the expiration of the Plan Year for which the Employee has elected to participate (unless during the Annual Enrollment Period for the next Plan Year the Participant elects to continue participating);
- (b) the termination of the Health Care FSA;
- (c) the date the Participant ceases to be an Eligible Employee; or
- (d) the date the Participant revokes the election to participate on account of and consistent with events permitting exception to the irrevocability rule pursuant to Section 4.5.

Termination of an Employee's participation in this Health Care FSA shall cause the Participant's elections made under this Health Care FSA to be automatically revoked. Reimbursements after termination of participation will be made pursuant to Sections 5.7 and 5.8.

Reinstatement of Former Participants by Reason of Civil Service Appeal

When employment of a Participant is terminated and reinstated within the same Plan Year by reason of a Civil Service appeal, elections shall be reinstated retroactive to the date that employment was terminated. In the event the terminated Participant is not reinstated prior to the end of the Plan Year in which he was terminated, he shall no longer be a Participant and he shall no longer be an Eligible Employee. To the extent COBRA applies, the Participant may continue coverage under COBRA.

If this former Participant's employment is reinstated during a subsequent Plan Year, the former Participant will be permitted to enter the Health Care FSA upon return from his absence for the current Plan Year only.

3.6 Participation Following Rehire

If a Participant terminates his employment for any reason, including (but not limited to) disability, retirement, layoff, or voluntary resignation, and then is rehired within thirteen (13) weeks (26 weeks for educational institutions) after the date of the termination of employment, the Employee may enroll in this Health Care FSA.

3.7 Participation Following Transfer

A Participant who transfers from one Employer to another Employer within the participating Flex Plan payroll systems will continue to participate in the Health Care FSA on the same basis of participation as prior to the transfer.

3.8 FMLA Leaves of Absence

Notwithstanding any provision to the contrary in this Plan Document, if a Participant goes on a qualifying paid leave under the FMLA, he may elect to continue on the same basis as during active service or discontinue his coverage.

In the case when a Participant goes on a qualifying unpaid leave under the FMLA, he may elect to continue or discontinue his coverage. If he elects to continue, the Participant may pay his Salary Reduction in one of the following ways:

- (a) by pre-paying with pre-tax dollars the monthly portion of the Salary Reduction for the expected duration of the leave pursuant to the approved FMLA agreement and timely application to the OGB (i.e., GB-01). To pre-pay the Salary Reduction, the Participant must complete a GB-01 prior to the date that such Compensation would normally be made available (Pre-tax dollars may not be used to fund coverage during the next Plan Year) and upon return from the unpaid leave;
- (b) by paying with pre-tax dollars upon his return to work on a payroll reduction schedule pursuant to the approved FMLA agreement and timely application to the OGB (i.e., GB-01). The Participant must complete a GB-01 prior to and upon return from the unpaid leave; or
- (c) by paying with after-tax dollars in the form of monthly payments to the Employer by the due date established by the Employer.

If a Participant's coverage ceases while on unpaid FMLA leave, the Participant will be permitted to re-enter the Health Care FSA upon return from such unpaid leave on the same basis as when the Participant was participating in the Health Care FSA prior to the leave, or otherwise required by

FMLA.

3.8 Non-FMLA Leaves of Absence

Notwithstanding any provision to the contrary in this Plan Document, if a Participant goes on unpaid leave that does not affect eligibility, he may elect to continue or discontinue his coverage. If the Participant elects to continue his coverage, he may pay his Salary Reduction in one of the following ways:

- (a) by pre-paying with pre-tax dollars the monthly portion of the Salary Reduction for the expected duration of the leave pursuant to his Employer's approval of the leave and timely application to the OGB (i.e., GB-01). To pre-pay the Salary Reduction the Participant must also complete a GB-01 prior to the date that such Compensation would normally be made available (Pre-tax dollars may not be used to fund coverage during the next Plan Year) and upon return from the unpaid leave;
- (b) by paying with pre-tax dollars upon his return to work on a payroll reduction schedule pursuant to his Employer's approval of the leave and timely application to the OGB (i.e., GB-01). The Participant must complete a GB-01 prior to and upon return from the unpaid leave; or
- (c) by paying with after-tax dollars in the form of monthly payments to the Employer by the due date established by the Employer.

If a Participant goes on an unpaid leave that affects eligibility, the election change rules in Section 4.5 will apply. To the extent COBRA applies, the Participant may continue coverage under COBRA.

Article 4

BENEFITS and ELECTIONS

4.1 Administrative Fee

An election to participate in this Health Care FSA is an election to pay an Administrative Fee to receive Benefits in the form of reimbursements for Qualifying Medical Care Expenses.

4.2 Maximum and Minimum Benefits

Unless otherwise required by the IRS, the following shall apply for the 2025 Health Care FSA Plan Year:

- (a) *Plan Years.* The maximum annual Benefit amount that a Participant may elect to receive under this Health Care FSA in any Plan Year and/or Grace Period shall be \$3400 for Plan Year 2026. The minimum annual Benefit amount that a Participant may elect to receive under this Health Care FSA in any Plan Year and/or Grace Period shall be \$600.
- (b) *Short Plan Years.* The maximum annual Benefit amount that a Participant may elect to receive under this Health Care FSA in any Short Plan Year and/or Grace Period shall be \$1700 for Plan Year 2026. The minimum annual Benefit amount that a Participant may elect to receive under this Health Care FSA in any Short Plan Year and/or Grace Period shall be \$300.

4.3 Salary Reduction Contributions

Participants in this Health Care FSA must pay for the cost of Benefits on a pre-tax Salary Reduction basis pursuant to an Enrollment Form. The Participant's annual Contribution is equal to the annual Benefit amount elected by the Participant. For Participants paid monthly, the Salary Reduction for each pay period is an amount equal to the annual Contribution plus the annual Administrative Fee divided by 12. For Participants paid bi-weekly, the Salary Reduction for each pay period, except for a pay period associated with a third check in a given month, is an amount equal to the annual Contribution plus the annual Administrative Fee divided by 24. For Participants paid weekly, the Salary Reduction for each pay period is an amount equal to the annual Contribution plus the annual Administrative Fee divided by 52.

4.4 Irrevocability of Elections: Not Applicable for HSA

Except as provided in Section 4.5, a Participant's election to participate in this Health Care FSA is irrevocable for the duration of the Plan Year; therefore, the Participant may not change:

- (a) his participation in the Health Care FSA;
- (b) his elected annual Benefit amount; or
- (c) his Salary Reduction amount.

4.5 Events Permitting Exception to the Irrevocability Rule

Elections under the Health Care FSA may only be revoked or changed if and as provided in the OGB Plan-Recognized Qualified Life Events document, attached hereto.

