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Title 32
EMPLOYEE BENEFITS
Part I. General Provisions

Chapter 1. General Information

§101. Organizational Description

A. The Office of Group Benefits operates pursuant to R.S. 42:801 et seq. OGB is responsible for the general administration and management of all aspects of programs of benefits as authorized or provided for under the provisions of this Chapter.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 6:199 (May 1980), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:338 (February 2015), effective March 1, 2015.

§103. OGB Plan and Other Authorized Plans

A. OGB Plan and Plan Administrator. The OGB Plan is the program of benefits offered by or through OGB. OGB may offer a variety of self-funded or insured plans of benefits.

B. Other Plans: Plan Insurer and Plan Administrator. To the extent any governmental and administrative subdivisions, departments, or agencies of the executive, legislative, or judicial branches, or the governing boards and authorities of each state university, college, or public elementary and secondary school system in the state are authorized to procure private contracts of health insurance and/or operate or contract for all or a portion of the administration of a self-funded plan, such plans not directly operated or offered by OGB shall be governed by the terms and conditions of the applicable plan.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:338 (February 2015), effective March 1, 2015.

**Chapter 3. Uniform
Provisions—Participation in the
Office of Group Benefits**

**§301. Eligibility for Participation in OGB Health
Coverage and Life Insurance
[Formerly §303]**

A. Employees of a public entity who participate in the Louisiana State Employees Retirement System, Louisiana Teacher's Retirement System, State Police Pension and Retirement System, or the Louisiana School Employees Retirement System due to their status as an employee of such public entity are eligible to participate in OGB group

benefit programs pursuant to R.S. 42:808. No individual may participate in a program sponsored by OGB unless the school board, state agency or political subdivision through which the individual is actively employed or retired participates in OGB as a group.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Board of Trustees, State Employees Group Benefits Program, LR 6:199 (May 1980), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:338 (February 2015), effective March 1, 2015.

**§303. Enrollment Procedures for Participation in OGB
Health Coverage and Life Insurance**

A. Any state agency, school board, political subdivision, or other entity that seeks to participate in programs offered through OGB shall comply with the following.

1. The head of the agency shall submit a written request to OGB to commence participation in its programs, together with a resolution of authorization from the board, commission, or other governing authority, if applicable.

2. The request for participation shall be reviewed to verify the eligibility of the requesting agency.

3. The requesting agency shall obtain an experience rating from OGB.

a. The requesting agency shall submit claims experience under its prior plan for the 36-month period immediately prior to its application together with the required advance payment for the experience rating.

b. The actuarial consultant serving OGB shall conduct the experience rating and determine the premiums due.

c. For any state agency, school board, political subdivision, or other eligible entity that elects to participate in the OGB health and accident programs after participation in another group health and accident insurance program, the premium rate applicable to the employees and former employees of such group shall be the greater of the premium rate based on the loss experience of the group under the prior plan or the premium rate based on the loss experience of the classification into which the group is entering.

d. In the event that the initial premium is based on the loss experience of the group under the prior plan, such premium shall remain in effect for three years and then convert to the published rate for all other OGB enrollees.

B. Open enrollment is a period of time, designated by OGB, during which an eligible employee or retiree may enroll for benefits under an OGB plan. OGB will hold open

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enrollment for a coverage effective date of January 1 or such other date as may be determined by OGB. Transfer of coverage will only be allowed during open enrollment, unless otherwise allowed or required by OGB or state or federal law.

C. Any state agency, school board, political subdivision, or other eligible entity that elects to participate in the OGB health program remains responsible for its own compliance with enrollment and coverage requirements of the federal Patient Protection and Affordable Care Act.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:338 (February 2015), effective March 1, 2015, amended LR 41:2349 (November 2015), effective January 1, 2016.

§305. Retiree Eligibility

A. For the purpose of determining eligibility to participate in OGB health coverage and life insurance, the term *retiree* shall refer only to an individual who was an enrollee immediately prior to the date of retirement and who, upon retirement, satisfied one of the following categories:

1. immediately received a retirement plan distribution from an approved state or governmental agency defined benefit plan;

2. was not eligible for participation in such plan or legally opted not to participate in such plan, and either:

a. began employment prior to September 15, 1979, has 10 years of continuous state service, and has reached the age of 65;

b. began employment after September 15, 1979, has 10 years of continuous state service, and has reached the age of 70;

c. began employment after July 8, 1992, has 10 years of continuous state service, has a credit for a minimum of 40 quarters in the Social Security system at the time of employment, and has reached the age of 65; or

d. maintained continuous coverage with an OGB plan of benefits as an eligible dependent until he/she became eligible to receive a retirement plan distribution from an approved state governmental agency defined benefit plan as a former state employee; or

3. immediately received a retirement plan distribution from a state-approved or state governmental agency approved defined contribution plan and has accumulated the total number of years of creditable service which would have entitled him/her to receive a retirement plan distribution from the defined benefit plan of the retirement system for which the employee would have otherwise been eligible. The appropriate state governmental agency or retirement system responsible for administration of the defined contribution plan is responsible for certification of eligibility to OGB.

B. Retiree also means an individual who was a covered employee and continued the coverage through the provisions of COBRA immediately prior to the date of retirement and who, upon retirement, qualified for any of Paragraphs 1, 2, or 3 above.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:339 (February 2015), effective March 1, 2015, amended LR 41:2349 (November 2015), effective January 1, 2016.

§307. Persons to be Covered

A. Employee Coverage

1. For the purpose of determining eligibility to participate in OGB health coverage and life insurance, the term *employee* shall refer to a full-time employee as defined by a participating employer and in accordance with federal and state law.

2. Covered Persons, Both Employees. No one may be enrolled simultaneously as an employee and as a dependent under an OGB plan, nor may a dependent be covered as a dependent of more than one employee. If a covered dependent is eligible for coverage as an employee, he/she may choose to be covered separately at a later OGB designated enrollment period. Coverage shall be effective as directed by the OGB designated enrollment period.

3. Effective Dates of Coverage, New Employee, Transferring Employee. Coverage for each employee who follows the OGB procedures for enrollment and agrees to make the required payroll contributions to his/her participating employer is effective as follows:

a. if employment begins on the first day of the month, coverage is effective on the first day of the following month (for example, if employment begins on July 1, coverage will begin on August 1);

b. if employment begins on or after the second day of the month, coverage is effective on the first day of the second month following employment (for example, if employment begins on July 15, coverage will begin on September 1);

c. employee coverage will not become effective unless the employee completes an enrollment form within 30 days following the date employment begins;

d. an employee who transfers employment to another participating employer shall complete a transfer form within 30 days following the date of transfer to maintain coverage without interruption.

4. Effective Dates of Coverage, Existing Employee. Existing employees may only enroll in a plan during open enrollment or as otherwise specified by the OGB health plan document. Coverage for the employee will be effective on the first day of the new plan year or on the date set forth in the OGB health plan document.

5. Re-Enrollment Previous Employment for Health Benefits and Life Insurance

a. An employee whose employment terminated while covered who is re-employed within 12 months of the date of termination will be considered a re-enrollment previous employment applicant.

b. If an employee acquires an additional dependent during the period of termination, that dependent may be covered if added within 30 days of re-employment.

6. Members of Boards and Commissions. Except as otherwise provided by law, members of boards or commissions are not eligible for participation in an OGB plan of benefits. This Section does not apply to members of school boards or members of state boards or commissions who are determined by the participating employer and in accordance with federal and state law to be full-time employees.

7. Legislative Assistants. Legislative assistants are eligible to participate in an OGB plan if they are determined to be full-time employees by the participating employer under applicable federal and state law or pursuant to R.S. 24:31.5(C), either:

a. receive at least 60 percent of the total compensation available to employ the legislative assistant if a legislator employs only one legislative assistant; or

b. is the *primary legislative assistant* as defined in R.S. 24:31.5(C) when a legislator employs more than one legislative assistant.

B. Retiree Coverage

1. Eligibility

a. Retirees of participating employers are eligible for retiree coverage under an OGB plan.

b. An employee retired from a participating employer may not be covered as an active employee.

c. Coverage for re-employed retirees is governed by LAC 32:I.323.B, Employer Responsibility.

2. Effective Date of Coverage

a. Retiree coverage will be effective on the first day of the month following the date of retirement if the retiree and participating employer have agreed to make and are making the required contributions. For purposes of eligibility, the date of retirement shall be the date the person is eligible to receive a retirement plan distribution. (For example, if date of retirement is July 15, retiree coverage will begin August 1; if date of retirement is August 1, retiree coverage will begin September 1.)

C. Documented Dependent Coverage

1. Eligibility. A documented dependent, in the OGB primary plan document, of an eligible employee or retiree will be eligible for dependent coverage on the later of the following dates:

a. date the employee becomes eligible;

b. date the retiree becomes eligible; or

c. date the covered employee or covered retiree acquires a dependent.

2. Effective Dates of Coverage. Application for coverage is required to be made within 30 days of eligibility for coverage.

a. Documented Dependents of Employees. Coverage will be effective on the date of marriage for new spouses, the date of birth for newborn children, or the date acquired for other classifications of dependents, if application is made within 30 days of the date of eligibility.

b. Documented Dependents of Retirees. Coverage for dependents of retirees who were covered immediately prior to retirement will be effective on the first day of the month following the date of retirement. Coverage for dependents of retirees first becoming eligible for dependent coverage following the date of retirement will be effective on the date of marriage for new spouses, the date of birth for newborn children, or the date acquired for other classifications of dependents, if application is made within 30 days of the date of eligibility.

D. Special Enrollments—HIPAA. Certain eligible persons may enroll as provided for by HIPAA under circumstances, terms, and conditions for special enrollments.

E. Health Maintenance Organization (HMO) Option. In lieu of participating in an OGB self-funded health plan, enrollees may elect coverage under an OGB offered fully insured HMO.

F. Medicare Advantage Option for Retirees (effective January 1, 2016)

1. Retirees who are eligible to participate in an OGB sponsored Medicare Advantage plan who cancel participation in an OGB plan of benefits upon enrollment in an OGB sponsored Medicare Advantage plan may re-enroll in an OGB offered plan of benefits upon withdrawal from or termination of coverage in the Medicare Advantage plan at Medicare's open enrollment or OGB's open enrollment period.

2. Retirees who elect to participate in a Medicare Advantage plan not sponsored by OGB will not be allowed to re-enroll in a plan offered by OGB upon withdrawal from or termination of coverage in the Medicare Advantage plan.

G. Tricare for Life Option for Military Retirees. Retirees eligible to participate in the Tricare for Life (TFL) option on and after October 1, 2001 who cancel participation in an OGB plan of benefits upon enrollment in TFL may re-enroll in an OGB offered plan of benefits in the event that the TFL option is discontinued or its benefits are significantly reduced.

H. Eligibility requirements apply to all participants in OGB health coverage and life insurance programs.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:339 (February 2015), effective March 1, 2015, amended LR 41:2350 (November 2015), effective January 1, 2016.

§309. Medicare and OGB

A. When an individual is covered by an OGB plan of benefits and by Medicare, Medicare laws and regulations govern the order of benefit determination, that is, whether Medicare is the primary or secondary payer.

B. Except as provided in Subsection C (below), when an individual is covered by an OGB plan of benefits and by Medicare, and:

1. an OGB plan of benefits is the primary payer, benefits will be paid without regard to Medicare coverage;

2. Medicare is the primary payer, eligible expenses under an OGB plan of benefits will be limited to the amount allowed by Medicare, less the amount paid or payable by Medicare. All provisions of an OGB plan of benefits, including all provisions related to deductibles, co-insurance, limitations, exceptions, and exclusions will be applied.

C. The following applies to retirees and their covered spouses who attain or have attained the age of 65 on or after July 1, 2005, and who have no other group health coverage through present (active) employment.

1. A retiree or spouse of a retiree who attains or has attained age 65 when either has sufficient earnings credits to be eligible for Medicare, shall enroll in Medicare Part A and Medicare Part B in order to receive benefits under an OGB plan except as specifically provided in Paragraph 2, below.

2. If such retiree or spouse of a retiree is not enrolled in Medicare Part A and Medicare Part B, no benefits will be paid or payable under an OGB plan of benefits except benefits payable as secondary to the part of Medicare in which the individual is enrolled.

D. A retiree and spouse of a retiree who do not have sufficient earnings credits to be eligible for Medicare shall provide written verification from the Social Security Administration or its successor.

E. Medicare Coordination of Benefits (Retiree 100). Upon enrollment and payment of the additional monthly premium, an enrollee and dependents who are covered under Medicare Parts A and B (both) may choose to have full coordination of benefits with Medicare. Enrollment shall be made within 30 days of eligibility for Medicare, within 30 days of retirement if already eligible for Medicare, or at open enrollment.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:340 (February 2015), effective March 1, 2015.

§311. Reinstatement to Position Following Civil Service Appeal

A. Self-Funded Plan Participants. When coverage of a terminated employee who was enrolled in an OGB self-funded plan is reinstated by reason of a civil service appeal, coverage will be reinstated to the same level in the OGB plan of benefits retroactive to the date coverage terminated. The employee and participating employer are responsible for the payment of all premiums for the period of time from the date of termination to the date of the final order reinstating the employee to his/her position. The OGB plan is responsible for the payment of all eligible benefits for charges incurred during this period. All claims for expenses incurred during this period shall be filed with the OGB plan within 60 days following the date of the final order of reinstatement.

B. Fully Insured HMO Participants. When coverage of a terminated employee who was enrolled in a fully insured HMO is reinstated by reason of a civil service appeal, coverage will be reinstated in the fully insured HMO in which the employee was participating effective on the date of the final order of reinstatement. There will be no retroactive reinstatement of coverage and no premiums will be owed for the period during which coverage with the fully insured HMO was not effective.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:340 (February 2015), effective March 1, 2015.

§313. Enrollee Coverage Termination

A. An enrollee may terminate coverage as set forth in the applicable OGB health plan document. Applications made by active enrollees shall be provided to their HR liaison and applications made by retired enrollees shall be provided to OGB.

B. An Enrollee may terminate coverage during an OGB designated enrollment period. Application is required to be made as directed for the OGB designated enrollment period.

C. Subject to continuation of coverage and COBRA rules, all benefits of an enrollee will terminate, without application, under plans offered by OGB on the earliest of the following dates:

1. date OGB terminates;
2. date the group or agency employing the enrollee terminates or withdraws from OGB;
3. date contribution is due if the group or agency fails to pay the required contribution for the enrollee;
4. date contribution is due if the enrollee fails to make any contribution which is required for the continuation of coverage;
5. last day of the month of the enrollee's death; or
6. last day of the month in which the enrollee is eligible for OGB plan coverage.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:341 (February 2015), effective March 1, 2015, amended LR 41:2350 (November 2015), effective January 1, 2016.

§315. Dependent Coverage Termination

A. An enrollee may terminate dependent coverage as set forth in the applicable OGB health plan document. Applications made by active enrollees shall be provided to their HR liaison and applications made by retired enrollees shall be provided to OGB.

B. An enrollee may terminate dependent coverage during an OGB designated enrollment period. Application is required to be made as directed for the OGB designated enrollment period.

C. Subject to continuation of coverage and COBRA rules, dependent coverage will terminate, without application, under any OGB plan of benefits on the earliest of the following dates:

1. last day of the month the enrollee is covered;
2. last day of the month in which the dependent, as defined by OGB, is an eligible dependent of the enrollee;
3. for grandchildren for whom the enrollee does not have court ordered legal custody or has not adopted, on the date the child's parent loses eligibility under the respective OGB health; or
4. upon discontinuance of all dependent coverage under OGB plans.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:341 (February 2015), effective March 1, 2015, amended LR 41:2351 (November 2015), effective January 1, 2016.

§317. Change of Classification

A. Adding or Deleting Dependents. When a dependent is added to the enrollee's coverage due to a HIPAA special enrollment event or deleted from the enrollee's coverage consistent with a change in the dependent's status, as set forth in the applicable OGB health plan document, applications made by active enrollees shall be provided to their HR liaison and applications made by retired enrollees shall be provided to OGB. Application is required to be made within 30 days of the event unless a longer application period is required by federal or state law.

B. When a dependent is added to or deleted from the enrollee's coverage during an OGB designated enrollment period, application is required to be made as directed for the OGB designated enrollment period.

C. Effective Date of Change in Classification

1. When adding a dependent due to a HIPAA special enrollment event results in a change in classification, the

change in classification will be effective on the date of the event.

2. When the addition of a dependent changes the classification of coverage, the new premium rate will be charged for the entire month if the date of the HIPAA special enrollment event occurs before the fifteenth day of the month. If the date of the HIPAA special enrollment event occurs on or after the fifteenth day of the month, the new premium rate will not be charged until the first day of the following month.

D. Notification of Change. It is the enrollee's responsibility to make application for any change in classification of coverage that affects the enrollee's contribution amount.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:341 (February 2015), effective March 1, 2015, amended LR 41:2351 (November 2015), effective January 1, 2016, amended LR 42:51 (January 2016).

§319. Continued Coverage

A. Leave of Absence. If an enrollee is allowed an approved leave of absence by his/her participating employer, the enrollee may retain the coverage for up to one year if the premium is paid. Failure to pay the premium will result in cancellation of coverage. The enrollee and/or the participating employer shall notify OGB within 30 days of the effective date of the leave of absence.

1. Leave of Absence without Pay, Employer Contributions to Premiums

a. An enrollee who is granted leave of absence without pay due to a service related injury may continue coverage and the participating employer shall continue to pay its portion of health plan premiums for up to 12 months.

b. An enrollee who suffers a service related injury that meets the definition of a total and permanent disability under the workers' compensation laws of Louisiana may continue coverage and the participating employer shall continue to pay its portion of the premiums until the enrollee becomes gainfully employed or is placed on state disability retirement.

c. An enrollee who is granted leave of absence without pay in accordance with the federal Family and Medical Leave Act (F.M.L.A.) may continue coverage during the time of such leave and the participating employer shall continue to pay its portion of premiums if the enrollee continues his/her coverage.

2. Leave of Absence without Pay; No Employer Contributions to Premiums. An enrollee granted leave of absence without pay for reasons other than those stated in Paragraph A.1, may continue to participate in an OGB plan for a period up to 12 months upon the enrollee's payment of the full premiums due.

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B. Disability. Enrollees who have been granted a waiver of premium for basic or supplemental life insurance prior to July 1, 1984, may continue OGB plan coverage for the duration of the waiver if the enrollee pays the total contribution to the participating employer. Disability waivers were discontinued effective July 1, 1984.

C. Surviving Spouse/Dependents

1. Benefits under an OGB plan of benefits for covered dependents of a deceased enrollee will terminate on the last day of the month in which the enrollee's death occurred unless the surviving covered dependents elect to continue coverage.

a. The surviving legal spouse of an enrollee may continue coverage unless or until the surviving spouse is or becomes eligible for coverage in a group health plan other than Medicare.

b. The surviving dependent child of an enrollee may continue coverage unless or until such dependent child is or becomes eligible for coverage under a group health plan other than Medicare or until attainment of the termination age for children, whichever occurs first.

c. Surviving dependents will be entitled to receive the same participating employer premium contributions as enrollees, subject to the provisions of *Louisiana Revised Statutes*, title 42, section 851 and rules promulgated pursuant thereto by OGB.

d. Coverage provided by the Civilian Health and Medical Program for the Uniformed Service (CHAMPUS/TRICARE) or successor program will not be sufficient to terminate the coverage of an otherwise eligible surviving legal spouse or dependent child.

2. A surviving spouse or dependent child cannot add new dependents to continued coverage other than a child of the deceased enrollee born after the enrollee's death.

3. Participating Employer/Dependent Responsibilities

a. To continue coverage, it is the responsibility of the participating employer and surviving covered dependent to notify OGB within 60 days of the death of the enrollee.

b. OGB will notify the surviving dependents of their right to continue coverage.

c. Application for continued coverage shall be made in writing to OGB within 60 days of receipt of notification. Premiums for continued coverage shall be paid within 45 days of the coverage application date for the coverage to be effective on the date coverage would have otherwise terminated.

d. Coverage for the surviving spouse under this section will continue until the earliest of the following:

i. failure to pay the applicable premium timely;
or

ii. eligibility of the surviving spouse for coverage under a group health plan other than Medicare.

e. Coverage for a surviving dependent child under this Section will continue until the earliest of the following events:

i. failure to pay the applicable premium timely;

ii. eligibility of the surviving dependent child for coverage under any group health plan other than Medicare; or

iii. the attainment of the termination age for children.

4. The provisions of Paragraphs 1 through 3 of this Subsection are applicable to surviving dependents who, on or after July 1, 1999, elect to continue coverage following the death of an enrollee. Continued coverage for surviving dependents who made such election before July 1, 1999, shall be governed by the rules in effect at the time.

5. Dependent Spouse of Deceased Retiree (Special Spouse).

a. Notwithstanding the above, any person who previously participated in an OGB sponsored health program as a dependent spouse of a deceased retiree immediately prior to enrolling in an OGB sponsored health program as an active employee, shall, upon termination from state service, be eligible to obtain OGB health coverage as a special spouse provided all of the following conditions are met:

i. The person is enrolled in OGB health coverage as an active employee as of July 1, 2024.

ii. The person remains enrolled in OGB health coverage continuously until immediately prior to the date of termination.

iii. The person would have had surviving spouse coverage at the time of death of the retiree spouse but for his or her eligibility for coverage in a group health plan other than Medicare.

iv. The person pays the requisite premiums.

b. A special spouse shall be entitled to receive a state contribution to premiums that is the percentage of the total premium as provided for in applicable OGB rules. The employer premium contributions for a special spouse shall be the responsibility of the school board, state agency, or political subdivision from which the deceased retiree spouse originally retired.

c. A special spouse cannot add new dependents to special spouse coverage other than a child of the deceased retiree born after the enrollee's death.

d. A dependent child of a special spouse and the deceased retiree may continue coverage as a dependent child of the special spouse as long as other dependent child rules are met.

e. Participating Employer/Dependent Responsibilities

i. To continue coverage, it is the responsibility of the participating employer and special spouse to notify OGB

in writing within 30 days of the termination of employment from state service.

ii. Application for continued coverage shall be made in writing to OGB within 45 days of the termination of employment from state service. Premiums for special spouse coverage shall be paid within 45 days of the coverage application date for the coverage to be effective on the date coverage would have otherwise terminated.

iii. Coverage for the special spouse under this Paragraph will continue until the earliest of the following:

(a). failure to pay the applicable premium timely;

or

(b). eligibility of the special spouse for coverage under a group health plan other than Medicare.

iv. Coverage for a dependent child eligible for coverage under this Paragraph will continue until the earliest of the following events:

(a). failure to pay the applicable premium timely;

(b). eligibility of the special spouse for coverage under a group health plan other than Medicare;

(c). eligibility of the dependent child for coverage under any group health plan other than Medicare; or

(d). the attainment of the termination age for children.

D. Over-Age Dependents. If a dependent child who is the natural or adopted child of the enrollee is incapable of self-sustaining employment by reason of mental or physical incapacity and became incapable prior to attainment of age 26, the coverage for that dependent child may be continued for the duration of incapacity.

1. Prior to such dependent child's attainment of age 26, an application for continued coverage is required to be submitted to OGB together with current medical information from the dependent child's attending physician to establish eligibility for continued coverage.

2. OGB may require additional medical documentation regarding the dependent child's incapacity upon receipt of the application for continued coverage and as often as it may deem necessary thereafter.

3. The incapacity determination shall be a medical determination subject to the appeal procedures of the enrollee's plan of benefits.

E. Military Service. Members of the National Guard or of the United States military reserves who are called to active military duty and who are OGB enrollees or covered dependents will have access to continued coverage under OGB's health and life plans of benefits.

1. Health Plan Participation. When called to active military duty, enrollees and covered dependents may:

a. continue participation in any OGB self-funded plan during the period of active military service and the

participating employer may continue to pay its portion of premiums; or

b. cancel participation in any OGB self-funded plan during the period of active military service and apply for reinstatement of OGB coverage within 30 days of:

i. the date of the enrollee's reemployment with a participating employer;

ii. the dependent's date of discharge from active military duty; or

iii. the date of termination of extended health coverage provided as a benefit of active military duty, such as TRICARE Reserve Select.

2. Plan participants who elect this option and timely apply for reinstatement of OGB coverage will not experience any adverse consequences with respect to the participation schedule set forth in R.S. 42:851(E) and the corresponding rules promulgated by OGB.

3. Life Insurance. When called to active military duty, enrollees with OGB life insurance coverage may:

a. continue participation in OGB life insurance during the period of active military service, but the accidental death and dismemberment coverage will not be in effect during the period of active military duty; or

b. cancel participation in OGB life insurance during the period of active military service and the enrollee may apply for reinstatement of OGB life insurance within 30 days of the date of the enrollee's reemployment with a participating employer; enrollees who elect this option and timely apply for reinstatement of OGB life insurance will not be required to provide evidence of insurability.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:341 (February 2015), effective March 1, 2015, amended LR 43:2152 (November 2017), effective January 1, 2018, amended LR 50:1822 (December 2024).

§321. COBRA

A. Employees

1. Coverage under OGB for an enrollee will terminate on the last day of the calendar month during which employment is terminated (voluntarily or involuntarily) or significantly reduced, the enrollee no longer meets the definition of an employee, or coverage under a leave of absence has expired, unless the enrollee elects to continue coverage at the enrollee's own expense. Employees terminated for gross misconduct are not eligible for COBRA coverage.

2. It is the responsibility of the participating employer to notify OGB within 30 days of the date coverage would have terminated because of any of the foregoing events, and OGB will notify the enrollee within 14 days of his/her right to continue coverage.

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3. Application for continued coverage shall be made in writing to OGB within 60 days of the date of the election notification and premium payment shall be made within 45 days of the date the employee elects continued coverage, for coverage retroactive to the date coverage would have otherwise terminated. After the first payment, monthly payments for COBRA coverage are due on the first day of the month for that month's coverage. A grace period of 30 days after the first day of the month will be provided for each monthly payment.

4. Coverage under this section will continue until the earliest of the following:

- a. failure to pay the applicable premium timely;
 - b. 18 months from the date coverage would have otherwise terminated;
 - c. entitlement to Medicare;
 - d. date coverage begins under a group health plan;
- or
- e. the employer ceases to provide any group health plan coverage for its employees.

5. If employment for a covered employee is terminated (voluntarily or involuntarily) or significantly reduced, the enrollee no longer meets the definition of an employee, or a leave of absence has expired, and the employee has not elected to continue coverage, the covered dependents may elect to continue coverage at his/her/their own expense. The elected coverage will be subject to the above-stated notification and termination provisions.

B. Surviving Dependents

1. Coverage under an OGB plan for covered surviving dependents will terminate on the last day of the month in which the enrollee's death occurs, unless the surviving covered dependents elect to continue coverage at their own expense.

2. It is the responsibility of the participating employer or surviving covered dependents to notify OGB within 30 days of the death of the enrollee. OGB will notify the surviving dependents of their right to continue coverage. Application for continued coverage shall be made in writing to OGB within 60 days of the date of the election notification.

3. Premium payment shall be made within 45 days of the date the continued coverage was elected, retroactive to the date coverage would have terminated. After the first payment for COBRA coverage, monthly payments for each subsequent month of COBRA coverage are due on the first day of the month for that month's COBRA coverage. A grace period of 30 days after the first day of the month will be provided for each monthly payment.

4. Coverage for the surviving dependents under this section will continue until the earliest of the following:

- a. failure to pay the applicable premium timely;

- b. 36 months beyond the date coverage would have otherwise terminated;

- c. entitlement to Medicare;

- d. date coverage begins under a group health plan;

or

- e. the employer ceases to provide any group health plan coverage for its employees.

C. Divorced Spouse

1. Coverage under OGB for an enrollee's spouse will terminate on the last day of the month during which dissolution of the marriage occurs by virtue of a legal decree of divorce from the enrollee, unless the covered divorced spouse elects to continue coverage at his/her own expense.

2. It is the responsibility of the divorced spouse to notify OGB within 60 days from the date of divorce and OGB will notify the divorced spouse within 14 days of his/her right to continue coverage. Application for continued coverage shall be made in writing to OGB within 60 days of the election notification.

3. Premium payment shall be made within 45 days of the date continued coverage is elected, for coverage retroactive to the date coverage would have otherwise terminated. After the first payment for COBRA coverage, monthly payments for each subsequent month of COBRA coverage are due on the first day of the month for that month's COBRA coverage. A grace period of 30 days after the first day of the month will be provided for each monthly payment.

4. Coverage for the divorced spouse under this Section will continue until the earliest of the following:

- a. failure to pay the applicable premium timely;

- b. 36 months beyond the date coverage would have otherwise terminated;

- c. entitlement to Medicare;

- d. date coverage begins under a group health plan;

or

- e. the employer ceases to provide any group health plan coverage for its employees.

D. Dependent Children

1. Coverage under an OGB plan for a covered dependent child of an enrollee will terminate on the last day of the month during which the dependent child no longer meets the definition of an eligible covered dependent, unless the dependent elects to continue coverage at his/her own expense.

2. It is the responsibility of the dependent to notify OGB within 60 days of the date coverage would have terminated and OGB will notify the dependent within 14 days of his/her right to continue coverage. Application for continued coverage shall be made in writing to OGB within 60 days of receipt of the election notification.

3. Premium payment shall be made within 45 days of the date the continued coverage is elected, for coverage retroactive to the date coverage would have otherwise terminated. After the first payment for COBRA coverage, monthly payments for each subsequent month of COBRA coverage are due on the first day of the month for that month's COBRA coverage. A grace period of 30 days after the first day of the month will be provided for each monthly payment.

4. Coverage for children under this section will continue until the earliest of the following:

- a. failure to pay the applicable premium timely;
 - b. 36 months beyond the date coverage would have otherwise terminated;
 - c. entitlement to Medicare;
 - d. date coverage begins under a group health plan;
- or
- e. the employer ceases to provide any group health plan coverage for its employees.

E. Dependents of COBRA Participants

1. If a covered terminated employee has elected to continue coverage for him/herself and covered dependents, and the enrollee dies, divorces his/her spouse, or the covered dependent child no longer meets the definition of an eligible dependent during the COBRA coverage period, then the dependents may elect to continue COBRA coverage. Coverage will not be continued beyond 36 months from the employee terminated.

2. It is the responsibility of the spouse and/or the dependent child to notify OGB within 60 days of the date COBRA coverage would have terminated.

3. Monthly payments for each month of COBRA coverage are due on the first day of the month for that month's COBRA coverage. A grace period of 30 days after the first day of the month will be provided for each monthly payment.

4. Coverage for children under this section will continue until the earliest of the following:

- a. failure to pay the applicable premium timely;
 - b. 36 months beyond the date coverage would have otherwise terminated;
 - c. entitlement to Medicare;
 - d. date coverage begins under a group health plan;
- or
- e. the employer ceases to provide any group health plan coverage for its employees.

F. Disability COBRA

1. If a plan participant is determined by the Social Security Administration or by OGB (in the case of a person who is ineligible for Social Security disability benefits due to insufficient "quarters" of employment), to have been

totally disabled on the date the plan participant became eligible for continued coverage or within the initial 18 months of coverage, coverage under an OGB plan for the plan participant who is totally disabled may be extended at his/her own expense up to a maximum of 29 months from the date the plan participant first became eligible for COBRA coverage.

2. To qualify, the plan participant shall:

a. submit a copy of his/her Social Security Administration's disability determination to OGB before the initial 18-month continued coverage period expires and within 60 days after the latest of:

- i. the date of issuance of the Social Security Administration's disability determination; or
- ii. the date on which the plan participant loses (or would lose) coverage under the terms of the OGB plan as a result of the enrollee's termination or reduction of hours;

b. in the case of a person who is ineligible for Social Security disability benefits due to insufficient "quarters" of employment, submit proof of total disability to OGB before the initial 18-month continued coverage period expires. OGB will make the determination of total disability based upon medical evidence, not conclusions, presented by the applicant's physicians, work history, and other relevant evidence presented by the applicant.

3. For purposes of eligibility for continued coverage under this section, total disability means the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to last for a continuous period of 12 months. To meet this definition one shall have a severe impairment which makes one unable to do his/her previous work or any other substantial gainful activity which exists in the national economy, based upon a person's residual functional capacity, age, education, and work experience.

4. Monthly payments for each month of extended COBRA coverage are due on the first day of the month for that month's COBRA coverage. A grace period of 30 days after the first day of the month will be provided for each monthly payment.

5. Coverage under this Section will continue until the earliest of the following:

- a. failure to pay the applicable premium timely;
- b. 29 months from the date coverage would have otherwise terminated;
- c. entitlement to Medicare;
- d. date coverage begins under a group health plan;
- e. the employer ceases to provide any group health plan coverage for its employees; or
- f. 30 days after the month in which the Social Security Administration determines that the plan participant is no longer disabled. (The plan participant shall report the determination to OGB within 30 days after the date of

issuance by the Social Security Administration.) In the case of a person who is ineligible for Social Security disability benefits due to insufficient "quarters" of employment, 30 days after the month in which OGB determines that the plan participant is no longer disabled.

G. Medicare COBRA

1. If an enrollee becomes entitled to Medicare less than 18 months before the date the enrollee's eligibility for benefits under OGB terminates, the period of continued coverage available for the enrollee's covered dependents will continue until the earliest of the following:

- a. failure to pay the applicable premium timely;
 - b. 36 months from the date of the enrollee's Medicare entitlement;
 - c. entitlement to Medicare;
 - d. date coverage begins under a group health plan;
- or
- e. the employer ceases to provide any group health plan coverage for its employees.

2. Monthly payments for each month of COBRA coverage are due on the first day of the month for that month's COBRA coverage. A grace period of 30 days after the first day of the month will be provided for each monthly payment.

H. Miscellaneous Provisions

1. During the COBRA coverage period, benefits will be identical to those provided to others enrolled in an OGB plan under its standard eligibility provisions for enrollees.

2. In the event OGB contracts for COBRA administration services, OGB may direct each plan participant eligible for COBRA coverage to follow the directions provided by OGB's COBRA administrator.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:343 (February 2015), effective March 1, 2015.

§323. Employer Responsibility

A. It is the responsibility of the participating employer to submit timely enrollment and coverage changes using OGB's electronic enrollment system or other approved submission method, and to review and certify all necessary documentation to OGB on behalf of its employees. Employees of a participating employer will not, by virtue of furnishing any documentation to OGB be considered agents of OGB, and no representation made by any participating employer at any time will change the provisions of an OGB plan of benefits.

B. A participating employer shall immediately inform OGB when a retiree with OGB coverage returns to benefit-eligible employment. The enrollee shall be placed in the re-employed retiree category for premium calculation. The re-employed retiree premium classification applies to retirees

with and without Medicare. The premium rates applicable to the re-employed retiree premium classification shall be identical to the premium rates applicable to the classification for retirees without Medicare. If the re-employed retiree suspends retirement benefits and returns to benefit-eligible employment with the agency from which the re-employed retiree originally retired, the employee portion of the premium shall be withheld by payroll deduction and the employing agency shall remain responsible for the employer portion of the premium. If the re-employed retiree suspends retirement benefits and returns to benefit-eligible employment with an OGB participating agency other than the agency from which the re-employed retiree originally retired, the employee portion of the premium shall be withheld by payroll deduction, and the employing agency shall be responsible for the employer portion of the premium throughout the duration of employment. If the re-employed retiree returns to benefit-eligible employment, yet does not suspend retirement benefits as allowed by law, the employee portion of the premium shall be withheld by payroll deduction, and the employing OGB participating agency shall be responsible for the employer portion of the premium throughout the duration of employment. When the re-employed retiree separates from employment with the OGB participating employer, the employer shall notify OGB of such separation within 30 days. After the re-employed retiree again separates from employment with an OGB participating employer, the agency from which the re-employed retiree originally retired shall again be responsible for the employer portion of the premium.

C. A participating employer that receives a Medicare secondary payer (MSP) collection notice or demand letter shall deliver the MSP notice to OGB within 15 days of receipt. If timely forwarded, OGB will assume responsibility for medical benefits, interest, fines and penalties due to Medicare for a plan participant. If not timely forwarded, OGB will assume responsibility only for covered plan benefits due to Medicare for a plan participant. The participating employer will be responsible for interest, fines, and penalties due.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:345 (February 2015), effective March 1, 2015, amended LR 41:2351 (November 2015), effective January 1, 2016, LR 43:2152 (November 2017), effective January 1, 2018.

Chapter 5. Uniform Provisions—Plan Administration

§501. Claims

A. To obtain the highest level of benefits available, the plan participant should always verify that a provider is a current network provider in the enrollee's plan of benefits before the service is rendered.

B. For OGB plan of benefits reimbursements, a claim shall include:

1. enrollee's name;
2. name of patient;
3. name, address, and telephone number of the provider of care;
4. diagnosis;
5. type of services rendered, with diagnosis and/or procedure codes that are valid and current for the date of service;
6. date and place of service;
7. charges;
8. enrollee's plan of benefits identification number;
9. provider tax identification number;
10. Medicare explanation of benefits, if applicable.

C. OGB or its agent may require additional documentation in order to determine the extent of coverage or the appropriate reimbursement. Failure to furnish information within the time period allowed by the respective OGB plan of benefits may constitute a reason for the denial of benefits.

D. A claim for benefits, under any self-funded plan of benefits offered by OGB shall be received by the enrollee's plan of benefits within one year from the date on which the medical expenses were incurred. The receipt date for electronically filed claims is the date on which the enrollee's plan of benefits receives the claim, not the date on which the claim is submitted to a clearinghouse or to the provider's practice management system.

E. Requests for review of payment or corrected bills shall be submitted within 12 months of receipt date of the original claim. Requests for review of payment or corrected bills received after that time will not be considered.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:345 (February 2015), effective March 1, 2015.

§503. Right to Receive and Release Information

A. To the extent permitted by federal or state law, OGB or its contractors may release to or obtain from any company, organization, or person, any information regarding any person which OGB or its contractors deem necessary to carry out the provisions of any OGB plan, or to determine how, or if, they apply. Any claimant under any OGB plan shall furnish OGB or its contractors with any information necessary to implement this provision. OGB or its contractors shall retain information for the minimum period of time required by law. After such time, information may no longer be available.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:345 (February 2015), effective March 1, 2015.

§505. Automated Claims Adjusting

A. Any OGB plan of benefits may utilize commercially licensed software that applies all claims against its medical logic program to identify improperly billed charges and charges for which an OGB plan of benefits provides no benefits. Any claim with diagnosis or procedure codes deemed inadequate or inappropriate will be automatically reduced or denied. Providers accepting assignment of benefits cannot bill the plan participant for the differential on the denial amount, in whole or in part.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:345 (February 2015), effective March 1, 2015.

§507. Legal Limitations and Statement of Contractual Agreement

A. A plan participant's rights and benefits under any OGB plan of benefits are personal to him/her.

B. The OGB self-funded plan, as amended, including the schedule of benefits, together with the application for coverage and any related documents executed by or on behalf of the enrollee, constitute the entire agreement between the parties.

C. In the event of any conflict between the written provisions of the OGB plan or any OGB plan of benefits with any information provided by OGB or its contractors or rules or regulations promulgated by OGB, the written provisions of the OGB plan or plan of benefits shall supersede and control.

D. A plan participant shall exhaust the administrative claims review procedure before filing a suit for benefits. No legal action shall be brought to recover benefits under an OGB plan or plan of benefits more than one year after the time a claim is required to be filed or more than 30 days after mailing of the notice of a final administrative decision, whichever is later, unless otherwise provided in the terms of the participant's plan. A decision is not final until all levels of the administrative appeals process are exhausted.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:346 (February 2015), effective March 1, 2015.

§509. Benefit Payments to Other Group Health Plans

A. When payments that should have been made under an OGB plan of benefits, have been made by another group health plan, OGB may pay to the other plan the sum proper to satisfy the terms of the enrollee's OGB plan benefits.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:346 (February 2015), effective March 1, 2015.

§511. Recovery of Overpayments

A. If an overpayment occurs, OGB retains the right to recover the overpayment. The plan participant, institution, or provider receiving the overpayment must return the overpayment. At OGB's discretion, the overpayment may be deducted from future claims. Should legal action be required as a result of fraudulent statements or deliberate omissions on the application for coverage or a claim for benefits, the defendant shall be responsible for attorney fees of 25 percent of the overpayment or \$1,000, whichever is greater. The defendant shall also be responsible for court costs and legal interest from the date of judicial demand until paid.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:346 (February 2015), effective March 1, 2015.

§513. Subrogation and Reimbursement

A. Upon payment of any eligible benefits covered under an OGB plan of benefits, OGB shall succeed and be subrogated to all rights of recovery of the plan participant or his/her heirs or assigns for whose benefit payment is made and he/she shall execute and deliver instruments and papers and do whatever is necessary to secure such rights and shall do nothing to prejudice such rights.