4.6 Election Modifications Required by Administrator

The Administrator may, at any time, require any Participant or class of Participants to amend his/her enrollment in Benefits for a Plan Year if the Administrator determines such action is necessary or advisable in order to:

- (a) satisfy any of the Code's nondiscrimination requirements applicable to this Health Care FSA or the Flex Plan;
- (b) prevent any Employee or class of Employees from having to recognize more income for federal income tax purposes due to the receipt of benefits hereunder than would otherwise be recognized; or
- (c) maintain the qualified status of Benefits received under this Health Care FSA.

In the event participation in Benefits need to be reduced for a class of Participants, the Administrator will reduce the participation in Benefits for each affected Participant, beginning with the Participant in the class who elected the greatest participation in Benefits, continuing with the Participant in the class who elected the next greatest participation in Benefits, and so forth, until the defect is corrected.

Article 5

REIMBURSEMENT PROCEDURE

5.1 Reimbursable Expenses

- (a) *Qualifying Medical Care Expenses.* A Participant may receive reimbursement for Qualifying Medical Care Expenses incurred during the Plan Year and/or Grace Period for which an election is in force. A Qualifying Medical Care Expense is incurred at the time the medical care or service giving rise to the expense is furnished, and not when the Participant is formally billed, is formally charged, or pays for the medical care.
1. If it is determined that a Participant has received payments under this Plan for ineligible expenses or a Participant has failed to provide substantiation in the timeframe allowed, after written notice, the Plan Administrator, its Third Party Administrator, and/or Employer may:
 - i. deactivate the Participant's debit card,
 - ii. require repayment of the improper amount,
 - iii. withhold the amount of the improper payment from the Participant's pay,
 - iv. apply a claims substitution or offset to resolve the improper payment, and/or
 - v. treat the improper payment as a business indebtedness, including reporting the improper payment on the Participant's W-2.
 2. The Office of Group Benefits shall give the Participant prompt written notice of any such improper payment.
- (b) *Over-the-Counter Medications, Menstrual Care Products, Prescription Medicines/Drugs.* The Plan Administrator (in its sole discretion and on a uniform and consistent basis) shall determine, based upon prevailing IRS guidance, whether a particular item is an over-the-counter medication, menstrual care product, or prescription medicine or drug.
- (c) *Coordination of Benefits with HSA.* The Health Care FSA shall not be considered to be a group health plan and Health Care FSA Benefits shall not be taken into account for coordination of benefits purposes. In the event an expense is eligible for reimbursement under both the Health Care FSA and the HSA, the Participant may choose to seek reimbursement from either the Health Care FSA or the HSA, but not both.

5.2 Maximum and Minimum Reimbursement

- (a) *Maximum Reimbursement Available.* Reimbursement for Qualifying Medical Care Expenses of the maximum dollar amount elected by the Participant for a Short Plan Year or Plan Year (reduced by prior reimbursements and Qualified Reservist Distribution(s) during the Short Plan Year or Plan Year) shall be available at all times during the Plan Year and/or Grace Period, regardless of the actual amounts credited to the Participant's Health Care FSA Account pursuant to Section 5.3. Notwithstanding the foregoing, no reimbursements will be available for expenses incurred after coverage under this Health Care FSA has terminated, unless the Participant has elected COBRA as provided in Section 5.7. Payment shall be made to the Participant in cash as reimbursement for Qualifying Medical Care Expenses incurred during the Short Plan Year or Plan Year and/or Grace Period for which the Participant's election is effective, provided that the Participant has complied with all other requirements of this Plan Document.

(b) *Maximum and Minimum Annual Benefit Amounts.*

1. *Short Plan Year.* The maximum Benefit amount that a Participant may elect to receive under this Health Care FSA in any Short Plan Year and/or Grace Period shall be \$1,700 for Plan Year 2026, subject to Section 5.3(c), below. The minimum Benefit amount that a Participant may elect to receive under this Health Care FSA in any Short Plan Year and/or Grace Period shall be \$300. Reimbursements due for Qualifying Medical Care Expenses incurred by the Participant, Participant's Spouse or Participant's Dependents as well as any Qualified Reservist Distribution(s) shall be charged against the Participant's Health Care FSA Account.
2. *Plan Year.* The maximum annual Benefit amount that a Participant may elect to receive under this Health Care FSA in any Plan Year and/or Grace Period shall be \$3400 for Plan year 2026, subject to Section 5.3(c), below. The minimum annual Benefit amount that a Participant may elect to receive under this Health Care FSA in any Plan Year and/or Grace Period shall be \$600. Reimbursements due for Qualifying Medical Care Expenses incurred by the Participant, Participant's spouse or Participant's Dependents as well as any Qualified Reservist Distribution(s) shall be charged against the Participant's Health Care FSA Account.

- (c) *Changes; No Proration.* For subsequent Plan Years, the maximum and minimum annual Benefit amount may be changed by the Administrator and shall be communicated to Employees through the Enrollment Form or another document. If a Participant wishes to increase an election mid-year as permitted under Section 4.5, the Participant may elect coverage up to the maximum annual Benefit amount, as applicable.
- (d) *Effect on Maximum Benefits if Election Change Permitted.* Any change in an election under Section 4.5 affecting the maximum annual Benefit amount for a Participant's Health Care FSA Account also will change the maximum reimbursement of Benefits for the balance of the Plan Year commencing with the election change. Such maximum reimbursement of Benefits for the balance of the Plan Year shall be calculated by adding the Contributions made by the Participant (if any) as of the end of the portion of the Plan Year immediately preceding the change in election to the total Contributions scheduled to be made by the Participant during the remainder of such Plan Year to the Health Care FSA Account, reduced by all reimbursements and distributions made during the entire Plan Year.

5.3 Establishment of Account

The Administrator will establish and maintain on its books a Health Care FSA Account with respect to each Participant who has elected to participate in the Health Care FSA, but it will not create a separate fund or otherwise segregate assets for this purpose. The Account so established will be merely a record-keeping account for the purpose of keeping track of Contributions and determining forfeitures under Section 5.8.

- (a) *Crediting of Accounts.* A Participant's Health Care FSA Account will be credited periodically during each Plan Year with an amount equal to the Participant's maximum annual Benefit amount elected to be allocated to such Account. The Administrative Fee is not credited to the Account.
- (b) *Debiting of Accounts.* A Participant's Health Care FSA Account will be debited during each Plan Year for any reimbursement of Qualifying Medical Care Expenses incurred, or Qualified Reservist Distribution(s) during the Plan Year and/or the Grace Period.

- (c) *Available Amount Not Based on Credited Amount.* The amount available for reimbursement of Qualifying Medical Care Expenses is the Participant's maximum annual Benefit amount, reduced by prior reimbursements and any Qualified Reservist Distribution(s) during the Plan Year; it is not based on the amount credited to the Health Care FSA Account at a particular point in time. Thus, a Participant's Health Care FSA Account may have a negative balance during the Plan Year, but any such negative amount shall never exceed the maximum annual Benefit amount elected by the Participant under this Health Care FSA.