B. OGB has an automatic lien against and shall be entitled, to the extent of any payment made to a plan participant, to 100 percent of the proceeds of any settlement or judgment that may result from the exercise of any rights of recovery of a plan participant against any person or entity legally responsible for the disease, illness, accident, or injury for which said payment was made.

C. To this end, plan participants agree to immediately notify OGB or its agent of any action taken to attempt to collect any sums against any person or entity responsible for the disease, illness, accident, or injury.

D. These subrogation and reimbursement rights also apply, but are not limited to, when a plan participant recovers under an uninsured or underinsured motorist plan, homeowner's plan, renter's plan, medical malpractice plan, worker's compensation plan or any general liability plan.

E. Under these subrogation and reimbursement rights, OGB has a right of first recovery to the extent of any judgment, settlement, or any payment made to the plan participant, his/her heirs or assigns. These rights apply whether such recovery is designated as payment for pain and suffering, medical benefits, or other specified damages, even if he/she is not made whole (i.e., fully compensated for his/her injuries).

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:346 (February 2015), effective March 1, 2015.

§515. Program Responsibility

A. OGB will administer its self-funded plans in accordance with the plan terms, state and federal law, and OGB's established policies, interpretations, practices, and procedures. OGB will have maximum legal discretionary authority to construe and interpret the terms and provisions of the plan and its plan of benefits, to make determinations regarding eligibility for benefits, and to decide disputes which may arise relative to a plan participant's rights.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:346 (February 2015), effective March 1, 2015.

§517. Amendments to or Termination of the OGB Plan

A. OGB has the statutory responsibility of providing life, health, and other benefit programs to the extent that funds are available. OGB reserves the right to terminate, amend, or make adjustment to the eligibility and benefit provisions of any OGB plan or any plan benefits from time to time as necessary to prudently discharge its duties. Except for the pharmacy benefits management program, such modifications will be promulgated subject to the applicable provisions of law. Nothing contained herein shall be construed to guarantee or vest benefits for any plan participant.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:346 (February 2015), effective March 1, 2015.

§519. Eligible Expenses

A. Eligible expenses are the charges incurred for the services, drugs, supplies, and devices covered by the applicable plan of benefits, when performed, prescribed, or ordered by a physician or other authorized provider under a plan of benefits and medically necessary for the treatment of a plan participant. All charges are subject to applicable deductibles, co-payments, and/or co-insurance amounts, fee schedule limitations, schedule of benefits, limitations, exclusions, prior authorization requirements, benefit limits, drug utilization management, pharmacy benefits formulary, and other provisions of the plan of benefits. A charge is incurred on the date that the service, drug, supply, or device is performed or furnished.

B. Eligible expenses may be different depending on the plan of benefits selected by the enrollee. Eligible expenses for each plan of benefits are included in the respective plan document. OGB will make available a copy of its plan documents to its enrollees at the beginning of the plan year.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:346 (February 2015), effective March 1, 2015.

§521. Severability

A. If any provision or item of these rules or the application thereof is held invalid, such invalidity shall not affect other provisions, items, or applications of these rules which can be given effect without the invalidated provisions, items, or applications and to this end the provisions of these rules are hereby declared severable.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:347 (February 2015), effective March 1, 2015.

Chapter 7. Group Benefits Policy and Planning Board

§701. Elected Board Member Seats

A. Per R.S. 42:882, the Group Benefits Policy and Planning Board (OGB board) shall be composed of 11 voting members, with 2 members elected by retired participants of OGB plans of benefits, as follows:

1. one retiree member who shall be elected from among retired teachers or other school employees;

2. one retiree member who shall be elected from among retired state employees.

B. Elected members shall be confirmed by the Senate.

C. The chief executive officer shall certify election results to the Secretary of State and to the Senate for confirmation.

D. Upon appointment or election, each member for an elected seat shall serve with authority to act until his/her term expires or until the secretary of the Senate communicates that a member is rejected or not confirmed, whichever occurs first. Upon notice that a member for an elected seat is rejected or not confirmed, the respective member shall cease all member acts immediately.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:2351 (November 2015), effective January 1, 2016.

§703. Candidate Eligibility

A. A candidate for a position on the OGB board must be a participant in an OGB plan of benefits as of the specified nomination date.

B. If elected, the board member must continue to be a participant in an OGB plan of benefits during his/her tenure on the board.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 6:200 (May 1980), amended by the Office of the Governor, Division of Administration, Office of Group Benefits,

LR 41:347 (February 2015), effective March 1, 2015, LR 41:2351 (November 2015), effective January 1, 2016.

§705. Petitions for Candidacy

A. To become a candidate, a person must be nominated by petition of 25 or more OGB plan enrollees from the constituency he/she will represent.

B. Each enrollee's signature must be accompanied by his/her printed name, the last four digits of their Social Security number, and the agency they are affiliated with.

C. Each petition for candidacy must be signed by the OGB chief executive officer or his/her designated representative certifying that each candidate and each petitioner is a plan participant from the constituency he/she will represent, on the specified nomination date.

D. Petitions for candidacy must be received by OGB on or before the date indicated on the nomination materials.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 6:200 (May 1980), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:347 (February 2015), effective March 1, 2015, LR 41:2352 (November 2015), effective January 1, 2016.

§707. Ballot Preparation and Distribution

A. Ballot positions of candidates will be determined by a drawing.

B. All candidates will be notified of the time and place of the drawing.

C. All candidates or his/her representative may attend the drawing.

D. Ballots and information sheets on candidates will be provided to eligible voters by OGB or its election vendor.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 6:200 (May 1980), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:347 (February 2015), effective March 1, 2015.

§709. Balloting Procedure

A. All retired enrollees in an OGB plan of benefits on the specified election date are eligible to vote.

B. Each eligible retired enrollee may cast only one vote for any candidate listed on the ballot for his respective retiree group.

C. Each eligible retired enrollee must follow the voting directions provided by OGB. In the event OGB contracts with an election vendor for a particular election, each eligible retired enrollee must follow the voting directions provided by OGB's election vendor for his/her vote to be counted.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

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HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 6:200 (May 1980), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:347 (February 2015), effective March 1, 2015, LR 41:2352 (November 2015), effective January 1, 2016.

§711. Ballot Counting

A. The ballots will be counted by the ballot counting committee.

1. The ballot counting committee shall be composed of OGB employees appointed by the chief executive officer.

2. The ballot counting committee and all candidates will be notified at the time and date fixed for tallying the ballots.

3. The ballot counting committee will be responsible for the opening, preparation, and counting of the ballots.

4. All candidates or his/her representative may observe the ballot counting procedure.

B. In the event OGB contracts with an election vendor for a particular election, the election vendor will handle counting and verification of the ballots.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 6:200 (May 1980), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:347 (February 2015), effective March 1, 2015.

§713. Election Results

A. The chief executive officer will certify the election results to the Senate for confirmation.

B. The chief executive officer will notify the successful candidates of his/her election.

C. The chief executive officer will announce the election results at the first regularly scheduled board meeting following the election.

D. The chief executive officer will certify the election results to the Secretary of State.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 6:200 (May 1980), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:348 (February 2015), effective March 1, 2015, LR 41:2352 (November 2015), effective January 1, 2016.

§715. Uniform Election Dates

A. For each election date, the following dates will apply:

1. On second Wednesday in January, OGB submits nomination sheets to each agency benefits coordinator.

2. The second Wednesday in February is the nomination cutoff date. Nominees must be certified by the

OGB chief executive officer or his/her designee before nominations can be accepted by OGB.

3. On the third Wednesday in February, OGB will hold the drawing at its principal office to determine the position each candidate will have on the ballot. All candidates are invited to attend or send a representative.

4. Prior to the first Wednesday in March, ballots will be sent to the proper authority for distribution.

5. The second Wednesday in April is the deadline for OGB to receive completed ballots.

6. By the third Wednesday in April, all completed ballots shall be counted.

7. By the first Wednesday in May, the chief executive officer shall certify the election results to the Senate for confirmation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 7:122 (March 1981), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:348 (February 2015), effective March 1, 2015, LR 41:2352 (November 2015), effective January 1, 2016.

§717. Petition Form

A. Nominating Petition. Nominations will be submitted on a form substantially in compliance with the following.

We the undersigned OGB enrollees are retired teachers or retired school employees/retired state employees and hereby nominate _____ for membership on the Office of Group Benefits Policy and Planning Board.				
Signature	Printed Name	Last 4 of SSN	Agency	Date
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				
16.				
17.				
18.				
19.				
20.				
21.				
22.				
23.				
24.				
25.				
I hereby certify the persons signing this petition are retired teachers or other school employees/retired state employees and OGB retired enrollees as of the specified nomination date.				
_____ OGB Chief Executive Officer or his/her designated representative				

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 7:50 (February 1981), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:348 (February 2015), effective March 1, 2015, LR 41:2352 (November 2015), effective January 1, 2016.

Chapter 9. Managed Care Arrangements Contracting Criteria

§901. Notice of Intent to Contract

A. Notice of intent to contract with managed care arrangements shall be given by publication in the official journal of the State of Louisiana or by written direct solicitation setting forth OGB's intent to contract, describing the services sought, and providing a contact point for requesting a detailed explanation of the services sought and the criteria to be used in developing contracts.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 25:859 (May 1999), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:348 (February 2015), effective March 1, 2015.

§903. Managed Care Arrangements Criteria

A. The following criteria shall govern contracting with managed care arrangements for the OGB plan of benefits.

1. The managed care arrangement shall be appropriately licensed in accordance with the laws of this state.

2. The managed care arrangement shall execute a contract with OGB.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:348 (February 2015), effective March 1, 2015.

Chapter 11. Contributions

§1101. Collection and Deposit of Contributions

A. OGB shall be responsible for preparing and transmitting to each participating employer a monthly invoice premium statement delineating the enrolled employees of that agency as determined by the employer, each enrollee's class of coverage, total amount of employer and employee contributions due to OGB, and such other items as are deemed necessary by OGB.

B. It shall be the responsibility of the participating employer to reconcile the monthly invoice premium statement, collect employee contributions by payroll deduction or otherwise, and remit the reconciled monthly invoice premium statement and both the employer and employee contributions to OGB within 30 days after receipt of the monthly premium invoice statement.

C. Payments received by OGB shall be allocated as follows:

1. first, to any late payment penalty due by the participating employer;
2. second, to any balance due from prior invoices; and
3. third, to the amount due under the current invoice.

D. All employer and employee premium contributions for the payment of premiums for OGB offered coverage shall be deposited directly with OGB. OGB shall pay all monies due for such benefits as they become due and payable.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 8:285 (June 1982), amended LR 26:2788 (December 2000), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:349 (February 2015), effective March 1, 2015.

§1103. Adjustments for Terminated Employees

A. Credit adjustments for premiums paid on behalf of enrollees whose coverage under an OGB plan of benefits is terminated by reason of termination of employment may not be made by the participating employer after reconciliation of the second invoice following the date of termination of employment.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 26:2788 (December 2000), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:349 (February 2015), effective March 1, 2015.

§1105. Penalty for Late Payment of Premiums

A. If any participating employer fails to remit, in full, both the employer and employee contributions to OGB within 30 days after receipt of the monthly invoice premium statement, then at the request of OGB, the state treasurer shall withhold from state funds due the participating employer the full amount of the delinquent employer and employee contributions. The participating employer shall also pay a penalty equal to 1 percent of the total amount due and unpaid, compounded monthly. The state treasurer shall remit this amount directly to OGB.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 26:2788 (December 2000), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:349 (February 2015), effective March 1, 2015, LR 41:2353 (November 2015), effective January 1, 2016.

§1107. State Contribution toward Retirees' Health Premiums

A. For any person who is an active employee, as defined by R.S. 42:808 or OGB rule, and who does not participate in

an OGB plan of benefits before January 1, 2002, but subsequently enrolls in an OGB plan of benefits, or any person who commences employment with an OGB participating employer on or after January 1, 2002, the state contribution of the premium for participation in an OGB plan of benefits plan upon retirement shall be:

1. 19 percent for those persons with less than 10 years of participation in an OGB plan of benefits before retirement;

2. 38 percent for those persons with 10 years of participation but less than 15 years of participation in an OGB plan of benefits before retirement;

3. 56 percent for those persons with 15 years of participation but less than 20 years of participation in an OGB plan of benefits before retirement;

4. 75 percent for those persons with 20 or more years of participation in an OGB plan of benefits before retirement.

B. The foregoing schedule will also apply to the state contribution toward premiums for surviving spouse and/or surviving dependent coverage for survivors of employees who retire on or after January 1, 2002, if such spouse and dependents are not enrolled in an OGB plan of benefits before July 1, 2002.

C. This rule does not affect the contributions paid by the state for:

1. any participant who is a covered retiree before January 1, 2002;

2. any active employee who is enrolled in an OGB plan of benefits before January 1, 2002, and maintains continuous coverage through retirement;

3. surviving spouse and/or surviving dependent coverage for survivors of employees who retire on or after January 1, 2002, if such spouse and dependents are enrolled in an OGB plan of benefits before July 1, 2002, and continuous coverage is maintained until the employee's death.

D. For the purpose of determining the percentage of the state contribution toward premiums in accordance with this rule, the number of years of participation in OGB plan of benefits must be certified by the participating employer from which the employee retires on a form provided by OGB.

1. Such certification must be based upon business records maintained by the participating employer or provided by the employee.

2. Business records upon which certification is based must be available to OGB, the Division of Administration, and to the Legislative Auditor.

3. Not more than 120 days prior an employee's scheduled date of retirement, OGB will provide to the participating employer, upon request, all information in its possession relating to an employee's participation.

4. At the time of application for surviving spouse and/or surviving dependent coverage, OGB will provide, upon request, all information in its possession relating to participation of such surviving spouse and/or surviving dependent.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 28:306 (February 2002), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:349 (February 2015), effective March 1, 2015.

§1109. Retirees with Medicare Parts A and B

A. Employees who retire on or after July 1, 1997, and who are not rehired retirees in a benefit-eligible position, shall receive a reduced premium rate when enrolled in Medicare Parts A and B.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 24:496 (March 1998), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:350 (February 2015), effective March 1, 2015, LR 43:2152 (November 2017), effective January 1, 2018.

Chapter 15. Participation by Active or Retired Members of the Louisiana National Guard

§1501. Eligibility

A. Any active or retired member of the Louisiana National Guard shall be eligible to participate in OGB sponsored life, health, or other programs provided that:

1. other coverage is not available through the member's employment; and

2. the member is not eligible for Medicare coverage.

B. Eligible dependents of such active or retired members of the Louisiana National Guard shall be eligible for dependent coverage in accordance with the terms, conditions, requirements and limitations applicable to dependents of other eligible employees and retirees as set forth in the rules of OGB.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C), 802(B)(2), and 42:808.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 31:2009 (August 2005).

§1503. Certification

A. Any eligible active or retired member of the Louisiana National Guard who submits an enrollment application to participate in OGB sponsored life, health, or other programs shall provide, contemporaneous with the enrollment application, written certification as follows:

1. from the member's employer, that other coverage is not available through the member's employment; and

2. from the appropriate federal administrative agency that the member is not eligible for Medicare;

3. OGB may require additional written certification at such times as it deems necessary to verify eligibility for participation in its sponsored programs.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C), 802(B)(2), and 42:808.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 31:2009 (August 2005).

§1505. Payment of Premiums

A. The member must agree to pay the full amount of all premiums due for selected coverage without contribution from the state of Louisiana or any of the governmental or administrative subdivisions, departments, or agencies of the executive, legislative, or judicial branches of the state of Louisiana, or the governing boards and authorities of the state universities, colleges, and public elementary and secondary school systems in the state.

B. Contemporaneous with the enrollment application, the member must complete and submit to OGB all documentation necessary to provide for the payment of premiums via electronic funds transfer (EFT) from a licensed financial institution doing business in the state of Louisiana.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C), 802(B)(2), and 42:808.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 31:2010 (August 2005).

§1507. Effective Dates of Health Coverage

A. Unless an earlier effective date is mandated by applicable law or regulation, the effective date of health coverage for active or retired members of the Louisiana National Guard and their eligible dependents shall be:

1. the first day of the month following the date of receipt by OGB of the properly completed enrollment application, together with all required documentation, when such application and documentation are received by OGB prior to the fifteenth of the month;

2. the first day of the second month following the date of the receipt by OGB of the properly completed enrollment application and all required documentation when such application and documentation are received by OGB on or after the fifteenth of the month.

B. Coverage for eligible dependents of such active or retired members of the Louisiana National Guard shall become effective in accordance with the terms, conditions, requirements and limitations applicable to dependents of other eligible employees and retirees as set forth in the rules of OGB.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C), 802(B)(2), and 42:808.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 31:2010 (August 2005).

§1511. Term Life Insurance

A. Evidence of Insurability. Any active or retired member of the Louisiana National Guard or dependent(s) of such member for whom application for life insurance is made shall, in addition to all other required documentation, provide evidence of insurability acceptable to the insurer providing the OGB sponsored term life insurance. Such evidence of insurability shall be provided at no cost to OGB and/or the insurer providing the OGB sponsored term life insurance.

B. Effective Date

1. Unless delayed as set forth below, the effective date of life insurance will be the first of the month next following OGB's receipt of approval of the application for coverage from the insurer providing the OGB sponsored term life insurance.

2. Delay of Effective Date. If an active or retired member of the Louisiana National Guard, or dependent(s) of such member, is/are confined for medical care or treatment at home or elsewhere on the date that life insurance coverage would otherwise be effective, coverage for such individual(s) will take effect upon final medical release from such confinement.

C. Amount of Life Insurance

1. Option 1—Basic Life Insurance:

a. active or retired member of the Louisiana National Guard—\$5,000;

b. dependent(s) of active or retired member of the Louisiana National Guard:

i. spouse—\$2,000 and \$1,000 per eligible child;

or

ii. spouse—\$1,000 and \$500 per eligible child.

2. Option 2—Basic Life Insurance plus Supplemental Life Insurance:

a. active or retired member of the Louisiana National Guard—\$20,000;

b. dependent(s) of active or retired member of the Louisiana National Guard:

i. spouse—\$4,000 and \$2,000 per eligible child;

or

ii. spouse—\$2,000 and \$1,000 per eligible child.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C), 802(B)(2), and 42:808.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 31:2010 (August 2005).

§1513. Termination of Coverage

A. All benefits will terminate on the earliest of the following dates:

1. on the last day of the month in which the active or retired member of the Louisiana National Guard ceases to be eligible to participate in OGB sponsored life, health, or other programs, as provided herein;

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2. on the due date of any unpaid premium/contribution required for continuation of coverage; or

3. on the date that coverage would otherwise terminate for any other employee or retiree, or dependent(s) of such employee or retiree, participating in OGB sponsored health, life, or other programs in accordance with OGB rules.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C), 802(B)(2), and 42:808.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 31:2011 (August 2005).

§1515. Other Issues

A. Other issues pertaining to eligibility for or participation in OGB sponsored life, health, or other programs by any active or retired member of the Louisiana National Guard not specifically addressed herein shall be resolved in accordance with OGB rules pertaining to other eligible employees and retirees. Nothing herein shall be construed to confer upon any active or retired member of the Louisiana National Guard greater rights relative to eligibility for or participation in OGB sponsored life, health, or other programs than those applicable to other eligible employees and retirees.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C), 802(B)(2), and 42:808.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 31:2011 (August 2005).

Chapter 17. Rulemaking Petitions

§1701. Submission of a Rulemaking Petition

A. In accordance with R.S. 49:953(C)(1), any interested person may petition an agency to adopt a new rule, or to amend or repeal an existing rule.

B. To petition an agency within the Division of Administration for changes to the agency's current rules, or for the adoption of new rules within the agency's purview, an interested person shall submit a written petition to the

Division of Administration, Office of the Commissioner. The petition shall include:

1. the petitioner's name and address;
2. the name of the promulgating agency for the rule in question;
3. specific text or a description of the proposed language desired for the adoption or amendment of a rule, or the specific rule and language identified for repeal;
4. justification for the proposed action; and
5. the petitioner's signature.

C. The rulemaking petition shall be submitted by certified mail and addressed to:

Office of the Commissioner, Division of Administration
Re: Rulemaking Petition
P.O. Box 94095, Capital Station
Baton Rouge, LA 70804-9095

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C), 802(B)(1), and 49:953, et seq.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 46:332 (March 2020).

§1703. Consideration of a Rulemaking Petition

A. Upon receipt, a rulemaking petition shall be forwarded to the promulgating agency for review.

B. Within 90 days of receipt of the rulemaking petition, the agency shall either:

1. initiate rulemaking procedures to adopt a new rule, or to amend or repeal an existing rule; or
2. notify the petitioner in writing of the denial to proceed with rulemaking, stating the reason(s) therefor.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C), 802(B)(1), and 49:953, et seq.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits LR 46:332 (March 2020).

Title 32
EMPLOYEE BENEFITS
Part III. Primary Plan of Benefits

Chapter 1. Operation of Primary Plan

§101. HMO Plan Structure—Magnolia Local Plus

A. Pursuant to R.S. 42:851H(1), OGB has authority to designate a primary plan. The Magnolia Local Plus Plan is designated hereby as the OGB primary plan.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:350 (February 2015), effective March 1, 2015.

§103. Deductibles

Deductible Amount Per Benefit Period		
Individual:	Network	Non-Network
Active Employee/Retirees on or after March 1, 2015	\$400	No Coverage
Retirees prior to March 1, 2015 (With and Without Medicare)	\$0	No Coverage
Individual, Plus One Dependent:		
Active Employee/Retirees on or after March 1, 2015	\$800	No Coverage
Retirees prior to March 1, 2015 (With and Without Medicare)	\$0	No Coverage
Individual, Plus Two or More Dependents:		
Active Employee/Retirees on or after March 1, 2015	\$1,200	No Coverage
Retirees prior to March 1, 2015 (With and Without Medicare)	\$0	No Coverage

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:350 (February 2015), effective March 1, 2015.

§105. Out of Pocket Maximums

A. Plan Participants When OGB Is the Primary Payer for All Plan Participants

Out-of-Pocket Maximum Per Benefit Period (Includes All Eligible Copayments, Coinsurance Amounts and Deductibles)		
	Network	Non-Network
Individual:		
Active Employee/Retirees on or after March 1, 2015	\$3,500	No Coverage
Retirees prior to March 1, 2015	\$2,000	No Coverage
Individual, Plus One Dependent:		
Active Employee/Retirees on or after March 1, 2015	\$6,000	No Coverage
Retirees prior to March 1, 2015	\$3,000	No Coverage
Individual, Plus Two or More Dependents:		
Active Employee/Retirees on or after March 1, 2015	\$8,500	No Coverage
Retirees prior to March 1, 2015	\$4,000	No Coverage

B. Plan Participants When Medicare Is the Primary Payer for at Least One Plan Participant

Out-of-Pocket Maximum ¹ Per Benefit Period (Includes All Eligible Copayments, Coinsurance Amounts and Deductibles)		
	Network	Non-Network
Individual:		
Active Employee/Retirees on or after March 1, 2015	Medical: \$1,500 Prescription: \$2,000	No Coverage
Retirees prior to March 1, 2015	Medical: \$500 Prescription: \$1,500	No Coverage
Individual, Plus One Dependent (Medicare Paying Primary for One):		
Active Employee/Retirees on or after March 1, 2015	Medical: \$4,000 Prescription: \$2,000	No Coverage
Retirees prior to March 1, 2015	Medical: \$1,500 Prescription: \$1,500	No Coverage
Individual, Plus One Dependent (Medicare Paying Primary for Two):		
Active Employee/Retirees on or after March 1, 2015	Medical: \$2,000 Prescription: \$2,000 per participant	No Coverage
Retirees prior to March 1, 2015	Medical: \$0 Prescription: \$1,500 per participant	No Coverage
Individual, Plus Two or More Dependents (Medicare Paying Primary for One):		
Active Employee/Retirees on or after March 1, 2015	Medical: \$6,500 Prescription: \$2,000 per participant	No Coverage
Retirees prior to March 1, 2015	Medical: \$2,500 Prescription: \$1,500 per participant	No Coverage
Individual, Plus Two or More Dependents (Medicare Paying Primary for Two):		
Active Employee/Retirees on or after March 1, 2015	Medical: \$4,000 Prescription: \$2,000 per participant	No Coverage
Retirees prior to March 1, 2015	Medical: \$1,000 Prescription: \$1,500 per participant	No Coverage

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Out-of-Pocket Maximum ¹ Per Benefit Period (Includes All Eligible Copayments, Coinsurance Amounts and Deductibles)		
Individual, Plus Two or More Dependents (Medicare Paying Primary for Three):		
Active Employee/Retirees on or after March 1, 2015	Medical: \$2,500 Prescription: \$2,000 per participant	No Coverage
Retirees prior to March 1, 2015	Medical: \$0 Prescription: \$1,500	No Coverage

¹ Medical Out-of-Pocket Maximum applies to medical expenditures for all Plan Participants and to Prescription expenditures for Plan Participants when OGB is the primary payer. Prescription Out-of-Pocket Maximum applies to each Plan Participant when Medicare is the primary payer.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:350 (February 2015), effective March 1, 2015, amended LR 43:2153 (November 2017), effective January 1, 2018, LR 50:1467 (October 2024), effective January 1, 2025.

§107. Schedule of Benefits

A. Benefits, Copayments, and Coinsurance

	Copayments and Coinsurance	
	Network Providers	Non-Network Providers
Physician Office Visits <ul style="list-style-type: none"> • General Practice • Family Practice • Internal Medicine • OB/GYN • Pediatrics 	\$25 Copayment per Visit	No Coverage
Allied Health/Other Professional Visits: <ul style="list-style-type: none"> • Chiropractors • Federally Funded Qualified Rural Health Clinics • Nurse Practitioners • Retail Health Clinics • Physician Assistants 	\$25 Copayment per Visit	No Coverage
Specialist Office Visits including surgery performed in an office setting: <ul style="list-style-type: none"> • Physician • Podiatrist • Optometrist • Midwife • Audiologist • Registered Dietician • Sleep Disorder Clinic 	\$50 Copayment per Visit	No Coverage
Ambulance Services - Air (for Emergency Medical Transportation only) Non-Emergency requires prior authorization ²	\$250 Copayment	No Coverage

	Copayments and Coinsurance	
	Network Providers	Non-Network Providers
Ambulatory Surgical Center and Outpatient Surgical Facility	\$100 Copayment	No Coverage
Bariatric Surgery Services – Facility Services ⁴	\$2,500.00 Copayment ^{2,3}	No Coverage
Bariatric Surgery Services – Professional Services ⁴	90% - 10% ^{2,3}	No Coverage
Bariatric Surgery Services – Preoperative and Postoperative Medical Services ⁴	80% - 20% ^{2,3}	No Coverage
Birth Control Devices – Insertion and Removal (as listed in the Preventive and Wellness Article in the Benefit Plan)	100% - 0%	No Coverage
Cardiac Rehabilitation (limit of 36 visits per Plan Year)	\$25/\$50 Copayment per day depending on Provider Type ² \$50 Copayment - Outpatient Facility ²	No Coverage
Chemotherapy/Radiation Therapy (Authorization not required when performed in Physician's office)	Office - \$25 Copayment per Visit Outpatient Facility 100% - 0% ^{1,2}	No Coverage
Diabetes Treatment	80% - 20% ¹	No Coverage
Diabetic/Nutritional Counseling - Clinics and Outpatient Facilities	\$25 Copayment	No Coverage
Dialysis	100% - 0% ¹	No Coverage
Durable Medical Equipment (DME), Prosthetic Appliances and Orthotic Devices	80% - 20% ^{1,2} of first \$5,000 Allowable per Plan Year; 100% - 0% of Allowable in Excess of \$5,000 per Plan Year	No Coverage
Emergency Ground Ambulance Services; In-State	\$50 Copayment	\$50 Copayment
Emergency Ground Ambulance Services; Out-of-State	\$50 Copayment	\$50 Copayment
Non-Emergency Ground Ambulance Services	\$50 Copayment	No Coverage
Emergency Room (Facility Charge)	\$200 Copayment; Waived if admitted to the same facility	
Emergency Medical Services (Non-Facility Charges)	100% - 0% ¹	100% - 0% ¹
Eye-glass Frames and One Pair of Eye-glass Lenses or One Pair of Contact Lenses (purchased within six months following cataract surgery)	Eye-glass Frames – Limited to a Maximum Benefit of \$50 ¹	No Coverage
Flu shots and H1N1 vaccines (administered at Network Providers, Non-Network Providers, Pharmacy, Job Site or Health Fair)	100% - 0%	100% - 0%
Hearing Aids (Hearing Aids are not covered for individuals age eighteen (18) and older.)	80% - 20% ^{1,3}	No Coverage
Hearing Impaired Interpreter Expense	100% - 0%	No Coverage

	Copayments and Coinsurance	
	Network Providers	Non-Network Providers
High-Tech Imaging - Outpatient <ul style="list-style-type: none"> • CT Scans • MRA/MRI • Nuclear Cardiology • PET Scans 	\$50 Copayment ²	No Coverage
Home Health Care <i>(limit of 60 Visits per Plan Year)</i>	100% - 0% ^{1,2}	No Coverage
Hospice Care <i>(limit of 180 Days per Plan Year)</i>	100% - 0% ^{1,2}	No Coverage
Injections Received in a Physician's Office <i>(when no other health service is received)</i>	100% - 0% ¹	No Coverage
Inpatient Hospital Admission, All Inpatient Hospital Services Included	\$100 Copayment per day ² , maximum of \$300 per Admission	No Coverage
Inpatient and Outpatient Professional Services for Which a Copayment Is Not Applicable	100% - 0% ¹	No Coverage
Mastectomy Bras - Ortho-Mammary Surgical <i>(limited to three (3) per Plan Year)</i>	80% - 20% ¹ of first \$5,000 Allowable per Plan Year; 100% - 0% of Allowable in Excess of \$5,000 per Plan Year	No Coverage
Mental Health/Substance Abuse - Inpatient Treatment and Intensive Outpatient Programs	\$100 Copayment per day ² , maximum of \$300 per Admission	No Coverage
Mental Health/Substance Abuse - Office Visit and Outpatient Treatment (Other than Intensive Outpatient Programs)	\$25 Copayment per Visit	No Coverage
Newborn - Sick, Services excluding Facility	100% - 0% ¹	No Coverage
Newborn - Sick, Facility	\$100 Copayment per day ² , maximum of \$300 per Admission	No Coverage

	Copayments and Coinsurance	
	Network Providers	Non-Network Providers
Oral Surgery	100% - 0% ^{1,2}	No Coverage
Pregnancy Care - Physician Services	\$90 Copayment per pregnancy	No Coverage
Preventive Care - Services include screening to detect illness or health risks during a Physician office visit. The Covered Services are based on prevailing medical standards and may vary according to age and family history. <i>(For a complete list of benefits, refer to the Preventive and Wellness Article in the Benefit Plan.)</i>	100% - 0% ³	No Coverage
Rehabilitation Services - Outpatient: <ul style="list-style-type: none"> • Speech • Physical/Occupational <i>(Limited to 50 Visits combined PT/OT per Plan Year. Authorization required for visits over the combined limit of 50.) (Visit limits do not apply when services are provided for Autism Spectrum Disorders.)</i> 	\$25 Copayment per Visit	No Coverage
Skilled Nursing Facility <i>(limit of 90 days per Plan Year)</i>	\$100 Copayment per day ² , maximum of \$300 per Admission	No Coverage
Sonograms and Ultrasounds <i>(Outpatient)</i>	\$50 Copayment	No Coverage
Urgent Care Center	\$50 Copayment	No Coverage
Vision Care (Non-Routine) Exam	\$25/\$50 Copayment depending on Provider Type	No Coverage
X-ray and Laboratory Services <i>(low-tech imaging)</i>	Hospital Facility 100%-0% ¹ Office or Independent Lab 100%-0%	No Coverage

¹Subject to Plan Year Deductible, if applicable
²Pre-Authorization Required, if applicable. Not applicable for Medicare primary.
³Age and/or Time Restrictions Apply
⁴No Benefits will be payable unless Prior Authorization is obtained, including Plan Participants with Medicare as the Primary Plan.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:350 (February 2015), effective March 1, 2015, amended LR 43:2153 (November 2017), effective January 1, 2018, LR 49:1377 (August 2023), LR 50:780 (June 2024).

§109. Prescription Drug Benefits

A. Prescription Drug Benefits

EMPLOYEE BENEFITS

Network Pharmacy	Member pays
Tier 1- Generic	50% up to \$30
Tier 2- Preferred	50% up to \$55
Tier 3- Non-preferred	65% up to \$80
Tier 4- Specialty	50% up to \$80
90 day supplies for maintenance drugs from mail order OR at participating 90-day retail network pharmacies	Two and a half times the cost of your applicable copayment
Co-Payment after the Out Of Pocket Amount of \$1,500 Is Met	
Tier 1- Generic	\$0
Tier 2- Preferred	\$20
Tier 3- Non-preferred	\$40
Tier 4- Specialty	\$40
Prescription drug benefits-31 day refill	
Plan pays balance of eligible expenses	
Diabetic supplies are not subject to a copayment if enrolled in the In-Health/Disease Management Program.	
Member who chooses a brand-name drug for which an approved generic version is available, pays the cost difference between the brand-name drug and the generic drug, plus the co-pay for the brand-name drug; the cost difference does not apply to the \$1,500 out of pocket amount.	
Medications available over-the-counter in the same prescribed strength are not covered under the pharmacy plan.	

<p style="text-align: center;">Smoking Cessation Medications:</p> <p>Benefits are available for Prescription and over-the-counter (OTC) smoking cessation medications when prescribed by a physician. (Prescription is required for over-the-counter medications). Smoking cessation medications are covered at 100%.</p>
<p>This plan allows benefits for drugs and medicines approved by the Food and Drug Administration or its successor that require a prescription. Utilization management criteria may apply to specific drugs or drug categories to be determined by PBM.</p>

B. OGB shall have discretion to adopt a pharmacy benefits formulary to help enrollees select the most appropriate, lowest-cost options. The formulary will be reviewed on a quarterly basis to reassess drug tiers based on the current prescription drug market. The formulary may be changed from time to time subject to any applicable advance notice requirements. The amount enrollees pay toward prescription medications will depend on whether they purchase a generic, preferred brand, non-preferred brand, or specialty drug.

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Title 32 EMPLOYEE BENEFITS

Part V. Additional Plans and Operations

Chapter 1. Authority for OGB Alternative Plan Options

§101. OGB Authority

A. Pursuant to R.S. 42:851H(1) OGB may adopt, administer, operate, or contract for all or a portion of the administration, operation, or both of a primary self-funded program or additional programs with premium rate structures and state contribution rates which are different from the primary program.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:355 (February 2015), effective March 1, 2015.

Chapter 2. PPO Plan Structure—Magnolia Open Access Plan

§201. Deductibles

Deductible Amount Per Benefit Period		
Individual:	Network	Non-Network
Active Employee/Retirees on or after March 1, 2015	\$900	\$900
Retirees prior to March 1, 2015 (With and Without Medicare)	\$300	
Individual, Plus One Dependent (Spouse or Child):		

B. Plan Participants When Medicare Is the Primary Payer for at Least One Plan Participant

Out-of-Pocket Maximums ¹ (Includes All Eligible Copayments, Coinsurance Amounts and Deductibles)					
	Active Employee/Retirees on or after March 1, 2015		Retirees prior to March 1, 2015 Without Medicare		Retirees prior to March 1, 2015 With Medicare
	Network	Non-Network	Network	Non-Network	Network and Non- Network
Individual Only	Medical: \$1,500 Prescription: \$2,000	\$4,700	See Subsection A	See Subsection A	Medical: \$1,300 Prescription: \$2,000
Individual Plus One Dependent (Medicare Paying Primary for One)	Medical: \$4,000 Prescription: \$2,000	\$8,500	Medical: \$1,600 Prescription: \$2,000	\$7,600	Medical: \$3,600 Prescription: \$2,000
Individual Plus One Dependent (Medicare Paying Primary for Two)	Medical: \$2,000 Prescription: \$2,000 per participant	\$8,500	Not Applicable	Not Applicable	Medical: \$1,600 Prescription: \$2,000 per participant

Active Employee/Retirees on or after March 1, 2015	\$1,800	\$1,800
Retirees prior to March 1, 2015 (With and Without Medicare)	\$600	
Individual, Plus Two or More Dependents:		
Active Employee/Retirees on or after March 1, 2015	\$2,700	\$2,700
Retirees prior to March 1, 2015 (With and Without Medicare)	\$900	

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:355 (February 2015), effective March 1, 2015.

§203. Out of Pocket Maximums

A. Plan Participants When OGB Is the Primary Payer for All Plan Participants

	Active Employee/Retirees on or after March 1, 2015		Retirees prior to March 1, 2015 Without Medicare	
	Network	Non- Network	Network	Non-Network
Individual Only	\$3,500	\$4,700	\$2,300	\$4,300
Individual Plus One Dependent	\$6,000	\$8,500	\$3,600	\$7,600
Individual Plus Two or More Dependents	\$8,500	\$12,250	\$4,900	\$10,900

EMPLOYEE BENEFITS

Out-of-Pocket Maximums ¹ (Includes All Eligible Copayments, Coinsurance Amounts and Deductibles)					
	Active Employee/Retirees on or after March 1, 2015		Retirees prior to March 1, 2015 Without Medicare		Retirees prior to March 1, 2015 With Medicare
	Network	Non-Network	Network	Non-Network	Network and Non- Network
Individual Plus Two or More Dependents (Medicare Paying Primary for One)	Medical: \$6,500 Prescription: \$2,000	\$12,250	Medical: \$2,900 Prescription: \$2,000	\$10,900	Medical: \$5,900 Prescription: \$2,000
Individual Plus Two or More Dependents (Medicare Paying Primary for Two)	Medical: \$4,500 Prescription: \$2,000 per participant	\$12,250	Medical: \$900 Prescription: \$2,000 per participant	\$10,900	Medical: \$3,900 Prescription: \$2,000 per participant
Individual Plus Two or More Dependents (Medicare Paying Primary for Three)	Medical: \$2,500 Prescription: \$2,000 per participant	\$12,250	Medical: \$0 Prescription: \$2,000 per participant	\$10,900	Medical: \$1,900 Prescription: \$2,000 per participant

¹Medical Out-of-Pocket Maximum applies to medical expenditures for all Plan Participants and to Prescription expenditures for Plan Participants when OGB is the primary payer. Prescription Out-of-Pocket Maximum applies to each Plan Participant when Medicare is the primary payer.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

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§205. Schedule of Benefits

A. Benefits and Coinsurance

	Coinsurance		
	Active Employees/ Non-Medicare Retirees (regardless of retire date)		Retirees with Medicare (regardless of retire date)
	Network Providers	Non- Network	Network Providers
Physician Office Visits including surgery performed in an office setting: <ul style="list-style-type: none"> • General Practice • Family Practice • Internal Medicine • OB/GYN • Pediatrics 	90% - 10% ¹	70% - 30% ¹	80% - 20% ¹
Allied Health/Other Professional Visits: <ul style="list-style-type: none"> • Chiropractors • Federally Funded Qualified Rural Health Clinics • Nurse Practitioners • Retail Health Clinics • Physician Assistants 	90% - 10% ¹	70% - 30% ¹	80% - 20% ¹
Specialist (Physician) Office Visits including surgery performed in an office setting: <ul style="list-style-type: none"> • Physician • Podiatrist • Optometrist • Midwife • Audiologist • Registered Dietician • Sleep Disorder Clinic 	90% - 10% ¹	70% - 30% ¹	80% - 20% ¹

	Coinsurance		
	Active Employees/ Non-Medicare Retirees (regardless of retire date)		Retirees with Medicare (regardless of retire date)
	Network Providers	Non- Network	Network Providers
Ambulance Services - Air (for Emergency Medical Transportation only) Non-emergency requires prior authorization ²	90% - 10% ¹	70% - 30% ¹	80% - 20% ¹
Ambulatory Surgical Center and Outpatient Surgical Facility	90% - 10% ¹	70% - 30% ¹	80% - 20% ¹
Bariatric Surgery Services – Facility Services ⁴	\$2,500.00 Copayment ^{2,3}	Not Covered	Network Providers \$2,500.00 Copayment ^{2,3} Non-Network Providers Not Covered
Bariatric Surgery Services – Professional Services ⁴	90% - 10% ^{2,3}	Not Covered	Network Providers 90% - 10% ^{2,3} Non-Network Providers Not Covered
Bariatric Surgery Services – Preoperative and Postoperative Medical Services ⁴	80% - 20% ^{2,3}	Not Covered	Network Providers 80% - 20% ^{2,3} Non-Network Providers Not Covered
Birth Control Devices - Insertion and Removal (as listed in the Preventive and Wellness Care Article in the Benefit Plan)	100% - 0%	70% - 30% ¹	Network Providers 100% - 0% Non-Network Providers 80% - 20% ¹
Cardiac Rehabilitation (limit of 36 visits per Plan Year)	90% - 10% ^{1,2}	70% - 30% ^{1,2}	80% - 20% ^{1,2}
Chemotherapy/Radiation Therapy (Authorization not required when performed in Physician's office)	90% - 10% ^{1,2}	70% - 30% ^{1,2}	80% - 20% ^{1,2}
Diabetes Treatment	90% - 10% ¹	70% - 30% ¹	80% - 20% ¹