5.4 Qualified Reservist Distribution (QRD)

Notwithstanding any other provision of the Plan to the contrary, a Participant who meets each of the following requirements may elect to receive a distribution of certain funds from his Health Care FSA Account for a Plan Year:

- (a) The Participant's Contributions to his Health Care FSA Account for the Plan year as of the date of the request for a QRD exceed the reimbursements he has received from his Health Care FSA Account for the Plan Year as of that date.
- (b) The Participant is called or ordered to active military duty for a period of at least one hundred eighty (180) days or for an indefinite period by reason of being a member of the Army National Guard of the United States, the Army Reserve, the Navy Reserve, the Marine Corps Reserve, the Air National Guard of the United States, the Air Force Reserve, the Coast Guard Reserve, or the Reserve Corps of the Public Health Service.
- (c) The Participant has provided the Administrator with a copy of the call or order to active duty. A call or order to active duty of less than one hundred eighty (180) days duration must be supplemented by subsequent calls or orders to reach a total of one hundred eighty (180) or more days.
- (d) The Participant is called or ordered to active military duty on or after January 1, 2009, or his period of active duty begins before January 1, 2009, and continues on or after that date.
- (e) During the period beginning on the date of the call or order to active duty and ending on the last day of the Plan Year during which the call or order occurred, the Participant delivers a written election to the Administrator (or its designee) in such form as the Administrator may prescribe, requesting a QRD.

The amount of the QRD shall be no more than the Participant's Contributions to his Health Care FSA Account for the Plan Year as of the date of the QRD request, minus the reimbursements he has received from his Account for the Plan Year as of the date of the request. Notwithstanding any other provision of the Plan to the contrary, this portion of the Participant's balance may be distributed without regard to whether Qualifying Medical Care Expenses have been incurred. The QRD is subject to employment taxes and will be reported as wages on the Participant's employee Form W-2 for the year in which the QRD is paid.

The QRD is limited by the Participant's Contributions and prior reimbursements. The Participant continues to participate through the entire Plan Year and multiple QRDs are allowed with respect to any one Participant during the same Plan Year as long as the total dollar amount of all QRDs and reimbursements for Qualifying Medical Care Expenses do not exceed the amount of the Participant's election under the Health Care FSA for the Plan Year. The QRD may not be made with respect to a Plan Year ending before the order or call to active duty.

The Qualified Reservist Distribution will be made as soon as practicable not to exceed sixty (60) days, or the Administrator will notify the Participant that his distribution was denied within a reasonable time not to exceed sixty (60) days after receipt of the QRD request.

5.5 Procedure for Claiming Reimbursement

A Participant who has elected to receive Benefits for a Plan Year may apply for reimbursement by submitting an application in writing to the Administrator in such form as the Administrator may prescribe no later than the close of the Run-Out Period for the Plan Year in which the Qualifying Medical Care Expenses were incurred, setting forth:

- (a) the person or persons on whose behalf Qualifying Medical Care Expenses have been incurred;
- (b) the nature and date of the expenses so incurred;
- (c) the amount of the requested reimbursement; and
- (d) a statement that such expenses have not otherwise been reimbursed and are not reimbursable through any other source.

Such application shall be accompanied by bills, invoices, or other statements from an independent third party showing that the Qualifying Medical Care Expenses have been incurred and the amount of such Qualifying Medical Care Expenses, together with any additional documentation that the Administrator may request.

5.6 Timing of Reimbursement

As soon as practicable after the Participant submits a reimbursement claim to the Administrator, the Administrator will reimburse the Participant for his Qualifying Medical Care Expenses, or will notify the Participant that his claim has been denied within a reasonable period of time not to exceed sixty (60) days after receipt of a claim.

5.7 Termination of Benefits

When a Participant ceases to be a Participant under Section 3.5, the Participant's Salary Reduction will terminate, as will the Participant's election to receive reimbursements. The Participant will not be able to receive reimbursements for Qualifying Medical Care Expenses incurred after his participation terminates. However, such Participant (or the Participant's estate) may claim reimbursement for any Qualifying Medical Care Expenses incurred during the Plan Year and/or the Grace Period prior to termination, provided that the Participant (or the Participant's estate) files a claim no later than the close of the Run-Out Period for the Plan Year in which the expense(s) arose.

Notwithstanding any provision to the contrary in this Plan Document, to the extent required by COBRA, a Participant and his spouse and Dependents, whose coverage terminates under the Health Care FSA because of a COBRA qualifying event, shall be given the opportunity to continue coverage under the Health Care FSA on an after-tax basis for the periods prescribed by COBRA (subject to all conditions and limitations under COBRA.) Specifically, such individuals will be eligible for COBRA continuation coverage only if, under Section 5.3, they have a positive Health Care FSA Account balance at the time of a COBRA qualifying event (taking into account all claims submitted before the date of the qualifying event.) Such individuals will be notified if they are eligible for COBRA continuation coverage. If COBRA is elected, it will be available only for the Plan Year in which the qualifying event occurs; such COBRA coverage for the Health Care FSA will cease at the end of the Grace Period for the respective Plan Year and cannot be continued for the next Plan Year.

5.8 Use or Lose Rule; Forfeiture of Accounts

If a Participant has a positive (greater than \$0) balance in his Health Care FSA Account for a Plan Year after all reimbursements have been made for the Plan Year and/or the Grace Period, such balance shall not be carried over to reimburse the Participant for Qualifying Medical Care Expenses incurred during a subsequent Plan Year. The Participant shall forfeit all rights with respect to such balance.

All forfeitures under this Health Care FSA shall be used as follows: first, to reduce the cost of administering this Health Care FSA during the Plan Year (All such administrative costs shall be documented by the Administrator.); and second, to be returned to the Participants in the form of cash on a per Participant uniform basis. In no case will the forfeitures be allocated among Participants based directly or indirectly on their individual claims experience.

Article 6

APPEALS PROCEDURE

6.1 Review of Administrative Decisions

Any Participant may request a review of any administrative decision or action of the Administrator in accordance with the provisions of this Health Care FSA. The purpose of the review procedure as set forth herein is to provide a procedure by which a denial under this Health Care FSA may receive a full and fair review by the Appeals Panel.

6.2 Eligibility Appeals

OGB retains the authority to make all determinations regarding eligibility in relation to this Health Care FSA. To obtain review of a Health Care FSA eligibility determination, one shall request a review by filing a written application for review by the Appeals Panel with the State of Louisiana Office of Group Benefits, P. O. Box 44036, Baton Rouge, Louisiana 70804, within sixty (60) days after receipt by the applicant of written notice of the denial. In connection with this request for review, the applicant may review pertinent Plan documents and submit issues and/or comments in writing to the Administrator.