	Coinsurance		
	Active Employees/ Non-Medicare Retirees (regardless of retire date)		Retirees with Medicare (regardless of retire date)
	Network Providers	Non- Network	Network Providers
Diabetic/Nutritional Counseling - Clinics and Outpatient Facilities	90% - 10% ¹	Not Covered	80% - 20% ¹
Dialysis	90% - 10% ¹	70% - 30% ¹	80% - 20% ¹
Durable Medical Equipment (DME), Prosthetic Appliances and Orthotic Devices	90% - 10% ^{1,2}	70% - 30% ^{1,2}	80% - 20% ^{1,2}
Emergency Ground Ambulance Services; In-State	90% - 10% ¹	90% - 10% ¹	80% - 20% ¹
Emergency Ground Ambulance Services; Out-of-State	90% - 10% ¹	70% - 30% ¹	80% - 20% ¹
Non-Emergency Ground Ambulance Services	90% - 10% ¹	70% - 30% ¹	80% - 20% ¹
Emergency Room (Facility Charge)	\$200 Copayment ¹ ; Waived if admitted to the same facility		
Emergency Medical Services (Non-Facility Charges)	90% - 10% ¹	90% - 10% ¹	80% - 20% ¹
Eyeglass Frames and One Pair of Eyeglass Lenses or One Pair of Contact Lenses (purchased within six months following cataract surgery)	Eyeglass Frames - Limited to a Maximum Benefit of \$50 ¹		
Flu shots and H1N1 vaccines (administered at Network Providers, Non-Network Providers, Pharmacy, Job Site or Health Fair)	100% - 0%	100% - 0%	100% - 0%
Hearing Aids (Hearing Aids are not covered for individuals age eighteen (18) and older)	90% - 10% ^{1,3}	70% - 30% ^{1,3}	80% - 20% ^{1,3}
Hearing Impaired Interpreter Expense	100% - 0%	100% - 0%	100% - 0%
High-Tech Imaging – Outpatient <ul style="list-style-type: none"> • CT Scans • MRA/MRI • Nuclear Cardiology • PET Scans 	90% - 10% ^{1,2}	70% - 30% ^{1,2}	80% - 20% ^{1,2}
Home Health Care (limit of 60 Visits per Plan Year)	90% - 10% ^{1,2}	70% - 30% ^{1,2}	Not Covered
Hospice Care (limit of 180 Days per Plan Year)	80% - 20% ^{1,2}	70% - 30% ^{1,2}	Not Covered
Injections Received in a Physician’s Office (when no other health service is received)	90% - 10% ¹	70% - 30% ¹	80% - 20% ¹
Inpatient Hospital Admission, All Inpatient Hospital Services Included Per Day Copayment Day Maximum Coinsurance	\$0 Not Applicable 90% - 10% ^{1,2}	\$50 5 Days 70% - 30% ^{1,2}	\$0 Not Applicable 80% - 20% ^{1,2}
Inpatient and Outpatient Professional Services	90% - 10% ¹	70% - 30% ¹	80% - 20% ¹
Mastectomy Bras - Ortho-Mammary Surgical (limit of three (3) per Plan Year)	90% - 10% ¹	70% - 30% ¹	80% - 20% ¹

	Coinsurance		
	Active Employees/ Non-Medicare Retirees (regardless of retire date)		Retirees with Medicare (regardless of retire date)
	Network Providers	Non- Network	Network Providers
Mental Health/Substance Abuse - Inpatient Treatment and Intensive Outpatient Programs <i>Per Day Copayment Day Maximum Coinsurance</i>	\$0 Not Applicable 90% - 10% ^{1,2}	\$50 5 Days 70% - 30% ^{1,2}	\$0 Not Applicable 80% - 20% ^{1,2}
Mental Health/Substance Abuse – Office Visit and Outpatient Treatment (Other than Intensive Outpatient Programs)	90% - 10% ¹	70% - 30% ¹	80% - 20% ¹
Newborn - Sick, Services Excluding Facility	90% - 10% ¹	70% - 30% ¹	80% - 20% ¹
Newborn - Sick, Facility <i>Per Day Copayment Day Maximum Coinsurance</i>	\$0 Not Applicable 90% - 10% ^{1,2}	\$50 5 Days 70% - 30% ^{1,2}	\$0 Not Applicable 80% - 20% ^{1,2}
Oral Surgery for Impacted Teeth	90% - 10% ^{1,2}	70% - 30% ^{1,2}	80% - 20% ^{1,2}
Pregnancy Care - Physician Services	90% - 10% ¹	70% - 30% ¹	80% - 20% ¹
Preventive Care - Services include screening to detect illness or health risks during a Physician office visit. The Covered Services are based on prevailing medical standards and may vary according to age and family history. (For a complete list of benefits, refer to the Preventive and Wellness Care Article in the Benefit Plan.)	100% - 0% ³	70% - 30% ^{1,3}	Network 100% - 0 ³ Non-Network 80% - 20% ^{1,3}
Rehabilitation Services - Outpatient: <ul style="list-style-type: none"> • Speech • Physical/ Occupational (Limited to 50 Visits combined PT/OT per Plan Year. Authorization required for visits over the combined limit of 50.) (Visit limits do not apply when services are provided for Autism Spectrum Disorders)	90% - 10% ¹	70% - 30% ¹	80% - 20% ¹
Skilled Nursing Facility (limit 90 days per Plan Year)	90% - 10% ^{1,2}	70% - 30% ^{1,2}	80% - 20% ^{1,2}
Sonograms and Ultrasounds (Outpatient)	90% - 10% ¹	70% - 30% ¹	80% - 20% ¹
Urgent Care Center	90% - 10% ¹	70% - 30% ¹	80% - 20% ¹
Vision Care (Non-Routine) Exam	90% - 10% ¹	70% - 30% ¹	80% - 20% ¹
X-ray and Laboratory Services (low-tech imaging)	90% - 10% ¹	70% - 30% ¹	80% - 20% ¹

EMPLOYEE BENEFITS

	Coinsurance		
	Active Employees/ Non-Medicare Retirees (regardless of retire date)		Retirees with Medicare (regardless of retire date)
	Network Providers	Non- Network	Network Providers
¹ Subject to Plan Year Deductible, if applicable			
² Pre-Authorization Required, if applicable. Not applicable for Medicare primary.			
³ Age and/or Time Restrictions Apply			
⁴ No Benefits will be payable unless Prior Authorization is obtained, including Plan Participants with Medicare as the Primary Plan.			

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

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§207. Prescription Drug Benefits

A. Prescription Drug Benefits

Network Pharmacy	Member Pays
Tier 1- Generic	50% up to \$30
Tier 2- Preferred	50% up to \$55
Tier 3- Non-preferred	65% up to \$80
Tier 4- Specialty	50% up to \$80
90 day supplies for maintenance drugs from mail order OR at participating 90-day retail network pharmacies	Two and a half times the cost of your applicable copayment
Co-Payment after the Out Of Pocket Amount of \$1,500 Is Met	
Tier 1- Generic	\$0
Tier 2- Preferred	\$20
Tier 3- Non-preferred	\$40
Tier 4- Specialty	\$40
Prescription drug benefits-31 day refill	
Plan pays balance of eligible expenses	
Diabetic supplies are not subject to a copayment if enrolled in the In-Health/Disease Management Program.	
Member who chooses a brand-name drug for which an approved generic version is available, pays the cost difference between the brand-name drug and the generic drug, plus the co-pay for the brand-name drug; the cost difference does not apply to the \$1,500 out of pocket amount.	
Medications available over-the-counter in the same prescribed strength are not covered under the pharmacy plan.	
Smoking Cessation Medications: Benefits are available for Prescription and over-the-counter (OTC) smoking cessation medications when prescribed by a physician. (Prescription is required for over-the-counter medications). Smoking cessation medications are covered at 100%.	
This plan allows benefits for drugs and medicines approved by the Food and Drug Administration or its successor that require a prescription. Utilization management criteria may apply to specific drugs or drug categories to be determined by PBM.	

B. OGB shall have discretion to adopt a pharmacy benefits formulary to help enrollees select the most appropriate, lowest-cost options. The formulary will be reviewed on a quarterly basis to reassess drug tiers based on the current prescription drug market. The formulary may be

changed from time to time subject to any applicable advance notice requirements. The amount enrollees pay toward prescription medications will depend on whether they purchase a generic, preferred brand, non-preferred brand, or specialty drug.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

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**Chapter 3. Narrow Network HMO
Plan Structure—Magnolia Local Plan
(in certain geographical areas)**

§301. Deductibles

Deductible Amount Per Benefit Period		
Individual:	Network	Non-Network
Active Employee/Retirees on or after March 1, 2015	\$400	No Coverage
Retirees prior to March 1, 2015 (With and Without Medicare)	\$0	No Coverage
Individual, Plus One Dependent:		
Active Employee/Retirees on or after March 1, 2015	\$800	No Coverage
Retirees prior to March 1, 2015 (With and Without Medicare)	\$0	No Coverage
Individual, Plus Two or More Dependents:		
Active Employee/Retirees on or after March 1, 2015	\$1,200	No Coverage
Retirees prior to March 1, 2015 (With and Without Medicare)	\$0	No Coverage

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:358 (February 2015), effective March 1, 2015.

§303. Out of Pocket Maximums

A. Plan Participants When OGB Is the Primary Payer for All Plan Participants

Out-of-Pocket Maximum Per Benefit Period (Includes All Eligible Copayments, Coinsurance Amounts and Deductibles)		
	Network	Non-Network
Individual:		
Active Employee/Retirees on or after March 1, 2015	\$2,500	No Coverage
Retirees prior to March 1, 2015	\$1,000	No Coverage
Individual, Plus One Dependent:		
Active Employee/Retirees on or after March 1, 2015	\$5,000	No Coverage
Retirees prior to March 1, 2015	\$2,000	No Coverage
Individual, Plus Two or More Dependents:		
Active Employee/Retirees on or after March 1, 2015	\$7,500	No Coverage
Retirees prior to March 1, 2015	\$3,000	No Coverage

B. Plan Participants When Medicare Is the Primary Payer for at Least One Plan Participant

expenditures for Plan Participants when OGB is the primary payer. Prescription Out-of-Pocket Maximum applies to each Plan Participant when Medicare is the primary payer.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:359 (February 2015), effective March 1, 2015, amended LR 50:1469 (October 2024), effective January 1, 2025.

§305. Schedule of Benefits

A. Benefits, Copayments, and Coinsurance

Out-of-Pocket Maximum ¹ Per Benefit Period (Includes All Eligible Copayments, Coinsurance Amounts and Deductibles)		
	Network	Non-Network
Individual:		
Active Employee/Retirees on or after March 1, 2015	Medical: \$500 Prescription: \$2,000	No Coverage
Retirees prior to March 1, 2015	Medical: \$0 Prescription: \$1000	No Coverage
Individual, Plus One Dependent (Medicare Paying Primary for One):		
Active Employee/Retirees on or after March 1, 2015	Medical: \$3,000 Prescription: \$2,000	No Coverage
Retirees prior to March 1, 2015	Medical: \$1,000 Prescription: \$1,000	No Coverage
Individual, Plus One Dependent (Medicare Paying Primary for Two):		
Active Employee/Retirees on or after March 1, 2015	Medical: \$1,000 Prescription: \$2,000 per participant	No Coverage
Retirees prior to March 1, 2015	Medical: \$0 Prescription: \$1,000 per participant	No Coverage
Individual, Plus Two or More Dependents (Medicare Paying Primary for One):		
Active Employee/Retirees on or after March 1, 2015	Medical: \$5,500 Prescription: \$2,000	No Coverage
Retirees prior to March 1, 2015	Medical: \$2,000 Prescription: \$1,000	No Coverage
Individual, Plus Two or More Dependents (Medicare Paying Primary for Two):		
Active Employee/Retirees on or after March 1, 2015	Medical: \$3,500 Prescription: \$2,000 per participant	No Coverage
Retirees prior to March 1, 2015	Medical: \$1,000 Prescription: \$1,000 per participant	No Coverage
Individual, Plus Two or More Dependents (Three with Medicare Paying Primary):		
Active Employee/Retirees on or after March 1, 2015	Medical: \$1,500 Prescription: \$2,000 per participant	No Coverage
Retirees prior to March 1, 2015	Medical: \$0 Prescription: \$1,000 per participant	No Coverage

¹ Medical Out-of-Pocket Maximum applies to medical expenditures for all Plan Participants and to Prescription

	Copayments and Coinsurance	
	Network Providers	Non-Network Providers
Physician Office <ul style="list-style-type: none"> • General Practice • Family Practice • Internal Medicine • OB/GYN • Pediatrics 	\$25 Copayment per Visit	No Coverage
Allied Health/Other Professional Visits: <ul style="list-style-type: none"> • Chiropractors • Federally Funded Qualified Rural • Health Clinics • Nurse Practitioners • Retail Health Clinics • Physician Assistants 	\$25 Copayment per Visit	No Coverage
Specialist Office Visits including surgery performed in an office setting: <ul style="list-style-type: none"> • Physician • Podiatrist • Optometrist • Midwife • Audiologist • Registered Dietician • Sleep Disorder Clinic 	\$50 Copayment per Visit	No Coverage
Ambulance Services - Air (for Emergency Medical Transportation only) Non-emergency requires prior authorization ²	\$250 Copayment	No Coverage
Ambulatory Surgical Center and Outpatient Surgical Facility	\$100 Copayment	No Coverage
Bariatric Surgery Services – Facility Services ⁴	\$2,500.00 Copayment ^{2,3}	No Coverage
Bariatric Surgery Services – Professional Services ⁴	90% - 10% ^{2,3}	No Coverage
Bariatric Surgery Services – Preoperative and Postoperative Medical Services ⁴	80% - 20% ^{2,3}	No Coverage
Birth Control Devices - Insertion and Removal (as listed in the Preventive and Wellness Article in the Benefit Plan.)	100% - 0%	No Coverage
Cardiac Rehabilitation (limit of 36visits per Plan Year)	\$25/\$50 Copayment per day depending on Provider Type ² \$50 Copayment-Outpatient Facility ²	No Coverage

EMPLOYEE BENEFITS

	Copayments and Coinsurance	
	Network Providers	Non-Network Providers
Chemotherapy/Radiation Therapy <i>(Authorization not required when performed in Physician's office)</i>	Office – \$25 Copayment per Visit Outpatient Facility 100% - 0% ^{1,2}	No Coverage
Diabetes Treatment	80% - 20% ¹	No Coverage
Diabetic/Nutritional Counseling - Clinics and Outpatient Facilities	\$25 Copayment	No Coverage
Dialysis	100% - 0% ¹	No Coverage
Durable Medical Equipment (DME), Prosthetic Appliances and Orthotic Devices	80% - 20% ^{1,2} of first \$5,000 Allowable per Plan Year; 100% - 0% of Allowable in Excess of \$5,000 per Plan Year	No Coverage
Emergency Ground Ambulance Services; In-State	\$50 Copayment	\$50 Copayment
Emergency Ground Ambulance Services; Out-of-State	\$50 Copayment	\$50 Copayment
Non-Emergency Ground Ambulance Services	\$50 Copayment	No Coverage
Emergency Room (<i>Facility Charge</i>)	\$200 Copayment; Waived if admitted to the same facility	
Emergency Medical Services (<i>Non-Facility Charges</i>)	100% - 0% ¹	100% - 0% ¹
Eyeglass Frames and One Pair of Eyeglass Lenses or One Pair of Contact Lenses (<i>purchased within six months following cataract surgery</i>)	Eyeglass Frames – Limited to a Maximum Benefit of \$50 ¹	No Coverage
Flu shots and H1N1 vaccines (<i>administered at Network Providers, Non-Network Providers, Pharmacy, Job Site or Health Fair</i>)	100% - 0%	100% - 0%
Hearing Aids (<i>Hearing Aids are not covered for individuals age eighteen (18) and older.</i>)	80% - 20% ^{1,3}	No Coverage
Hearing Impaired Interpreter Expense	100% - 0%	No Coverage
High-Tech Imaging - Outpatient <ul style="list-style-type: none"> CT Scans MRA/MRI Nuclear Cardiology PET Scans 	\$50 Copayment ²	No Coverage
Home Health Care (<i>limit of 60 Visits per Plan Year</i>)	100% - 0% ^{1,2}	No Coverage
Hospice Care (<i>limit of 180 Days per Plan Year</i>)	100% - 0% ^{1,2}	No Coverage
Injections Received in a Physician's Office (<i>when no other health service is received</i>)	100% - 0% ¹	No Coverage
Inpatient Hospital Admission, All Inpatient Hospital Services Included	\$100 Copayment per day ² , maximum of \$300 per Admission	No Coverage
Inpatient and Outpatient Professional Services for which a Copayment is Not Applicable	100% - 0% ¹	No Coverage

	Copayments and Coinsurance	
	Network Providers	Non-Network Providers
Mastectomy Bras (<i>limited to three (3) per Plan Year</i>)	80% - 20% ¹ of first \$5,000 Allowable per Plan Year; 100% - 0% of Allowable in Excess of \$5,000 per Plan Year	No Coverage
Mental Health/Substance Abuse - Inpatient Treatment and Intensive Outpatient Programs	\$100 Copayment per day ² , maximum of \$300 per Admission	No Coverage
Mental Health/Substance Abuse – Office Visit and Outpatient Treatment (Other than Intensive Outpatient Programs)	\$25 Copayment per Visit	No Coverage
Newborn - Sick, Services excluding Facility	100% - 0% ¹	No Coverage
Newborn - Sick, Facility	\$100 Copayment per day ² , maximum of \$300 per Admission	No Coverage
Oral Surgery	100% - 0% ^{1,2}	No Coverage
Pregnancy Care - Physician Services	\$90 Copayment per pregnancy	No Coverage
Preventive Care - Services include screening to detect illness or health risks during a Physician office visit. The Covered Services are based on prevailing medical standards and may vary according to age and family history. (<i>For a complete list of benefits, refer to the Preventive and Wellness Article in the Benefit Plan.</i>)	100% - 0% ³	No Coverage
Rehabilitation Services - Outpatient: <ul style="list-style-type: none"> Speech Physical/Occupational <i>(Limited to 50 Visits combined PT/OT per Plan Year. Authorization required for visits over the combined limit of 50.) (Visit limits do not apply when services are provided for Autism Spectrum Disorders.)</i>	\$25 Copayment per Visit	No Coverage
Skilled Nursing Facility (<i>limit of 90 days per Plan Year</i>)	\$100 Copayment per day ² , maximum of \$300 per Admission	No Coverage
Sonograms and Ultrasounds (<i>Outpatient</i>)	\$50 Copayment	No Coverage
Urgent Care Center	\$50 Copayment	No Coverage
Vision Care (Non-Routine) Exam	\$25/\$50 Copayment depending on Provider Type	No Coverage
X-ray and Laboratory Services (<i>low-tech imaging</i>)	Hospital Facility 100% - 0% ¹ Office or Independent Lab 100% - 0%	No Coverage

¹Subject to Plan Year Deductible, if applicable

²Pre-Authorization Required, if applicable. Not applicable for Medicare primary.

³Age and/or Time Restrictions Apply

⁴No Benefits will be payable unless Prior Authorization is obtained, including Plan Participants with Medicare as the Primary Plan.

43:2158 (November 2017), effective January 1, 2018, LR 50:782 (June 2024).

Chapter 4.PPO/Consumer-Driven Health Plan Structure—Pelican HSA 775 Plan

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:359 (February 2015), effective March 1, 2015, amended LR 43:2157 (November 2017), effective January 1, 2018, LR 48:2770 (November 2022), LR 49:1379 (August 2023), LR 50:781 (June 2024).

§307. Prescription Drug Benefits

A. Prescription Drug Benefits

Network Pharmacy	Member pays
Tier 1- Generic	50% up to \$30
Tier 2- Preferred	50% up to \$55
Tier 3- Non-preferred	65% up to \$80
Tier 4- Specialty	50% up to \$80
90 day supplies for maintenance drugs from mail order OR at participating 90-day retail network pharmacies	Two and a half times the cost of your applicable copayment
Co-Payment after the Out Of Pocket Amount of \$1,500 Is Met	
Tier 1- Generic	\$0
Tier 2- Preferred	\$20
Tier 3- Non-preferred	\$40
Tier 4- Specialty	\$40
Prescription drug benefits-31 day refill Plan pays balance of eligible expenses	
Diabetic supplies are not subject to a copayment if enrolled in the In-Health/Disease Management Program.	
Member who chooses a brand-name drug for which an approved generic version is available, pays the cost difference between the brand-name drug & the generic drug, plus the co-pay for the brand-name drug; the cost difference does not apply to the \$1,500 out of pocket amount.	
Medications available over-the-counter in the same prescribed strength are not covered under the pharmacy plan.	
Smoking Cessation Medications:	
Benefits are available for Prescription and over-the-counter (OTC) smoking cessation medications when prescribed by a physician. (Prescription is required for over-the-counter medications). Smoking cessation medications are covered at 100%.	
This plan allows benefits for drugs and medicines approved by the Food and Drug Administration or its successor that require a prescription. Utilization management criteria may apply to specific drugs or drug categories to be determined by PBM.	

B. OGB shall have discretion to adopt a pharmacy benefits formulary to help enrollees select the most appropriate, lowest-cost options. The formulary will be reviewed on a quarterly basis to reassess drug tiers based on the current prescription drug market. The formulary may be changed from time to time subject to any applicable advance notice requirements. The amount enrollees pay toward prescription medications will depend on whether they purchase a generic, preferred brand, non-preferred brand, or specialty drug.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:360 (February 2015), effective March 1, 2015, amended LR

§401. Deductibles

Deductible Amount Per Benefit Period:	Network	Non-Network
Individual:	\$2,000	\$4,000
Family:	\$4,000	\$8,000
Coinsurance:	Plan	Plan Participant
Network Providers	80%	20%
Non-Network Providers	60%	40%

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:361 (February 2015), effective March 1, 2015.

§403. Out of Pocket Maximums

A. Out-of-Pocket Maximum Per Benefit Period

Includes All Eligible Deductibles Coinsurance Amounts and Prescription Drug Copayments:		
	Network	Non-Network
Individual:	\$5,000	\$10,000
Family:	\$10,000	\$20,000

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:361 (February 2015), effective March 1, 2015.

§405. Schedule of Benefits

A. Benefits and Coinsurance

	Coinsurance	
	Network Providers	Non-Network Providers
Physician's Office Visits including surgery performed in an office setting: <ul style="list-style-type: none"> • General Practice • Family Practice • Internal Medicine • OB/GYN • Pediatrics 	80% - 20% ¹	60% - 40% ¹
Allied Health/Other Office Visits: <ul style="list-style-type: none"> • Chiropractors • Federally Funded Qualified Rural Health Clinics • Retail Health Clinics • Nurse Practitioners • Physician's Assistants 	80% - 20% ¹	60% - 40% ¹

EMPLOYEE BENEFITS

	Coinsurance	
	Network Providers	Non-Network Providers
Specialist Office Visits including surgery performed in an office setting: <ul style="list-style-type: none"> Physician Podiatrist Optometrist Midwife Audiologist Registered Dietician Sleep Disorder Clinic 	80% - 20% ¹	60% - 40% ¹
Ambulance Services – Air (for Emergency Medical Transportation Only) Non-emergency requires prior authorization ²	80% - 20% ¹	80% - 20% ¹
Ambulatory Surgical Center and Outpatient Surgical Facility	80% - 20% ¹	60% - 40% ¹
Birth Control Devices - Insertion and Removal (as listed in the Preventive and Wellness Article in the Benefit Plan)	100% - 0%	60% - 40% ¹
Cardiac Rehabilitation (limited to 36 visits per Plan Year)	80% - 20% ^{1,2}	60% - 40% ^{1,2}
Chemotherapy/Radiation Therapy (Authorization not required when performed in Physician's office)	80% - 20% ^{1,2}	60% - 40% ^{1,2}
Diabetes Treatment	80% - 20% ¹	60% - 40% ¹
Diabetic/Nutritional Counseling – Clinics and Outpatient Facilities	80% - 20% ¹	Not Covered
Dialysis	80% - 20% ¹	60% - 40% ¹
Durable Medical Equipment (DME), Prosthetic Appliances and Orthotic Devices	80% - 20% ^{1,2}	60% - 40% ^{1,2}
Emergency Ground Ambulance Services; In-State	80% - 20% ¹	80% - 20% ¹
Emergency Ground Ambulance Services; Out-of-State	80% - 20% ¹	80% - 20% ¹
Non-Emergency Ground Ambulance Services	80% - 20% ¹	80% - 20% ¹
Emergency Room (Facility Charge)	80% - 20% ¹	80% - 20% ¹
Emergency Medical Services (Non-Facility Charge)	80% - 20% ¹	80% - 20% ¹
Eye-glass Frames and One Pair of Eye-glass Lenses or One Pair of Contact Lenses (purchased within six months following cataract surgery)	Eye-glass Frames – Limited to a Maximum Benefit of \$50 ¹	No Coverage
Flu Shots and H1N1 vaccines (administered at Network Providers, Non-Network Providers, Pharmacy, Job Site or Health Fair)	100% - 0%	100% - 0%
Hearing Aids (Hearing Aids are not covered for individuals age eighteen (18) and older)	80% - 20% ^{1,3}	Not Covered
Hearing Impaired Interpreter Expense	100% - 0%	100% - 0%
High-Tech Imaging – Outpatient <ul style="list-style-type: none"> CT Scans MRA/MRI Nuclear Cardiology PET Scans 	80% - 20% ^{1,2}	60% - 40% ^{1,2}
Home Health Care (limit of 60 Visits per Plan Year)	80% - 20% ^{1,2}	60% - 40% ^{1,2}
Hospice Care (limit of 180 Days per Plan Year)	80% - 20% ^{1,2}	60% - 40% ^{1,2}
Injections Received in a Physician's Office (when no other health service is received)	80% - 20% ¹	60% - 40% ¹
Inpatient Hospital Admission (all Inpatient Hospital services included)	80% - 20% ^{1,2}	60% - 40% ^{1,2}

	Coinsurance	
	Network Providers	Non-Network Providers
Inpatient and Outpatient Professional Services	80% - 20% ¹	60% - 40% ¹
Mastectomy Bras (limited to three (3) per Plan Year)	80% - 20% ¹	60% - 40% ¹
Mental Health/Substance Abuse – Inpatient Treatment and Intensive Outpatient Programs	80% - 20% ^{1,2}	60% - 40% ^{1,2}
Mental Health/Substance Abuse – Office Visits and Outpatient Treatment (Other than Intensive Outpatient Programs)	80% - 20% ¹	60% - 40% ¹
Newborn – Sick, Services excluding Facility	80% - 20% ¹	60% - 40% ¹
Newborn – Sick, Facility	80% - 20% ^{1,2}	60% - 40% ^{1,2}
Oral Surgery	80% - 20% ^{1,2}	60% - 40% ^{1,2}
Pregnancy Care - Physician Services	80% - 20% ¹	60% - 40% ¹
Preventive Care - Services include screening to detect illness or health risks during a Physician office visit. The Covered Services are based on prevailing medical standards and may vary according to age and family history. (For a complete list of benefits, refer to the Preventive and Wellness/Routine Care Article in the Benefit Plan.)	100% - 0% ³	100% - 0% ³
Rehabilitation Services - Outpatient: <ul style="list-style-type: none"> Speech Physical/Occupational (Limited to 50 Visits combined PT/OT per Plan Year. Authorization required for visits over the combined limit of 50.) (Visit limits do not apply when services are provided for Autism Spectrum Disorders.)	80% - 20% ¹	60% - 40% ¹
Skilled Nursing Facility (limit 90 Days per Plan Year)	80% - 20% ^{1,2}	60% - 40% ^{1,2}
Sonograms and Ultrasounds - Outpatient	80% - 20% ¹	60% - 40% ¹
Urgent Care Center	80% - 20% ¹	60% - 40% ¹
Vision Care (Non-Routine) Exam	80% - 20% ¹	60% - 40% ¹
X-Ray and Laboratory Services (low-tech imaging)	80% - 20% ¹	60% - 40% ¹
¹ Subject to Plan Year Deductible, if applicable ² Pre-Authorization Required, if applicable. Not applicable for Medicare primary. ³ Age and/or Time Restrictions Apply		

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:361 (February 2015), effective March 1, 2015, amended LR 43:2159 (November 2017), effective January 1, 2018, amended LR 50:782 (June 2024).

§407. Prescription Drug Benefits

A. Prescription Drug Benefits

Network Pharmacy	Member pays
Generic	\$10 co-pay
Preferred	\$25 co-pay
Non-preferred	\$50 co-pay
Specialty	\$50 co-pay
Prescription drug benefits-31 day refill	
Maintenance drugs: not subject to deductible; subject to applicable co-payments above.	
Plan pays balance of eligible expenses	

Member who chooses a brand-name drug for which an approved generic version is available, pays the cost difference between the brand-name drug & the generic drug, plus the co-pay for the brand-name drug
Medications available over-the-counter in the same prescribed strength are not covered under the pharmacy plan.
Smoking Cessation Medications: Benefits are available for Prescription and over-the-counter (OTC) smoking cessation medications when prescribed by a physician. (Prescription is required for over-the-counter medications). Smoking cessation medications are covered at 100%.
This plan allows benefits for drugs and medicines approved by the Food and Drug Administration or its successor that require a prescription. Utilization management criteria may apply to specific drugs or drug categories to be determined by PBM.

B. OGB shall have discretion to adopt a pharmacy benefits formulary to help enrollees select the most appropriate, lowest-cost options. The formulary will be reviewed on a quarterly basis to reassess drug tiers based on the current prescription drug market. The formulary may be changed from time to time subject to any applicable advance notice requirements. The amount enrollees pay toward prescription medications will depend on whether they purchase a generic, preferred brand, non-preferred brand, or specialty drug.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:362 (February 2015), effective March 1, 2015.

Chapter 5. PPO/Consumer-Driven Health Plan Structure—Pelican HRA 1000 Plan

§501. Deductibles

Deductible Amount Per Benefit Period:	Network	Non-Network
Individual:	\$2,000	\$4,000
Family:	\$4,000	\$8,000
Coinsurance:	Plan	Plan Participant
Network Providers	80%	20%
Non-Network Providers	60%	40%

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:363 (February 2015), effective March 1, 2015.

§503. Out of Pocket Maximums

A. Plan Participants When OGB Is the Primary Payer for All Plan Participants

Out-of-Pocket Maximum Per Benefit Period (Includes All Eligible Deductibles, Coinsurance Amounts and Copayments)		
	Network	Non-Network
Individual	\$5,000	\$10,000
Family	\$10,000	\$20,000

B. Plan Participants When Medicare Is the Primary Payer for at Least One Plan Participant

Out-of-Pocket Maximum ¹ Per Benefit Period (Includes All Eligible Deductibles, Coinsurance Amounts and Copayments)		
	Network	Non-Network
Individual	Medical: \$3,000 Prescription: \$2,000	\$10,000
Family (Medicare Paying Primary for One)	Medical: \$8,000 Prescription: \$2,000	\$20,000
Family (Medicare Paying Primary for Two)	Medical: \$6,000 Prescription: \$2,000 per participant	\$20,000
Family (Medicare Paying Primary for Three)	Medical: \$4,000 Prescription: \$2,000 per participant	\$20,000

¹ Medical Out-of-Pocket Maximum applies to medical expenditures for all Plan Participants and to Prescription expenditures for Plan Participants when OGB is the primary payer. Prescription Out-of-Pocket Maximum applies to each Plan Participant when Medicare is the primary payer.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:364 (February 2015), effective March 1, 2015, amended LR 50:1470 (October 2024), effective January 1, 2025.

§505. Schedule of Benefits

A. Benefits and Coinsurance

	Coinsurance	
	Network Providers	Non-Network Providers
Physician's Office Visits including surgery performed in an office setting: <ul style="list-style-type: none"> • General Practice • Family Practice • Internal Medicine • OB/GYN • Pediatrics 	80% - 20% ¹	60% - 40% ¹
Allied Health/Other Office Visits: <ul style="list-style-type: none"> • Chiropractors • Federally Funded Qualified Rural Health Clinics • Retail Health Clinics • Nurse Practitioners • Physician's Assistants 	80% - 20% ¹	60% - 40% ¹

EMPLOYEE BENEFITS

	Coinsurance	
	Network Providers	Non-Network Providers
Specialist Office Visits including surgery performed in an office setting: <ul style="list-style-type: none"> Physician Podiatrist Optometrist Midwife Audiologist Registered Dietician Sleep Disorder Clinic 	80% - 20% ¹	60% - 40% ¹
Ambulance Services – Air (for Emergency Medical Transportation only) Non-emergency requires prior authorization ²	80% - 20% ¹	80% - 20% ¹
Ambulatory Surgical Center and Outpatient Surgical Facility	80% - 20% ¹	60% - 40% ¹
Bariatric Surgery Services – Facility Services ⁴	\$2,500.00 Copayment ^{2,3}	No Coverage
Bariatric Surgery Services – Professional Services ⁴	90% - 10% ^{2,3}	No Coverage
Bariatric Surgery Services – Preoperative and Postoperative Medical Services ⁴	80% - 20% ^{2,3}	No Coverage
Birth Control Devices - Insertion and Removal (as listed in the Preventive and Wellness Article in the Benefit Plan)	100% - 0%	60% - 40% ¹
Cardiac Rehabilitation (limited to 36 visits per Plan Year)	80% - 20% ^{1,2}	60% - 40% ^{1,2}
Chemotherapy/Radiation Therapy (Authorization not required when performed in Physician's office)	80% - 20% ^{1,2}	60% - 40% ^{1,2}
Diabetes Treatment	80% - 20% ¹	60% - 40% ¹
Diabetic/Nutritional Counseling – Clinics and Outpatient Facilities	80% - 20% ¹	Not Covered
Dialysis	80% - 20% ¹	60% - 40% ¹
Durable Medical Equipment (DME), Prosthetic Appliances and Orthotic Devices	80% - 20% ^{1,2}	60% - 40% ^{1,2}
Emergency Ground Ambulance Services; In-State	80% - 20% ¹	80% - 20% ¹
Emergency Ground Ambulance Services; Out-of-State	80% - 20% ¹	80% - 20% ¹
Non-Emergency Ground Ambulance Services	80% - 20% ¹	80% - 20% ¹
Emergency Room (Facility Charge)	80% - 20% ¹	80% - 20% ¹
Emergency Medical Services (Non-Facility Charge)	80% - 20% ¹	80% - 20% ¹
Eyeglass Frames and One Pair of Eyeglass Lenses or One Pair of Contact Lenses (purchased within six months following cataract surgery)	Eyeglass Frames – Limited to a Maximum Benefit of \$50 ¹	No Coverage
Flu Shots and H1N1 vaccines (administered at Network Providers, Non-Network Providers, Pharmacy, Job Site or Health Fair)	100% - 0%	100% - 0%
Hearing Aids (Hearing Aids are not covered for individuals age eighteen (18) and older)	80% - 20% ^{1,3}	Not Covered
Hearing Impaired Interpreter Expense	100%-0%	100%-0%

	Coinsurance	
	Network Providers	Non-Network Providers
High-Tech Imaging - Outpatient <ul style="list-style-type: none"> CT Scans MRA/MRI Nuclear Cardiology PET Scans 	80% - 20% ^{1,2}	60% - 40% ^{1,2}
Home Health Care (limit of 60 Visits per Plan Year)	80% - 20% ^{1,2}	60% - 40% ^{1,2}
Hospice Care (limit of 180 Days per Plan Year)	80% - 20% ^{1,2}	60% - 40% ^{1,2}
Injections Received in a Physician's Office (when no other health service is received)	80% - 20% ¹	60% - 40% ¹
Inpatient Hospital Admission (all Inpatient Hospital services included)	80% - 20% ^{1,2}	60% - 40% ^{1,2}
Inpatient and Outpatient Professional Services	80% - 20% ¹	60% - 40% ¹
Mastectomy Bras (limited to three (3) per Plan Year)	80% - 20% ¹	60% - 40% ¹
Mental Health/Substance Abuse - Inpatient Treatment and Intensive Outpatient Programs	80% - 20% ^{1,2}	60% - 40% ^{1,2}
Mental Health/Substance Abuse – Office Visit and Outpatient Treatment (Other than Intensive Outpatient Programs)	80% - 20% ¹	60% - 40% ¹
Newborn - Sick, Services excluding Facility	80% - 20% ¹	60% - 40% ¹
Newborn - Sick, Facility	80% - 20% ^{1,2}	60% - 40% ^{1,2}
Oral Surgery	80% - 20% ^{1,2}	60% - 40% ^{1,2}
Pregnancy Care - Physician Services	80% - 20% ¹	60% - 40% ¹
Preventive Care - Services include screening to detect illness or health risks during a Physician office visit. The Covered Services are based on prevailing medical standards and may vary according to age and family history. (For a complete list of benefits, refer to the Preventive and Wellness/Routine Care Article in the Benefit Plan.)	100% - 0% ³	100% - 0% ³
Rehabilitation Services - Outpatient: <ul style="list-style-type: none"> Speech Physical/Occupational (Limited to 50 Visits combined PT/OT per Plan Year. Authorization required for visits over the combined limit of 50.) (Visit limits do not apply when services are provided for Autism Spectrum Disorders.) 	80% - 20% ¹	60% - 40% ¹
Skilled Nursing Facility (limit 90 Days per Plan Year)	80% - 20% ^{1,2}	60% - 40% ^{1,2}
Sonograms and Ultrasounds - Outpatient	80% - 20% ¹	60% - 40% ¹
Urgent Care Center	80% - 20% ¹	60% - 40% ¹
Vision Care (Non-Routine) Exam	80% - 20% ¹	60% - 40% ¹
X-Ray and Laboratory Services (low-tech imaging)	80% - 20% ¹	60% - 40% ¹

¹Subject to Plan Year Deductible, if applicable

²Pre-Authorization Required, if applicable. Not applicable for Medicare primary.

³Age and/or Time Restrictions Apply

⁴No Benefits will be payable unless Prior Authorization is obtained, including Plan Participants with Medicare as the Primary Plan.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:364 (February 2015), effective March 1, 2015, amended LR 43:2160 (November 2017), effective January 1, 2018, LR 49:1381 (August 2023), LR 50:782 (June 2024).

§507. Prescription Drug Benefits

A. Prescription Drug Benefits

Network Pharmacy	Member pays
Tier 1 - Generic	50% up to \$30
Tier 2 - Preferred	50% up to \$55
Tier 3 - Non-preferred	65% up to \$80
Tier 4 - Specialty	50% up to \$80
90 day supplies for maintenance drugs from mail order OR at participating 90-day retail network pharmacies	Two and a half times the cost of your applicable co-payment
Co-Payment after the Out Of Pocket Amount of \$1,500 Is Met	
Tier 1 - Generic	\$0
Tier 2 - Preferred	\$20
Tier 3 - Non-preferred	\$40
Tier 4 - Specialty	\$40
Prescription drug benefits-31 day refill	
Maintenance drugs: not subject to deductible; subject to applicable copayments above.	
Plan pays balance of eligible expenses.	
Diabetic supplies are not subject to a copayment if enrolled in the In-Health/Disease Management Program.	
Member who chooses a brand-name drug for which an approved generic version is available, pays the cost difference between the brand-name drug & the generic drug, plus the co-pay for the brand-name drug; the cost difference does not apply to the \$1,500 out of pocket amount.	

Medications available over-the-counter in the same prescribed strength are not covered under the pharmacy plan.
Smoking Cessation Medications: Benefits are available for Prescription and over-the-counter (OTC) smoking cessation medications when prescribed by a physician. (Prescription is required for over-the-counter medications). Smoking cessation medications are covered at 100%.
This plan allows benefits for drugs and medicines approved by the Food and Drug Administration or its successor that require a prescription. Utilization management criteria may apply to specific drugs or drug categories to be determined by PBM.

B. OGB shall have discretion to adopt a pharmacy benefits formulary to help enrollees select the most appropriate, lowest-cost options. The formulary will be reviewed on a quarterly basis to reassess drug tiers based on the current prescription drug market. The formulary may be changed from time to time subject to any applicable advance notice requirements. The amount enrollees pay toward prescription medications will depend on whether they purchase a generic, preferred brand, non-preferred brand, or specialty drug.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:365 (February 2015), effective March 1, 2015, amended LR 43:2161 (November 2017), effective January 1, 2018, amended LR 50:782 (June 2024).