6.3 Appeal of Denial of Claim for Reimbursement

To obtain a review of a denial of a claim for reimbursement of expenses for Plan Year 2025, and for any appeals not covered under Section 6.2, one shall request a review by filing a written application for review by the Appeals Panel with Total Administrative Services, ATTN: Claims Department, 2302 International Lane, Madison, WI 53704-3140, within sixty (60) days after receipt by the applicant of written notice of the denial. In connection with this request for review, the applicant may review pertinent Plan documents and submit issues and/or comments in writing to the address in this Section. To obtain a review of a denial of a claim for reimbursement of expenses for Plan Year 2026, and for any appeals not covered under Section 6.2, one shall request a review by filing a written application for review by the Appeals Panel with Total Administrative Services, ATTN: Claims Department, 2302 International Lane, Madison, WI 53704-3140, within sixty (60) days after receipt by the applicant of written notice of the denial. In connection with this request for review, the applicant may review pertinent Plan documents and submit issues and/or comments in writing to the address in this Section.

6.4 Decision on Review

Decisions on review shall be made in the following manner:

- (a) The decision on review shall be made by the Appeals Panel. The Appeals Panel shall make its decision promptly, and not later than sixty (60) days after the Appeals Panel receives the request for review, unless special circumstances require an extension of time for processing. In

such case, a decision shall be rendered as soon as possible, but not later than one hundred twenty (120) days after receipt of the request for review. If such an extension of time for review is required, written notice of the extension shall be furnished to the Participant prior to the commencement of the extension.

- (b) The decision on review shall be in writing and shall set forth the following in the event of a denial:
- (1) Information to identify the Participant's request;
 - (2) Specific reason(s) for the decision; and,
 - (3) Specific reference to pertinent Plan provisions on which the denial is based.

In the event that the decision on review is not furnished within the time period set forth in this Section 6.4, the claim shall be deemed denied on review.

Article 7

ADMINISTRATION

7.1 Administrator

The administration of the Health Care FSA shall be under the supervision of the Administrator. It is the principal duty of the Administrator to see that the terms of this Health Care FSA are carried out, in accordance with the terms of this Plan Document, for the exclusive benefit of persons entitled to participate in this Health Care FSA without discrimination among them.

7.2 Powers of the Administrator

The Administrator shall have such duties and powers, as it considers necessary or appropriate to discharge its duties. It shall have the exclusive right to interpret the Plan and to decide all matters thereunder, and all determinations of the Administrator with respect to any matter hereunder shall be conclusive and binding on all persons. Without limiting the generality of the foregoing, the Administrator shall have the following discretionary authority:

- (a) to construe and interpret this Plan Document, including all possible ambiguities, inconsistencies and omissions in the Plan Document and related documents, and to decide all questions of fact, questions relating to eligibility and participation, and questions of Benefits under this Health Care FSA (provided that, notwithstanding the first paragraph in this Section 7.2, the Appeals Panel shall exercise such exclusive power with respect to an appeal under Article 6);
- (b) to prescribe procedures to be followed and the forms to be used by Employees and Participants to make elections pursuant to this Health Care FSA;
- (c) to prepare and distribute information explaining this Health Care FSA and the Benefits under this Health Care FSA in such manner as the Administrator determines to be appropriate;
- (d) to request and receive from all Employees and Participants such information as the Administrator shall determine from time to time to be necessary for the proper administration of this Health Care FSA;
- (e) to furnish each Participant with such reports with respect to the administration of this Health Care FSA as the Administrator determines to be reasonable and appropriate, including appropriate statements setting forth the amounts by which a Participant's Compensation has been reduced in order to provide Benefits under this Health Care FSA;
- (f) to receive, review and keep on file such reports and information concerning the Benefits covered by this Health Care FSA as the Administrator determines from time to time to be necessary and proper;
- (g) to appoint and employ such individuals or entities to assist in the administration of this Health Care FSA as it determines to be necessary or advisable;
- (h) to sign documents for the purpose of administering this Health Care FSA, or to designate an individual or individuals to sign documents for the purposes of

administering this Health Care FSA; and

- (i) to maintain the books of accounts, records, and other data in the manner necessary for the proper administration of this Health Care FSA and to meet any applicable disclosure and reporting requirements.

The Administrator shall have no power to alter the terms of this Plan Document or to waive or fail to apply requirements governing eligibility or participation.

7.3 Reliance on Participant, Tables, etc.

The Administrator may rely upon the direction, information or election of a Participant as being proper under the Health Care FSA and shall not be responsible for any act or failure to act because of a direction or lack of direction by a Participant. The Administrator will also be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions, and reports that are furnished by accountants, attorneys, or other experts employed or engaged by the Administrator.

7.4 Fiduciary Liability

To the extent permitted by law, the Administrator shall not incur any liability for any acts or failure to act except for his own willful misconduct or willful breach of this Health Care FSA.

7.5 Inability to Locate Payee

If the Administrator is unable to make payment to any Participant or other person to whom a payment is due under this Health Care FSA because it cannot ascertain the identity or whereabouts of such Participant or other person after reasonable efforts have been made to identify or locate such person, then such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited sixty (60) days after the end of the Plan Year in accordance with Section 5.7.

7.6 Effect of Mistake

In the event of a mistake as to the eligibility or participation of an Employee, the allocations made to the Account of any Participant, or the amount of Benefits paid or to be paid to a Participant or other person, the Administrator shall, to the extent it deems possible and permissible under Code §125 or the regulations issued thereunder, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as it will in its judgment accord to such Participant or other person the credits to the Account or distributions to which he is properly entitled under this Health Care FSA. Such action by the Administrator may include withholding of any amounts due this Health Care FSA or the Employer from Compensation paid by the Employer.

Article 8

GENERAL PROVISIONS

8.1 Expenses

All reasonable expenses incurred in administering the Health Care FSA are currently paid by Administrative Fees and by forfeitures to the extent provided in Section 5.8.

8.2 No Contract of Employment

Nothing herein contained is intended to be or shall be construed as constituting a contract or other arrangement between any Employee and the Employer to the effect that such Employee will be employed for any specific period of time. All Employees are considered to be employed at the will of the Employer.

8.3 Amendment and Termination

This Health Care FSA has been established with the intent of being maintained for an indefinite period of time. Nonetheless, the Administrator may amend or terminate this Health Care FSA at any time by direction of the Office of Group Benefits, or by any person or persons authorized by the Office of Group Benefits to take such action, and any such amendment or termination will automatically apply to the related Employers which are participating in this Health Care FSA.

8.4 Governing Law

This Health Care FSA shall be construed, administered, and enforced according to the laws of the State of Louisiana, to the extent not superseded by the Code, or other federal law.

8.5 Code Compliance

It is intended that this Health Care FSA meets all applicable requirements of the Code, and all of the regulations issued thereunder. This Health Care FSA shall be construed, operated, and administered accordingly, and in the event of any conflict between any part, clause or provision of this Plan Document and the Code, the provisions of the Code shall be deemed controlling, and any conflicting part, clause, or provision of this Plan Document shall be deemed superseded to the extent of the conflict.

8.6 No Guarantee of Tax Consequences

Neither the Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Health Care FSA will be excludable from the Participant's gross income for federal, state, or local income tax purposes. It shall be the obligation of each Participant to determine whether each payment under this Health Care FSA is excludable from the Participant's gross income for federal, state and local income tax purposes, and to notify the Administrator if the Participant has any reason to believe that such payment is not so excludable.

8.7 Indemnification of Employer

If a Participant receives one or more payments or reimbursements under this Plan on a tax-free basis and if such payments do not qualify for such treatment under the Code, then such Participant shall indemnify and reimburse the Employer for any liability that it may incur for failure to withhold federal income taxes, Social Security taxes, or other taxes from such payments or reimbursements.

8.8 Non-Assignability of Rights

The right of any Participant to receive any reimbursement under this Health Care FSA shall not be alienable by the Participant by assignment or any other method and shall not be subject to claims by the Participant's creditors by any process whatsoever. Any attempt to cause such right to be so subjected will not be recognized, except to such extent as may be required by law.

8.9 National Medical Support Notices (NMSNs)/Qualified Medical Child Support Orders (QMCSOs)

In the event the Administrator receives a NMSN, the Administrator shall notify the affected Participant and any alternate recipient identified in the order of receipt of the order and the plan's procedures for determining whether such an order is appropriately completed and deemed to be a QMCSO. Within a reasonable period, the Administrator shall determine whether the NMSN is deemed to be a QMCSO and shall notify the Participant and alternate recipient of such determination. The IMEHRA will provide Benefits in accordance with the applicable requirements of any NMSN, even if the child does not meet the definition of "Dependent."

8.10 Plan Document Provisions Controlling

In the event the terms or provisions of any summary or description of this Health Care FSA, or of any other instrument, are in any construction interpreted as being in conflict with the provisions of this Plan Document as herein set forth, the provisions of this Plan Document shall be controlling.

8.11 Severability

In the event any provision of this Plan Document shall be held illegal or invalid for any reason, this illegality or invalidity shall not affect the remaining provisions of this Plan Document, and such remaining provisions shall be fully severable and this Plan Document shall, to the extent practicable, be construed and enforced as if the illegal or invalid provision had never been inserted therein.

EXHIBIT “1”
OGB PLAN-RECOGNIZED
QUALIFIED LIFE EVENTS

Office of Group Benefits Plan-Recognized Qualified Life Events (QLE) 2024



QLE Code	Plan Recognized Qualified Life Event	Enrollee change request to OGB plan ADD or DROP	Deadline to submit request and provide proof document	Proof or document <u>required</u>	Enrollee allowed to change (who meets the eligibility definition)	Effective Date of Change	ADD Dependent YES or NO	DROP Dependent YES or NO	DROP Self YES or NO	ADD or DROP Medical Coverage	CHANGE Health Plan YES or NO	COBRA Event YES or NO	Flexible Spending Plan – Health Care	Flexible Spending Plan - Dep. Care
BIRTH/ADOPTION														
A-1	Birth	ADD	Application <u>must</u> be made within 30 days of change in status	Birth Certificate or Birth Letter which includes newborn data, and eligibility data for any newly-eligible persons	Employee, new baby. Spouse may be added as a result of this event, but only if baby is added.	Baby’s date of birth if Application for enrollment is timely made	YES	NO	NO	ADD	YES	NO	May enroll or can increase amount	May enroll or increase amount
A-2	Adoption or placement for adoption	ADD	30 days from the effective date of adoption/placement for adoption	Adoption or placement for adoption legal document, and eligibility data for any newly-eligible persons	Employee and adopted child; spouse may be added as a result of this event but only if child is added.	Effective date of adoption or placement for adoption if Application for enrollment is timely made	YES	NO (but may drop dependent if dependent is placed for adoption)	NO	ADD	YES	NO	May enroll or can increase amount	May enroll or increase amt if dependent care expenses increased
DEATH/SURVIVING SPOUSE														
B-1	Death of covered dependent	DROP	60 days from the date of death (OGB has the discretion to retroactively terminate coverage if correct premium is not timely paid and Application for disenrollment is not timely made)	Copy of certified death certificate or other official document	Dependent who died. If spouse dies, stepchildren must be terminated and offered COBRA coverage.	End of the month in which the death occurs	NO	DROP the deceased and any stepchildren who are not adopted by the enrollee	NO	DROP for the deceased dependent or any stepchildren only	NO	Only for step-children if parent is the dependent who died	May decrease amount	May drop or decrease amount if dependent is child; May increase amount if event or death of spouse will increase dependent care expenses
B-2	Employee Deceased	DROP	30 days from the date of death (OGB has the discretion to retroactively terminate coverage if correct premium is not timely paid and Application for disenrollment is not timely made)	Copy of certified death certificate or other official document	Employee and eligible dependents (Eligible dependents will be offered survivor coverage)	End of month in which Employee’s death occurred	N/A	YES	YES	DROP	NO	YES	Automatic Cancel on date of death	Automatic Cancel on date of death

Office of Group Benefits Plan-Recognized Qualified Life Events (QLE) 2024



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DIVORCE														
C-1	Divorce, Annulment and Legal Separation (legal separation and annulment are qualified events only if recognized by law of state of the separation or annulment)	ADD	Application <u>must</u> be made within 30 days of change in status	Copy of divorce, annulment, or legal separation order and eligibility data for any newly-eligible persons	Self; children	Date of divorce order if Application for Enrollment is timely made	YES	N/A	N/A	ADD	YES	NO	May enroll or can increase amount if loss of coverage on spouse's health plan	Yes, if change affects the amount of time the child needs to be in dependent care and increases expenses OR lose coverage under spouse's Dep Daycare Flex Plan
C-2	Divorce, Annulment and Legal Separation (where annulment and legal separation are recognized by law of the state of the separation or annulment)	DROP	Application <u>must</u> be made within 30 days of change in status (OGB has the discretion to retroactively terminate coverage to the end of the month of the change in status if correct premium is not timely paid and application is not timely made)	Copy of official divorce, annulment or legal separation decree	Ex-spouse and ex-stepchildren	End of the Month of the divorce, annulment or legal separation if application is timely made	N/A	YES for Ex-Spouse and Ex-Stepchildren	NO	DROP	NO	YES	May decrease election	May decrease if divorce, annulment or legal separation lowers dependent daycare expenses
GAIN OF OTHER COVERAGE														
D-1	Gain Medicaid or state CHIP (Children's Health Insurance Program) coverage	DROP	Application <u>must</u> be made within 60 days from date Medicaid became effective	Official state document indicating who, when Medicaid /SCHIP coverage began	Self and dependents who gained such coverage (dependents cannot remain on the OGB plan without the Employee being covered)	The end of the month preceding the first full month in which other coverage became effective if application is timely made	N/A	YES	YES	DROP	NO	NO	May decrease or deactivate deductions if gain of Medicaid; no change if gain of SCHIP	No change