Title 32
EMPLOYEE BENEFITS
Part VII. Public Employee Deferred Compensation
Subpart 1. Deferred Compensation Plan

Chapter 1. Administration

§101. Definitions

Account Balance—

1. the bookkeeping account maintained with respect to each participant which reflects the value of the deferred compensation credited to the participant, including:

- a. the participant's total amount deferred;
- b. the earnings or loss of the fund (net of fund expenses) allocable to the participant;
- c. any transfers for the participant's benefit; and
- d. any distribution made to the participant or the participant's beneficiary:

i. if a participant has more than one beneficiary at the time of the participant's death, then each beneficiary's share of the account balance shall be treated as a separate account for each beneficiary;

2. the *account balance* includes:

- a. any account established under §505 for rollover contributions and plan-to-plan transfers made for a participant;
- b. the account established for a beneficiary after a participant's death; and
- c. any account or accounts established for an alternate payee [as defined in Code §414(p)(8)].

Administrator or Plan Administrator—the person, persons or entity appointed by the Louisiana Deferred Compensation Commission to administer the plan pursuant to LAC 32:VII.103.A, if any.

Age 50 or Older Catch-Up—the deferred amount described pursuant to LAC 32:VII.303.C.

Alternate Payee—the spouse, former spouse, child or other dependent of a participant who has acquired an interest in the participant's account pursuant to a Qualified Domestic Relations Order (QDRO) pursuant to §1503. Alternate payees shall be treated as beneficiaries for all purposes under the plan except that alternate payees shall be allowed to request a distribution of all or a portion of their account balance at any time, subject to the terms of the QDRO.

Beneficiary—the person, persons or entities designated by a participant pursuant to §301.A.5 who is entitled to receive benefits under the plan after the death of a participant.

Commission—the Louisiana Deferred Compensation Commission, as established in accordance with R.S. 42:1302, which shall be comprised of the state treasurer, the commissioner of administration, the commissioner of insurance, the commissioner of financial institutions (or their designees), and three participant members (elected by the participants).

Compensation—all payments paid by the employer to an employee or independent contractor as remuneration for services rendered, including salaries and fees, and, to the extent permitted by treasury regulations or other similar guidance, accrued vacation and sick leave pay paid within 2 and 1/2 months of participant's severance from employment so long as the employee would have been able to use the leave if employment had continued.

Custodial Account—the account established with a bank or trust company meeting the provisions of Internal Revenue Code (IRC) §401(f), that the commission has elected to satisfy the trust requirement of IRC §457(g) by setting aside plan assets in a custodial account.

Custodian—the bank or trust company or other person, if any selected by the commission to hold plan assets in a custodial account in accordance with regulations pursuant to IRC §457(g) and 401(f).

Deferred Compensation—the amount of compensation not yet earned, which the participant and the commission mutually agree, shall be deferred.

Designated Roth Account—a separate account maintained by the plan in accordance with IRC §402A and the regulations thereunder for accepting designated Roth contributions. A designated Roth contribution is an elective deferral that would otherwise be excludable from gross income but that has been designated by the participant who elects the deferral as not being so excludable, or an existing account which is converted to a *designated Roth account* in compliance with the *Internal Revenue Code*.

Eligible Designated Beneficiary—a participant's surviving spouse or child who has not reached the age of majority, a disabled or chronically ill person, or a person not more than ten years younger than the participant.

Employee—any individual who is employed by the employer, either as a common law employee or an independent contractor, including elected or appointed individuals providing personal services to the employer. Any *employee* who is included in a unit of employees covered by a collective bargaining agreement that does not specifically provide for participation in the plan shall be excluded.

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Includible Compensation—an employee's actual wages in Box 1 of Form W-2 for a year for services to the employer, but subject to a maximum of \$200,000 [or such higher maximum as may apply under Code §401(a)(17)] and increased (up to the dollar maximum) by any compensation reduction election under Code §§125, 132(f), 401(k), 403(b), or 457(b) [for purposes of the limitation set forth in §303.A, compensation for services performed for the employer as defined in IRC §457(e)(5)].

Independent Contractor—an individual (not a corporation, partnership, or other entity), who is receiving compensation for services rendered to or on behalf of the employer in accordance with a contract between such individual and the employer.

Interest or Interest in Deferred Compensation—under the plan, the aggregate of:

1. a participant's deferred compensation for his or her entire period of participation in the plan; and
2. the earnings or losses allocable to such amount. Such interest represents an accounting entry only and does not constitute an ownership interest, right or title in the assets so invested.

Investment Product—any form of investment designated by the commission for the purpose of receiving funds under the plan.

IRC—the *Internal Revenue Code* of 1986, as amended, or any future United States Internal Revenue law. References herein to specific section numbers shall be deemed to include treasury regulations thereunder and Internal Revenue Service guidance thereunder and to corresponding provisions of any future United States internal revenue law. All citations to sections of the Code are to such sections as they may from time to time be amended or renumbered.

Limited Catch-Up—the deferred amount described in LAC 32:VII.305.A.

Non-Elective Employer Contribution—any contribution made by an employer for the participant with respect to which the participant does not have the choice to receive the contribution in cash or property. Such term may also include an employer matching contribution.

Normal Retirement Age—

1. the age designated by a participant, which age shall be between:
 - a. the earliest date on which such participant is entitled to retire under the public retirement system of which that participant is a member without actuarial reduction in his or her benefit; and
 - b. age 70 1/2, provided, however, that if a participant continues in the employ of the employer beyond 70 1/2, *normal retirement age* means the age at which the participant severs employment;

2. if the participant is not a member of a defined benefit plan in any public retirement system, the participant's

normal retirement age may not be earlier than age 65, and may not be later than age 70 1/2. A special rule shall apply to qualified police or firefighters under the plan, if any. Any qualified police or firefighter, as defined under §415(b)(2)(H)(ii)(I), who is participating in the plan may choose a normal retirement age that is not earlier than age 40 nor later than age 70 1/2;

3. if a participant continues to be employed by employer after attaining age 70 1/2, not having previously elected an alternate normal retirement age, the participant's alternate normal retirement age shall not be later than the mandatory retirement age, if any, established by the employer, or the age at which the participant actually severs employment with the employer if the employer has no mandatory retirement age.

Participant—an individual who is eligible to defer compensation under the plan, and has executed an effective deferral authorization. *Participant* also includes an employee or independent contractor who has severance from employment but has not received a complete distribution of his or her interest in deferred compensation under the plan.

Participation Agreement—the agreement executed and filed by an individual who is eligible to defer compensation under the plan, and has executed an effective deferral authorization.

Pay Period—a regular accounting period designated by the employer for the purpose of measuring and paying compensation earned by an employee or independent contractor.

Plan—the State of Louisiana Public Employees Deferred Compensation Plan established by this document and any applicable amendment.

Plan Year—the calendar year.

Qualified Domestic Relations Order or *QDRO*—as specified in LAC 32:VII.1503.B.

Qualified Military Service—any service in the uniformed service (as defined in Chapter 43 of Title 38 of the United States Code as in effect as of December 12, 1994) by any individual if such individual is entitled to reemployment rights under such Chapter with respect to such service.

Required Beginning Date—for participants who reach age 73 on or after January 1, 2023, but before January 1, 2033, the required beginning date is April 1 of the calendar year following the calendar year in which the participant reaches age 73. For participants who reach age 74 on or after January 1, 2033, the required beginning date is April 1 of the calendar year following the calendar year in which the participant reaches age 75.

Section 3121 Participant—an individual who is using the Plan as a retirement system providing FICA replacement benefits pursuant to IRC §3121(b)(7)(F) and the regulations thereunder.

Separation from Service or *Separates from Service*—

1. with respect to an employee, the permanent severance of the employment relationship with the employer on account of such employee's:

- a. retirement;
- b. discharge by the employer;
- c. resignation;
- d. layoff; or

e. in the case of an employee who is an appointed or elected officer, the earlier of:

- i. the taking of the oath of office of such officer's successor; or
- ii. the cessation of the receipt of compensation

2. if an employee incurs a break in service for a period of less than 30 days or transfers among various Louisiana governmental entities, such break or transfer shall not be considered a separation from service;

3. with respect to an independent contractor, *separation from service* means that the expiration of all contracts pursuant to services performed for or on behalf of the employer.

Severance from Employment or Severs Employment—

1. the date the employee dies, retires, or otherwise has a severance from employment with the employer, as determined by the administrator (and taking into account guidance issued under the Code). An employee whose employment is interrupted by qualified military service under Code §414(u) shall be deemed severed from employment until such time as he or she is reemployed following the term of duty. A participant shall be deemed to have severed employment with the employer for purposes of this plan when both parties consider the employment relationship to have terminated and neither party anticipates any future employment of the participant by the employer. In the case of a participant who is an independent contractor, severance from employment shall be deemed to have occurred when:

- a. the participant's contract for services has completely expired and terminated;
- b. there is no foreseeable possibility that the employer shall renew the contract or enter into a new contract for services to be performed by the participant; and
- c. it is not anticipated that the participant shall become an employee of the employer;

2. with respect to an employee, the permanent severance of the employment relationship with the employer on account of such employee's:

- a. retirement;
- b. discharge by the employer;
- c. resignation;
- d. layoff; or

e. in the case of an employee who is an appointed or elected officer, the earlier of:

- i. the taking of the oath of office of such officer's successor; or
- ii. the cessation of the receipt of compensation;

3. if an employee incurs a break in service for a period of less than 30 days or transfers among various Louisiana governmental entities, such break or transfer shall not be considered a severance from employment.

Total Amount Deferred—with respect to each participant, the sum of all compensation deferred under the plan (plus investment gains and/or losses thereon, including amounts determined with reference to life insurance policies) calculated in accordance with the method designated in the participant's participation agreement(s) under which such compensation was deferred and any subsequent election(s) to change methods, less the amount of any expenses or distributions authorized by this plan.

Trustee—the commission or such other person, persons or entity selected by the commission who agrees to act as *trustee*. This term also refers to the person holding the assets of any custodial account or holding any annuity contract described in LAC 32:VII.317.

Unforeseeable Emergency—

1. severe financial hardship of a participant or beneficiary resulting from:

- a. an illness or accident of the participant or beneficiary, the participant's or beneficiary's spouse, or the participant's or beneficiary's dependent (as defined in IRC §152, and without regard to IRC §152(b)(1), (b)(2), and (d)(1)(B));
- b. loss of the participant's or beneficiary's property due to casualty (including the need to rebuild a home following damage to a home not otherwise covered by homeowner's insurance, such as damage that is the result of a natural disaster); or
- c. other similar extraordinary and unforeseeable circumstances arising as a result of events beyond the control of participant or beneficiary;

2. the definition of *unforeseeable emergency* does not include either the purchase of a home or the payment of college tuition;

3. The definition of *unforeseeable emergency* includes, but is not limited to, the following:

- a. payment of mortgage payments or rent due to imminent foreclosure of or eviction from the participant's or beneficiary's primary residence;
- b. the need to pay for medical expenses, including non-refundable deductibles, as well as for the cost of prescription drug medication; and

c. the need to pay for funeral expenses of a spouse or dependent (as defined above) of a participant or beneficiary.

AUTHORITY NOTE: Promulgated in accordance with IRC §457 and R.S. 42:1301-1308.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 24:1962 (October 1998), amended LR 28:1494 (June 2002), LR 32:118 (January 2006), LR 37:1617 (June 2011), LR 40:2281 (November 2014), LR 50:1011 (July 2024).

§103. Commission Authority

A. The commission shall have full power and authority to adopt rules or policies required to implement the plan and to interpret, amend or repeal any such rule or policy. In addition, the commission shall have full power and authority to administer the plan or to arrange for the administration of the plan through appropriate contracts or agents in accordance with applicable state law. The power and authority of such agents shall be limited to the powers enumerated in the contractual agreements between the commission and such agents.

AUTHORITY NOTE: Promulgated in accordance with IRC §457 and R.S. 42:1301-1308.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 24:1963 (October 1998).

§105. Duties of Commission

A. The duties shall include:

1. appointing one (or more) attorney, accountant, actuary, custodian, record keeper or any other party needed to administer the plan;
2. directing the trustee or custodian with respect to payments from assets held in the plan;
3. communicating with employees regarding their participation and benefits under the plan, including the administration of all claims procedures;
4. filing any returns and reports with the Internal Revenue Service or any other governmental agency;
5. reviewing and approving any financial reports, investment reviews, or other reports prepared by any party appointed under §105.A.1;
6. establishing a funding policy and investment objectives consistent with the purposes of the plan;
7. construing and resolving any question of plan interpretation. The commission's interpretation of plan provisions (including eligibility and benefits under the plan) is final;
8. appointing an emergency committee comprised of at least three individuals. Applications for a withdrawal of deferred compensation based on an unforeseeable emergency shall be approved or disapproved by such committee:

a. a participant shall furnish medical or other evidence to the emergency committee to establish and substantiate the existence of an unforeseeable emergency;

b. if an application for a withdrawal based on unforeseeable emergency is approved, the amount of the withdrawal shall be limited to the amount required to meet such emergency. Payment shall not be made to the extent such emergency is relieved:

- i. through reimbursement or compensation by insurance or otherwise;
- ii. by the liquidation of the participant's assets, provided the liquidation does not cause a financial hardship; or
- iii. by the revocation of the participant's deferral authorization.

AUTHORITY NOTE: Promulgated in accordance with IRC §457 and R.S. 42:1301-1308.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 24:1963 (October 1998), amended LR 28:1495 (June 2002).

§107. Administrative Fees and Expenses

A. The commission may, in its sole discretion, use one or more of the following methods to meet the costs of administering the plan. The commission may:

1. establish a reasonable monthly or annual administrative charge;
2. deduct an allocable portion of administrative costs from deferred compensation;
3. deduct an allocable portion of administrative costs from the income or earnings of investment products;
4. authorize any duly-appointed administrator to accept commissions from providers of investment products, provided, however, that the amount of such commissions may not exceed the amount of similar commissions paid to unrelated third parties;
5. deduct administrative costs from funds on deposit in financial institutions; and/or
6. deduct any other reasonable fee or commission required to defray the costs of administering the plan.

AUTHORITY NOTE: Promulgated in accordance with IRC §457 and R.S. 42:1301-1308.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 24:1963 (October 1998).

§109. Actions of Administrator

A. Every action taken by the commission shall be presumed to be a fair and reasonable exercise of the authority vested in or the duties imposed upon it. The commission shall be deemed to have exercised reasonable care, diligence and prudence and to have acted impartially as to all affected persons, unless the contrary is proven by affirmative evidence. No member, if a participant of the commission or a committee, shall make any determination (other than a policy decision which affects all participants) similarly situated with respect to his or her specific interest in deferred compensation under the plan. The commission

shall not be liable for amounts of compensation deferred by participants or for other amounts payable under the plan.

AUTHORITY NOTE: Promulgated in accordance with IRC §457 and R.S. 42:1301-1308.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 24:1964 (October 1998).

§111. Delegation

A. Subject to any applicable laws and any approvals required by the employer, the commission may delegate any or all of its powers and duties hereunder to another person, persons, or entity, and may pay reasonable compensation for such services as an administrative expense of the plan, to the extent such compensation is not otherwise paid.

AUTHORITY NOTE: Promulgated in accordance with IRC §457 and R.S. 42:1301-1308.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 24:1964 (October 1998).

Chapter 3. Plan Participation, Options and Requirements

§301. Enrollment in the Plan

A. The following applies to compensation deferred under the plan.

1. A participant may not defer any compensation unless a deferral authorization providing for such deferral has been completed by the participant and is filed in good order with the administrator. Such election shall become effective no earlier than the first payroll period after the first day of the month after such new election is made, and shall continue in effect until modified, disallowed or revoked in accordance with the terms of this plan, or until the participant ceases employment with the employer. With respect to a new employee, compensation will be deferred in the payroll period during which a participant first becomes an employee if a deferral authorization providing for such deferral is executed on or before the first day on which the participant becomes an employee. Any prior employee who was a participant in the plan and either revoked their participant agreement, or is rehired by employer, may resume participation in the plan by entering into a participation agreement, which shall take effect no earlier than the first payroll period after the first day of the month after such new participation agreement is entered into by the participant and accepted by the administrator. Any distributions being taken from this plan are to be terminated prior to the resumption of deferrals under the plan. Additionally, if distributions had not begun pursuant to a prior severance from employment, any deferred commencement date elected by such employee with respect to those prior plan assets shall be null and void.

2. In signing the participation agreement, the participant elects to participate in this plan and consents to the deferral by the employer of the amount specified in the participation agreement from the participant's gross compensation for each pay period. Such deferral shall continue in effect until modified, disallowed or revoked in

accordance with the terms of this plan. Unless the election specifies a later effective date, a change in the amount of the deferral shall take effect as of the first payroll period after the first day of the next following month, or as soon as administratively practicable, if later.

3. The minimum amount of compensation deferred under a deferral authorization shall be no less than \$20 each month; provided, however, that such minimum deferral shall not apply to a participant whose deferral authorization (or similar form) in effect on October 1, 1984, permitted a smaller deferral, or to a participant who elects to defer not less than 7.5 percent of compensation (voluntary and/or involuntary contributions) in lieu of Social Security coverage (§11332 of the Social Security Act and IRC §3121). The employer retains the right to establish minimum deferral amounts per pay period and to limit the number and/or timing of enrollments into the plan in the participation agreement.

4. Notwithstanding §301.A.1, to the extent permitted by applicable law, the administrator may establish procedures whereby each employee becomes a participant in the plan (automatic enrollment) and, as a term or condition of employment, elects to participate in the plan and consents to the deferral by the employer of a specified amount for any payroll period for which a participation agreement is not in effect. In the event such procedures are in place, a participant may elect to defer a different amount of compensation per payroll period, including zero, by entering into a participation agreement.

a. Within a reasonable period of time before each plan year, the commission shall give to each employee to whom an automatic enrollment arrangement described in §301.A.4 applies for such year notice of the employee's rights under such arrangement.

b. The notice provided for in §301.A.4.a above shall provide an explanation of the employee's rights and obligations under the arrangement, including the right to elect not to have contributions made on the employee's behalf or to have such contributions made at a different percentage. The notice shall also provide an explanation of how contributions made under the arrangement will be invested in the absence of any investment election by the employee.

5. Investment Selection and Beneficiary Designation

a. The participation election, or such other form as approved by the administrator, shall include the employee's designation of investment funds. Any such election shall remain in effect until a new election is filed. A change in the investment direction shall take effect as of the date provided by the administrator on a uniform basis for all employees.

b. Each participant shall initially designate in the participation agreement a beneficiary or beneficiaries to receive any amounts, which may be distributed in the event of the death of the participant prior to the complete distribution of benefits. A participant may change the designation of beneficiaries at any time by filing with the

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commission a written notice on a form approved by the commission. If no such designation is in effect at the time of participant's death, or if the designated beneficiary does not survive the participant by 30 days, his beneficiary shall be his surviving spouse, if any, and then his estate.

6. Information Provided by the Participant. Each employee enrolling in the plan should provide to the administrator at the time of initial enrollment, and later if there are any changes, any information necessary or advisable, in the sole discretion of the administrator, for the administrator to administer the plan, including, without limitation, whether the employee is a participant in any other eligible plan under Code §457(b).

AUTHORITY NOTE: Promulgated in accordance with IRC §457 and R.S. 42:1301-1308.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 24:1964 (October 1998), amended LR 28:1495 (June 2002), LR 32:119 (January 2006), LR 37:1620 (June 2011).

§303. Deferral Limitations

A. Except as provided in §305.A.1-2.a-b, the maximum that may be deferred under the plan for any taxable year of a participant shall not exceed the lesser of:

1. the applicable dollar amount in effect for the year, as adjusted for the calendar year in accordance with IRC §457(e)(15). [After 2006, the dollar amount is adjusted for cost-of-living under Code §415(d)]; or

2. 100 percent of the participant's includible compensation, each reduced by any amount specified in Subsection B of this §303 that taxable year. However, in no event can the deferred amount be more than the participant's compensation for such years unless the employer is making nonelective employer contributions;

a. the annual deferral amount does not include any rollover amounts received by the plan under treasury regulation §1.457-10(e).

B. The deferral limitation shall be reduced by any amount excludable from the participant's gross income attributable to elective deferrals to another eligible deferred compensation plan described in IRC §457(b).

C. A participant who attains age 50 or older by the end of a plan year and who does not utilize the limited catch-up for such plan year may make a deferral in excess of the limitation specified in Paragraphs A.1-2 of this §303, up to the amount specified in and subject to any other requirements under IRC §414(v).