Office of Group Benefits Plan-Recognized Qualified Life Events (QLE) 2024



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GAIN OF OTHER COVERAGE														
D-2	Dependent gains coverage under another group or individual health plan	DROP	Application <u>must</u> be made within 30 days from date other coverage becomes effective	Proof of other coverage, for whom, and the effective date of the coverage	Dependent who gained other coverage	The end of the month preceding the first full month in which other coverage became effective if application is timely made	N/A	YES	NO	DROP	NO	NO	No change	No change
D-3	Gain new coverage through Medicare Part A or Part B	Continue with OGB coverage as secondary (employee would be retired)	Application <u>must</u> be made within 30 days from date other coverage becomes effective	Official documentation of active enrollment on Medicare Part A or Part B; must show effective dates	Self and dependents	OGB coverage will remain primary until the last day of the month preceeding the first full month of Part A/B	N/A	Yes	N/A	N/A	YES; if spouse gains Medicare A & B after plan member has already gained both plan can be changed to Medicare Advantage only.	NO	N/A	N/A
D-4	Gain coverage through Medicare Part A or Part B, or coverage under spouse's group health plan or other group or individual health plan, or by court order releasing the employee from covering a dependent and ordering someone else to cover dependent	DROP	Application <u>must</u> be made within 30 days from date new coverage became effective	Official documentation of active enrollment on new plan; must show effective dates of each named dependent	Self and dependents who gained such coverage (dependents cannot remain on the OGB plan without the Employee/Retiree being covered)	The end of the month preceding the first full month in which other coverage became effective if application is timely made	N/A	YES	YES	DROP	NO; but any Health Savings Account contributions should cease once gain Medicare	NO	May decrease or deactivate amount	No change
D-5	*OGB Sponsored Medicare Advantage Plan Enrollment (Must have Medicare Part A and B)	ADD	Application must be made within 30 days from date Medicare Part B becomes effective	Official documentation of active enrollment on Medicare Part A and Part B; must show effective dates	Self and Medicare eligible spouse	First of month following the signatutre date.	N/A	YES	N/A	N/A	YES	NO	N/A	N/A

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COURT-ORDERED LEGAL GUARDIANSHIP OR COURT-ORDERED CUSTODY; QMCSO														
E-1	Qualified Medical Child Support Order (QMCSO)	ADD	30 days from date of the QMCSO or as otherwise specified by law	Copy of QMCSO and eligibility data for newly-eligible persons	Eligible Child dependent(s) covered by Order (and eligible employee if not currently enrolled)	1st of month following OGB receipt of application or as otherwise specified in the Order	Yes, only for the dependent(s) required by Order (and employee if not currently enrolled)	N/A	NO	only changes consistent with Order	YES	NO	May enroll or can increase amount	No change allowed
E-2	Court-Ordered Legal Guardianship or Court-Ordered Custody	ADD	Application <u>must</u> be made within 30 days from the date of the court-ordered legal guardianship or court-ordered custody	Certified copy of the signed court order granting custody or guardianship, and eligibility data for any newly-eligible persons	Newly Acquired Dependent(s)	The date of the court-ordered legal guardianship or custody or the effective date specified in the court order, if Application for enrollment is timely made	YES for newly-acquired dependent only	NO	NO	ADD	YES	NO	May enroll or can increase amount	May enroll or increase amount if dependent care expenses increased
E-3	Qualified Medical Child Support Order (QMCSO)	DROP	30 days from date of the Order releasing you from covering child or as otherwise specified by law.	Copy of QMCSO	Dependent child covered by Order, or Self and dependent child who was added as a result of the Order	End of month following OGB receipt of application, if application is timely made	NO	YES	YES	DROP	YES	YES, for child	May decrease or disenroll	No change allowed
E-4	Court-Ordered Legal Guardianship or Court-Ordered Custody	DROP	Application <u>must</u> be made within 30 days from date of the Order removing custody or guardianship	Copy of Order	Dependent child for whom custody or guardianship was lost	End of month following OGB receipt of timely application	NO	YES	NO	DROP	YES	YES, for child	May decrease amount or disenroll	May decrease amount if dependent care expenses decreased, or disenroll

Office of Group Benefits Plan-Recognized Qualified Life Events (QLE) 2024



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LOSS OF OTHER COVERAGE														
F-1	Lose coverage on spouse's employer-provided health insurance for any of the following reasons: 1) Spouse deceased, 2) Employment of Spouse terminated, 3) COBRA coverage under Spouse's plan terminated or expired, 4) Spouse loses employer's insurance due to no fault of the spouse, 5) Spouse terminates coverage on his/her plan during annual enrollment	ADD	Application <u>must</u> be made within 30 days from the date the health insurance ended	Documents from prior plan confirming coverage date and for whom, termination and eligibility data for any newly-eligible persons	Self and other dependent(s) who lost coverage	Date immediately following loss of previous coverage if Application for enrollment is timely made	YES to Add self and eligible dependents who lost coverage	N/A	N/A	ADD	YES	NO	May enroll or can increase amount	No change
F-2	*Eligible Dependent loses current coverage under another employment-based group health plan or individual health plan	ADD	Application <u>must</u> be made within 30 days from the date the health insurance ended (except when other coverage is Medicaid, then member has 60 days to apply)	Documents from prior plan confirming coverage termination and eligibility data for any newly-eligible persons	Self and other dependent(s) who lost coverage	Date immediately following loss of previous coverage if Application for enrollment is timely made	YES to Add eligible dependents who lost coverage or self and eligible dependent who lost coverage	N/A	N/A	ADD	YES	NO	May enroll or can increase amount	No change
F-3	Lose Medicaid or state CHIP (Children's Health Insurance Program) coverage because no longer eligible	ADD	Application <u>must</u> be made within 60 days from the date the Medicaid/CHIP health coverage ended	Official state document indicating for whom and when Medicaid/ CHIP coverage ended and eligibility data for any newly-eligible persons	Self and dependent(s) who lost coverage	Date immediately following end of Medicaid/CHIP coverage if Application is timely made	YES to add eligible dependents who lost coverage or self and eligible dependent who lost coverage	N/A	N/A	ADD	YES	N/A	May enroll or can increase amount if loss of Medicaid; no change if loss of CHIP coverage	No change
F-4	Lose another group or individual health plan sponsored by government or educational institution, including Indian Tribal government and foreign government, or other individual coverage	ADD	Application <u>must</u> be made within 30 days from the date the health insurance ended	Proof of loss of insurance on other plan, for whome and date of loss of coverage, and eligibility data for any newly-eligible persons	Self and dependent(s) who lost coverage	Date immediately following loss of previous coverage if application is timely made	YES	N/A	N/A	ADD	YES	N/A	No change	No change

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LOSS OF OTHER COVERAGE														
F-5	Member moves residence and becomes ineligible under current OGB plan	Transfer to another OGB Plan including Medicare Advantage plans	Application must be made within 30 days from date coverage ended under prior plan because of change in residence	Documentation proving date of change in residence (examples include voter registration card, homestead exemption, copy of water or electric bill, notarized attestation, etc)	Self; self and current covered dependents	First of the month following change in residence if Application is timely made	N/A (can only add persons who were previously covered)	NO	NO	CHANGE	YES	NO	No change	No change
MARRIAGE														
G-1	*Marriage	ADD	Application <u>must</u> be made within 30 days of date of marriage	Copy of certified marriage certificate and eligibility data for any newly-eligible persons	Self and new spouse and/or new stepchildren; employee may add child only if child was immediately previously covered under new spouse's insurance.	Date of the marriage if Application is timely made	YES (New Spouse and/or New Step-Children)	N/A	NO	ADD	YES	NO	May enroll or increase amount	May enroll or increase amount
G-2	Marriage	DROP	Application <u>must</u> be made within 30 days from the marriage	Copy of certified marriage certificate and proof of active enrollment on spouse's health plan	Self and current covered dependents	Coverage will be cancelled at the end of the month of marriage if timely Application for disenrollment is made	N/A	YES	YES	DROP	N/A	NO	May decrease if become covered under spouse's health plan	May decrease if spouse has Dependent FSA through his/her employer

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MILITARY LEAVE AND UNPAID LEAVE														
H-1	Employee who dropped coverage while on unpaid leave returning to work with pay from unpaid leave in same capacity	Reinstate coverage	Application <u>must</u> be made within 30 days of return to work with pay	Signed GB-01 from Employer	Can only reinstate prior election coverage	Date returns to work with paid status if Application is timely made	ADD (may add newly-acquired dependents only)	NO	N/A	Reinstate prior coverage	NO	NO	May re-enroll either: (a) at same level of benefits as before leave, which requires increased deduction amount for catch-up, or b) continue same deduction as before unpaid leave with no catch-up.	May re-enroll either: (a) at same level of benefits as before leave, which requires increased deduction amount for catch-up, or b) continue same deduction as before unpaid leave with no catch-up.
H-2	Employee on unpaid leave	DROP	Application <u>must</u> be made within 30 days of taking unpaid leave	Signed GB-01 from Employer	Self; self and current covered dependents	End of month unpaid leave begins if Application is timely made	N/A	DROP	YES	DROP	NO	NO	May pre-pay, decrease or deactivate deductions	May pre-pay, decrease or deactivate deductions
H-3	Employee on unpaid leave; elects to maintain coverage (may maintain for 12 months while on LWOP)	Retain coverage	Agency must immediately notify OGB of employee's LWOP status	Documentation (e.g., leave slip, letter on agency letterhead, or etc.) evidencing LWOP status	Self and covered dependents	N/A	NO	YES	NO	N/A	YES	NO, unless drop dependent	May pre-pay, decrease or deactivate deductions	May pre-pay, decrease or deactivate deductions
H-4	Military Employee goes on USERRA leave	DROP	Application <u>must</u> be made within 30 days of beginning USERRA leave	Signed GB-01 from Employer and any military orders, indicating when USERRA service begins	Self; self and current covered dependents	End of month that USERRA leave begins if Application is timely made	N/A	DROP	YES	DROP	NO	NO, unless drop dependent	May pre-pay, decrease or deactivate deductions	May pre-pay, decrease or deactivate deductions

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MILITARY LEAVE AND UNPAID LEAVE														
H-5	Military Employee returns from USERRA leave to full-time status.	Reinstate coverage	Application <u>must</u> be made within 30 days from re-employment or from date that Employee’s active duty military health benefits end, whichever is later	Documentation of military orders and of military health coverage end date	Can reinstate coverage for self; self and dependents who were covered prior to taking USERRA leave	Date returns to full-time active status from USERRA leave or the date that Employee’s active duty military health coverage ends, whichever is later, if Application is timely made	ADD (may only add newly acquired dependents)	N/A	N/A	Reinstate prior coverage; may also allow for a change in health plan	YES	NO	May re-enroll either; (a) at same level of benefits as before leave, which requires increased deduction amount for catch-up, or (b) continue same deduction as before military leave with no catch-up.	May re-enroll either; (a) at same level of benefits as before leave, which requires increased deduction amount for catch-up, or (b) continue same deduction as before military leave with no catch-up.
NEW HIRES AND TERMINATIONS, ACA REQUIREMENTS, AND CHANGE IN CLASSIFICATION														
I-1	New Full-Time Employee	ADD	Application <u>must</u> be made within 30 days from date of full-time employment	Signed GB-01 from Employer and eligibility data for any newly-eligible persons	Employee; employee and eligible dependent(s)	Based upon date of employment (Hire Date - 1st Day of the Month - Coverage effective on First day of the following month; Hire Date - 2nd day of the month or after - Coverage effective on the first day of the second month following employment) if Application is timely made	YES	N/A	N/A	ADD	N/A	NO	May Enroll	May Enroll
I-2	Non-Full-Time (variable, seasonal, part-time) Employee who is determined to be Full-Time at end of the Initial Measurement Period	ADD	Application <u>must</u> be made within 30 days of date of eligibility	Signed GB-01 from Employer and eligibility data for any newly-eligible persons	Employee; employee and eligible dependent(s)	First of the month following the end of the 30-day enrollment period if Application is timely made	YES	N/A	N/A	ADD	N/A	NO	May Enroll	May Enroll
I-3	Non-Full-Time (variable, seasonal, part-time) Employee who is determined to be Full-Time at end of the Standard Measurement Period	ADD	Application <u>must</u> be made within 30 days of date of eligibility	Signed GB-01 from Employer and eligibility data for any newly-eligible persons	Employee; employee and eligible dependent(s)	January 1 of following plan year if application is timely made	YES	N/A	N/A	ADD	N/A	NO	May Enroll	May Enroll

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NEW HIRES AND TERMINATIONS, ACA REQUIREMENTS, AND CHANGE IN CLASSIFICATION														
I-4	Non-Full-Time (variable, seasonal, part-time) Employee who experiences a Change in Classification to permanent Full-Time in any measurement or stability period (this requires a deliberate documented employer decision to make the employee a full-time employee)	ADD	Application <u>must</u> be made within 30 days of date of change in classification	Signed GB-01 from Employer and eligibility data for any newly-eligible persons	Employee; employee and eligible dependent(s)	First of the month following the end of the 30-day enrollment period if Application is timely made	YES	N/A	N/A	ADD	N/A	NO	May Enroll	May Enroll
I-5	Full-Time Employee returning full-time or part-time with less than 13 weeks (or less than 26 weeks for educational institutions) since Separation (this would include retirees who are rehired as WAEs)	ADD	Application <u>must</u> be made within 30 days following the return to work	Signed GB-01 from Employer and eligibility data for any newly-eligible persons	Employee; employee and eligible dependent(s)	Effective first of the month following the return of work.	YES	N/A	N/A	ADD	YES	NO	May Enroll; Original election must be kept if previously enrolled.	May Enroll; Original election must be kept if previously enrolled.
I-6	Employee changes from Full-Time status to non-Full-Time (requires deliberate documented decision to reduce hours below full time) (not in stability period)	Employee must continue coverage	Application <u>must</u> be made within 30 days of change in status confirming change in hours from Full-Time to non-Full-Time	Signed GB-01 from Employer	Employee; Employee and eligible dependent(s) would be dropped at the end of the plan year	Coverage terminates at the end of the plan year	N/A	N/A	N/A	N/A	NO	YES at the end of the plan year	Auto drop at the end of the plan year	Auto drop at the end of the plan year
I-7	Employee determined to be Full-Time during previous Measurement Period changes to Non-Full-Time under corresponding Stability Period	Employee must continue coverage	Application <u>must</u> be made within 30 days of change in status	Signed GB-01 from Employer	Employee; employee and eligible dependent(s) would be dropped at the end of the stability period on the last day of that month	Coverage terminates at the end of the stability period on the last day of that month	N/A	N/A	N/A	N/A	N/A	Upon termination of coverage	Auto drop at the end of the plan year health coverage ends	Auto drop at the end of the plan year health coverage ends

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NEW HIRES AND TERMINATIONS, ACA REQUIREMENTS, AND CHANGE IN CLASSIFICATION														
I-8	Full-time to Full-Time Transferring	Moving coverage from one OGB Participant Employer to another OGB Participant Employer (Employee may not Add or Drop coverage but may change health plans)	Transferring Participant Employer- Application to remove should be received within 30 days of transfer; New Participant Employer - Application to Add <u>must</u> be received within 30 days of hire	Signed GB-01 from the hiring Participant Employer	Employee; employee and eligible dependents	Continuous coverage, no gap. Hiring Participant's employer will assume coverage based upon date of hire. If hired the first day of the month, hiring Participant's employer will assume responsibility for plan member immediately. If hired the second day of the month, or after, the hiring Participant's employer will assume responsibility on the first of the second month following hire.	NO	NO	NO	N/A	YES	NO	May Enroll if transferring from a Non-Flex Participant Employer	May Enroll if transferring from a Non-Flex Participant Employer
I-9	Employee Terminated/separation of service (other than retirement)	DROP	30 days from the date of termination (OGB has the discretion to retroactively drop if correct premium is not timely paid and Application for disenrollment is not timely made)	GB-01 or it's electronic equivalent, signed by participant employer	Employee and all covered dependents	The end of the month in which Employee's termination is effective	N/A	YES	YES	DROP	NO	YES	Automatic Cancel on date of termination of employment	Automatic Cancel on date of termination of employment
NEW HIRES AND TERMINATIONS, ACA REQUIREMENTS, AND CHANGE IN CLASSIFICATION														
I-10	Annual Enrollment	ADD OR DROP	Annual Enrollment period designated by OGB	GB-01 or its electronic equivalent (LaGov) signed by participant employer. Retirees ONLY may submit a signed written request or enrollment form	Employee; employee and eligible dependents	January 1 of following plan year if Application is timely made	YES	YES	YES	ADD or DROP	YES	N/A	Changes allowed	Changes allowed

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OVER-AGE DEPENDENT														
J-1	Natural, Adopted or Stepchild dependent reaches attainment age for that dependent and is not capable of self-sustaining employment	Continuation of Coverage	Executed physician attestation on OGB Form "Request for Continuation of Coverage for Incapacitated Dependent Child" must be submitted prior to the dependent child reaching the age of 26	OGB Form "Request for Continuation of Coverage for Incapacitated Dependent Child"	Only child dependent currently enrolled in the plan who is reaching applicable attainment age and is incapable of self-sustaining employment by reason of physical or mental disability prior to reaching attainment age	First of the month following the child's reaching applicable attainment age if Application is timely made and accepted	N/A	N/A	N/A	N/A	NO	N/A	No change	No change
STATE PREMIUM SUBSIDY														
K-1	Obtain subsidy under state's premium assistance program	ADD	Application <u>must</u> be made within 60 days from date subsidy was awarded by state	Official state document indicating effective date when state subsidy was awarded and to whom and eligibility data for any newly-eligible persons	Self and dependent(s)	Date of award of subsidy (or effective date of subsidy if other than date of award) if Application for enrollment is timely made	YES	N/A	N/A	ADD	YES	N/A	May enroll or can increase amount	No change
RETIREMENT														
L-1	Retirement	Continuation of Coverage under current plan	Application must be made within 30 days from the date of retirement	Application	Continuation of Coverage only for Current Covered Dependents	First of the month following date of retirement	N/A	N/A	N/A	N/A	YES	N/A	NO	N/A
L-2	Retirement	DROP	Application must be made within 30 days from the date of retirement	Application	Self and covered dependents	End of month of retirement date	NO	YES	YES	DROP	YES, if drop dependent only	YES, for person dropped	NO	N/A

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RETIREMENT														
L-3	Retirement	ADD	Application must be made within 30 days from the date of retirement	Application	Eligible dependents	First of month following the date of retirement	YES (may not add Self)	N/A	N/A	N/A	YES	N/A	NO	N/A
L-4	Retirement with Medicare (Part A & B)-OGB Sponsored Medicare Advantage Plan Enrollments	ADD	Application must be made within 30 days from the date of retirement	Official documentation of active enrollment on Medicare Part A and Part B; must show effective dates	Self and Medicare eligible spouse	First of month following the signatutre date.	N/A	YES	N/A	N/A	YES	YES FSA COBRA - Yes, if account has a positive balance	NO	N/A
L-5	Rehired Retiree (with Active Retiree Coverage)	ADD	Application must be made within 30 days from the date of return to work.	Signed GB-01 from Employer	Self and eligible dependents	First of month following the return to work.	N/A	N/A	N/A	N/A	YES	NO	YES	YES
L-6**	Rehired Retiree (w/o Active Retiree Coverage)	ADD	Application must be made within 30 days from the date of return to work.	Signed GB-01 from Employer	Self and eligible dependents	Based upon date of employment (Hire Date - 1st Day of the Month - Coverage effective on First day of the following month; Hire Date - 2nd day of the month or after - Coverage effective on the first day of the second month following employment) if Application is timely made	YES	N/A	N/A	ADD	N/A	NO	YES	YES
L-7	Return to Retirement (with Active Retiree Coverage)	Continuation of Coverage	Application must be made within 30 days from the date of last day worked.	Signed GB-01 from Employer	Self and covered dependents	First of month following the date of last day worked for self-funded plans. 1st of month following signature date for MA plans.	YES	YES	N/A	N/A	YES	YES FSA COBRA Yes, if account has a positive balance	NO	N/A
L-8	Return to Retirement (w/o Active Retiree Coverage)	DROP	Application must be made within 30 days from the date of last day worked.	Signed GB-01 from Employer	Self and covered dependents	End of month following the last day worked.	NO	YES	YES	DROP	N/A	YES FSA COBRA Yes, if account has a positive balance	NO	N/A

Note: OGB reserves the right to supplement or amend the QLE chart at any time. Revised October 1, 2024

*Medicare Advantage Plans effective dates may be subject to CMS Guidelines.

** Premiums will be determined in accordance with La. R.S. 42:851 and applicable rules.