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:1301-1308 and IRC §457.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 24:1964 (October 1998), amended LR 28:1496 (June 2002), LR 32:120 (January 2006).

§305. Roth Catch-up Contributions

A. For one or more of the participant's last three taxable years ending before the taxable year in which normal

retirement age under the plan is attained, the maximum deferral shall be the lesser of:

1. twice the otherwise applicable dollar limit under IRC §457(e)(15) for that taxable year; reduced by any applicable amount specified in LAC 32:VII.303.B; or

2. the sum of:

a. an amount equal to the aggregate limit determined by §303A. of this Plan for the current year and any prior calendar years beginning after December 31, 2001, during which the participant was eligible to participate in this Plan, minus the aggregate amount of compensation that the participant deferred under this Plan during such years, plus

b. an amount equal to the aggregate limit referred to in IRC §457(b)(2) for each prior calendar year beginning after December 31, 1978, and before January 1, 2002, during which the participant was an employee, minus the aggregate contributions made by the participant to pre-2002 coordination plans for such years.

B. If a participant is not a member of a defined benefit plan in any public retirement system, normal retirement age may not be earlier than age 65, and may not be later than age 70 1/2.

C. Pre-2002 Coordination Years

1. For purposes of this §305, *Contributions to Pre-2002 Coordination Plans* means any employer contribution, salary reduction or elective contribution under:

a. any other eligible Code §457(b) plan; or

b. a salary reduction or elective contribution under any Code §401(k) qualified cash or deferred arrangement;

c. Code §402(h)(1)(B) simplified employee pension (SARSEP);

d. Code §403(b) annuity contract; and

e. Code §408(p) simple retirement account; or

f. any plan for which a deduction is allowed because of a contribution to an organization described in Code §501(c)(18), including plans, arrangements or accounts maintained by the employer or any employer for whom the participant performed services.

2. Contributions for any calendar year are only taken into account for purposes of this §305 to the extent that the total of such contributions does not exceed the aggregate limit referred to in Code §457(b)(2) for that year.

D. Beginning on January 1, 2026, for any participant whose wages exceeded \$145,000 in any calendar year (as adjusted under IRC §414(v)(7)(E)), any contribution made under this §305 in the subsequent calendar year must be a designated Roth contribution. Any otherwise eligible participant whose wages do not exceed \$145,000 in any calendar year (as adjusted under IRC §414(v)(7)(E)) may designate any contribution made under this §305 as a designated Roth contribution.

AUTHORITY NOTE: Promulgated in accordance with IRC §457 and R.S. 42:1301-1308.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 24:1965 (October 1998), amended LR 28:1496 (June 2002), LR 32:120 (January 2006), LR 37:1620 (June 2011), LR 50:1011 (July 2024).

§307. Participant Modification of Deferral

A. The participant shall be entitled to modify the amount (or percentage) of deferred compensation with respect to compensation payable no earlier than the payroll period after the first day of the next following month, or as soon as administratively practicable, if later, provided such modification is entered into by the participant and accepted by the commission. Notwithstanding the above, if a negative election procedure has been implemented pursuant to §301.A.4, a participant may enter into or modify a participation agreement at any time to provide for no deferral.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:1301-1308 and IRC §457.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 24:1965 (October 1998), amended LR 28:1496 (June 2002), LR 32:120 (January 2006).

§309. Employer Modification of Deferral

A. The commission shall have the right to modify or disallow the periodic deferral of compensation elected by the participant:

1. in excess of the limitations stated in LAC 32:VII.303.A and 305.A;

2. in excess of the participant's net compensation for any pay period;

3. upon any change in the length of pay period utilized by employer. In such case the periodic deferral shall be adjusted so that approximately the same percentage of pay shall be deferred on an annual basis;

4. in order to round down periodic deferrals to the nearest whole cent amount;

5. to reduce the future deferrals in the event that the amount actually deferred for any pay period exceeds, for any reason whatsoever, the amount elected by the participant. In the alternative, such amount of excess deferral may be refunded to the participant. No adjustment in future deferrals shall be made if a periodic deferral is missed or is less than the amount elected, for any reason whatsoever; or

6. if the deferral elected for any pay period is less than the minimum amount specified in LAC 32:VII.301.A.3.

B. To the extent permitted by, and in accordance with, the *Internal Revenue Code*, the employer or administrator may distribute the amount of a participant's deferral in excess of the distribution limitations stated in §§301, 303, 305, 307 and 309 notwithstanding the limitations of §701.A; provided, however, that the employer and the commission shall have no liability to any participant or beneficiary with

respect to the exercise of, or the failure to exercise, the authority provided in this §309.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:1301-1308 and IRC §457.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 24:1965 (October 1998), amended LR 28:1496 (June 2002), LR 32:121 (January 2006).

§311. Revocation

A. A participant may, at any time, revoke his or her deferral authorization by notifying the commission, in writing, on forms acceptable to the commission. Upon the acceptance of such notification, deferrals under the plan shall cease no later than the commencement of the first pay period beginning at least 30 days after acceptance; provided, however, that the commission shall not be responsible for any delay which occurs despite its good faith efforts. In no event shall the revocation of a participant's deferral authorization permit a distribution of deferred compensation, except as provided in §701.A of these rules, and shall be subject to the terms and provisions of the affected investment.

B. A participant's request for a distribution in the event of an unforeseeable emergency shall in addition be treated as a request for revocation of deferrals as of a date determined by the commission.

AUTHORITY NOTE: Promulgated in accordance with IRC §457 and R.S. 42:1301-1308.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 24:1965 (October 1998), amended LR 28:1496 (June 2002).

§313. Re-Enrollment

A. A participant who revokes the participation agreement as set forth in §311.A may execute a new participation agreement to defer compensation payable no earlier than the payroll period after the first day of the next following month, or as soon as administratively practicable, if later, provided such new participation agreement is executed by the participant and accepted by the commission.

B. A former participant who is rehired after retirement may rejoin the plan as an active participant unless ineligible to participate under other plan provisions.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:1301-1308 and IRC §457.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 24:1965 (October 1998), amended LR 28:1496 (June 2002), LR 32:121 (January 2006).

§315. Multiple Plans

A. Should a participant participate in more than one deferred compensation plan governed by IRC §457, the limitations set forth in LAC 32:VII.303 and 305 shall apply to all such plans considered together. For purposes of LAC 32:VII.303 and 305, compensation deferred shall be taken into account at its value in the later of the plan year in which deferred or the plan year in which such compensation

is no longer subject to a substantial risk of forfeiture (within the meaning of IRC §457).

AUTHORITY NOTE: Promulgated in accordance with IRC §457 and R.S. 42:1301-1308.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 24:1966 (October 1998).

§317. Custody of Plan Assets

A. All amounts of compensation deferred under the plan, all property and rights purchased with such amounts, and all income attributable to such amounts, property or rights shall be held for the exclusive benefit of participants and their beneficiaries. The trust requirement of IRC §457(g) shall be satisfied as plan assets and shall be set aside as follows.

1. Plan assets shall be set aside in one or more annuity contracts described in IRC §401(f). The owner of the annuity contract is the "deemed trustee" of the assets invested under the contract for purposes of IRC §457(g).

2. Plan assets shall be set aside in one or more custodial accounts described in IRC §401(f). The bank or trust company shall be the custodian and "deemed trustee" for purposes of IRC §457(g) and shall accept such appointment by executing same. The commission and custodian must enter into a separate written custody agreement.

3. All amounts deferred under the Plan shall be transferred by the employer to the Commission for investment through an account described in §317.A.1 or 2 above within 15 business days following the month in which such amounts would have otherwise been paid to the participant.

AUTHORITY NOTE: Promulgated in accordance with IRC §457 and R.S. 42:1301-1308.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 24:1966 (October 1998), LR 37:1620 (June 2011).

§319. Qualified Military Service

A. Notwithstanding any provision of this plan to the contrary, contributions and benefits with respect to qualified military service shall be provided in accordance with IRC §414(u).

B. Protection of Persons Who Serve in a Uniformed Service. An employee whose employment is interrupted by qualified military service under Code §414(u) may elect to make additional annual deferrals upon resumption of employment with the employer equal to the maximum annual deferrals that the employee could have elected during that period if the employee's employment with the employer had continued (at the same level of compensation) without the interruption or leave, reduced by the annual deferrals, if any, actually made for the employee during the period of the interruption or leave. This right applies for five years following the resumption of employment (or, if sooner, for a period equal to three times the period of the interruption or leave).

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:1301-1308 and IRC §457.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 24:1966 (October 1998), amended LR 32:121 (January 2006).

§321. Correction of Excess Deferrals

A. If the total amount deferred on behalf of a participant for any calendar year exceeds the limitations described above, or the total amount deferred on behalf of a participant for any calendar year exceeds the limitations described above when combined with other amounts deferred by the participant under another eligible deferred compensation plan under Code §457(b) for which the participant provides information that is accepted by the administrator, then the total amount deferred, to the extent in excess of the applicable limitation (adjusted for any income or loss in value, if any, allocable thereto), shall be distributed to the participant.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:1301-1308 and IRC §457.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 32:121 (January 2006).

§323. Section 3121 Participants

A. Notwithstanding any other provisions in this plan to the contrary, the following shall apply to all section 3121 participants:

1. annual allocations to each section 3121 participant's account must be equal to at least 7.5 percent of the participant's annual compensation;

2. all amounts deferred by a section 3121 participant shall be held in a non-forfeitable account. Such account shall be credited with earnings at a rate that is reasonable under all the facts and circumstances or employees' accounts are held in a separate trust that is subject to general fiduciary standards and are credited with actual net earnings on the trust fund, in accordance with IRS Treas. reg. §31.3121(b)(7)-2(e)(2)(iii);

3. no distributions from the Plan shall be made to a section 3121 participant before such Participant severs employment.

B. In the event a section 3121 participant no longer intends to use the plan as a retirement system providing FICA replacement benefits pursuant to IRC §3121(b)(7)(F) and the regulations thereunder, the participant may transfer any amounts being held pursuant to this Subsection to an account described in §505 of the plan.

AUTHORITY NOTE: Promulgated in accordance with IRC §457 and R.S. 42:1301-1308.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 37:1620 (June 2011).

Chapter 5. Investments

§501. Investment Options

A. The commission shall in its sole discretion select certain investment options to be used to determine income to be accrued on deferrals. These investment options may include specified life insurance policies, annuity contracts, or investment media issued by an insurance company. In any event, it shall be the sole responsibility of the commission to ensure that all investment options offered under the plan are appropriate and in compliance with any and all state laws pertaining to such investments.

B. The commission shall have the right to direct the trustee with respect to investments of the plan assets, may appoint an investment manager to direct investments, or may give the trustee sole investment management responsibility. Any investment directive shall be made in writing by the commission or investment manager. In the absence of such written directive, the trustee shall automatically invest the available cash in its discretion in an appropriate interim investment until specific investment directions are received. Such instructions regarding the delegation of investment responsibility shall remain in force until revoked or amended in writing. The trustee shall not be responsible for the propriety of any directed investment made and shall not be required to consult with or advise the commission regarding the investment quality of any directed investment held hereunder.

C. The commission may, from time to time, change the investment options under the plan. If the commission eliminates a certain investment option, all participants who had chosen that investment shall select another option. If no new option is selected by the participant, money remaining in the eliminated investment option shall be moved at the direction of the commission. The participants shall have no right to require the commission to select or retain any investment option. To the extent permitted by and subject to any rules or procedures adopted by the administrator, a participant may, from time to time, change his choice of investment option. Any change with respect to investment options made by the commission or a participant, however, shall be subject to the terms and conditions (including any rules or procedural requirements) of the affected investment options and may affect only income to be accrued after that change.

AUTHORITY NOTE: Promulgated in accordance with IRC §457 and R.S. 42:1301-1308.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 24:1966 (October 1998).

§503. Participant Investment Direction

A. Participants shall have the option to direct the investment of their personal contributions and their share of any employer contributions among alternative investment options established as part of the overall trust, unless otherwise specified by the employer. Such investment options shall be under the full control of the trustee. A participant's right to direct the investment of any

contribution shall apply only to making selections among the options made available under the plan.

B. Each participant shall designate on his or her participation agreement the investment that shall be used to determine the income to be accrued on amounts deferred. If the investment chosen by the participant experiences a gain, the participant's benefits under the plan likewise shall reflect income for that period. If the investment chosen by a participant experiences a loss, or if charges are made under such investment, the participant's benefits under the plan likewise shall reflect such loss or charge for that period.

C. Neither the commission, the administrator, the trustee nor any other person shall be liable for any losses incurred by virtue of following the participant's directions or with any reasonable administrative delay in implementing such directions.

AUTHORITY NOTE: Promulgated in accordance with IRC §457 and R.S. 42:1301-1308.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 24:1966 (October 1998).

§505. Participant Accounts

A. The commission shall maintain or cause to be maintained one or more individual deferred compensation ledger account or similar individual account(s) for each participant. Such accounts shall include separate accounts, as necessary, for IRC §457 Deferred Compensation, IRC §457 rollovers, IRA rollovers, other qualified plan and IRC §403(b) plan rollovers, and such other accounts as may be appropriate from time to time for plan administration. At regular intervals established by the commission, each participant's account shall be:

1. credited with the amount of any deferred compensation paid into the plan;
2. debited with any applicable administrative or investment expense, allocated on a reasonable and consistent basis;
3. credited or debited with investment gain or loss, as appropriate; and
4. debited with the amount of any distribution.

B. At least once per calendar quarter, each participant shall be notified in writing of his/her total amount deferred.

C. Beginning on January 1, 2011, the commission may maintain or cause to be maintained (for individual participants) designated Roth accounts.

AUTHORITY NOTE: Promulgated in accordance with IRC §457 and R.S. 42:1301-1308.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 24:1967 (October 1998), amended LR 28:1497 (June 2002), LR 40:2281 (November 2014).

§507. Distributions from the Plan

A. The payment of benefits in accordance with the terms of the plan may be made by the trustee, or by any custodian or other person so authorized by the commission to make

such distribution. Neither the commission, the trustee nor any other person shall be liable with respect to any distribution from the plan made at the direction of the employer or a person authorized by the employer to give disbursement direction.

AUTHORITY NOTE: Promulgated in accordance with IRC §457 and R.S. 42:1301-1308.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 24:1967 (October 1998).

Chapter 7. Distributions

§701. Conditions for Distributions

A. Payments from the participants §457 Deferred Compensation Plan account to the participant or beneficiary shall not be made, or made available, earlier than:

1. the participant's severance from employment pursuant to LAC 32:VII.703.A or death; or
2. the participant's account meets all of the requirements for an in-service de minimus distribution pursuant to LAC 32:VII.705.A and B; or
3. the participant incurs an approved unforeseeable emergency pursuant to LAC 32:VII.709.A; or
4. the participant transfers an amount to a defined benefit governmental plan pursuant to LAC 32:VII.705.C; or
5. the calendar year in which an in-service participant attains age 59 1/2; or
6. the participant makes a qualified birth or adoption distribution pursuant to §113 of the Setting Every Community Up for Retirement Act of 2019. Any such qualified birth or adoption distribution shall not exceed \$5,000 per birth or adoption. The commission or plan administrator may rely upon a participant's birth or adoption certificate for purposes of determining eligibility.

B. Payments from a Participant's Rollover Account(s). If a participant has a separate account attributable to rollover contributions to the plan, the participant may at any time elect to receive a distribution of all or any portion of the amount held in the rollover account(s).

C. In order to implement the provisions of the Setting Every Community Up for Retirement Enhancement (SECURE) Act, enacted on December 20, 2019, and SECURE 2.0 Act, enacted on December 29, 2022, relating to required minimum distributions, including but not limited to §707 and §711 of the Plan, the commission is hereby authorized to enter into any and all agreements with the plan administrator so that the plan is in compliance with all federal laws and regulations.

AUTHORITY NOTE: Promulgated in accordance with IRC §457 and R.S. 42: 1301-1308.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 24:1967 (October 1998), amended LR 28:1497 (June 2002), LR 32:121 (January 2006), LR 50:1011 (July 2024).

§703. Severance from Employment

A. Distributions to a participant shall commence following the date in which the participant severs employment, in a form and manner determined pursuant to LAC 32:VII.713.A, 715.A and 717.A.

B. Upon notice to participants, and subject to §§701.A, 703.B, and 721.A, the administrator may establish procedures under which a participant whose total §457 Deferred Compensation account balance is less than an amount specified by the administrator (not in excess of \$1,000 or other applicable limit under the Internal Revenue Code) may receive a lump sum distribution on the first regular distribution commencement date (as the employer or administrator may establish from time to time) following the participant's severance from employment, notwithstanding any election made by the participant pursuant to §721.A.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:1301-1308 and IRC §457.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 24:1967 (October 1998), amended LR 28:1497 (June 2002), LR 32:121 (January 2006).

§705. In-Service Distributions

A. Voluntary In-Service Distribution of De Minimis Accounts. A participant who is an active employee shall receive a distribution of the total amount payable to the participant under the plan if the following requirements are met:

1. the portion of the total amount payable to the participant under the plan does not exceed an amount specified from time to time by the commission (not in excess of \$5,000 or other applicable limit under the Internal Revenue Code);
2. the participant has not previously received an in-service distribution of the total amount payable to the participant under the plan;
3. no amount has been deferred under the plan with respect to the participant during the two-year period ending on the date of the in-service distribution; and
4. the participant elects to receive the distribution.

B. Involuntary In-Service Distribution of De Minimis Accounts. Upon notice to participants, and subject to LAC 32:VII.721.A, the commission may establish procedures under which the plan shall distribute the total amount payable under the plan to a participant who is an active employee if the following requirements are met:

1. the portion of the total amount payable to the participant under the plan does not exceed an amount specified from time to time by the commission (not in excess of \$1,000 or other applicable limit under the Internal Revenue Code);
2. the participant has not previously received an in-service distribution of the total amount payable to the participant under the plan; and

3. no amount has been deferred under the plan with respect to the participant during the two-year period ending on the date of the in-service distribution.

C. Participants in the plan providing FICA replacement retirement benefits pursuant to regulations under Code §3121(b)(7)(F) are not eligible for In-Service De Minimus distributions.

D. Purchase of Defined Benefit Plan Service Credit

1. If a participant is also a participant in a defined benefit governmental plan [as defined in IRC §414(d)], such participant may request the commission to transfer amounts from his or her account for:

a. the purchase of permissive service credit [as defined in IRC §415(n)(3)(A)] under such plan; or

b. a repayment to which IRC §415 does not apply by reason of IRC §415(k)(3).

2. Such transfer requests shall be granted in the sole discretion of the commission, and if granted, shall be made directly to the defined benefit governmental plan.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:1301-1308 and IRC §457.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 24:1967 (October 1998), amended LR 28:1497 (June 2002), LR 32:121 (January 2006).

§707. Deferred Commencement Date at Separation from Service

A. Following the date in which the participant severs employment, the participant may select a deferred commencement date for all or a portion of the participant's account balance. If the participant elects to defer the entire account balance, the future commencement date may not be later than April 1 of the calendar year following the calendar year in which the participant attains age 70 1/2.

B. If the participant is an independent contractor:

1. in no event shall distributions commence prior to the termination date on which all such participant's contracts to provide services to or on behalf of the employer expire; and

2. in no event shall a distribution payable to such participant pursuant to §703.A commence if, prior to the conclusion of the one-month period following cessation of services under contract, the participant performs services for the employer as an employee or independent contractor.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:1301-1308 and IRC §457.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 24:1967 (October 1998), amended LR 28:1498 (June 2002), LR 32:122 (January 2006).

§709. Unforeseeable Emergency

A. If a participant has incurred a genuine unforeseeable emergency and no other resources of financial relief are available, the commission may grant, in its sole discretion, a

participant's request for a payment from the participant's account. Any payment made under this provision shall be in a lump sum.

1. The commission shall have the right to request and review all pertinent information necessary to assure that hardship withdrawal requests are consistent with the provisions of IRC §457.

2. In no event, however, shall an unforeseeable emergency distribution be made if such hardship may be relieved:

a. through reimbursement or compensation by insurance or otherwise;

b. by liquidation of the participant's assets, to the extent the liquidation of the participant's assets would not itself cause a severe financial hardship; or

c. by cessation of deferrals under this plan.

3. The amount of any financial hardship benefit shall not exceed the lesser of:

a. the amount reasonably necessary, as determined by the commission, to satisfy the hardship; or

b. the amount of the participant's account.

4. Payment of a financial hardship distribution shall result in mandatory suspension of deferrals for a minimum of 6 months from the date of payment (or such other period as mandated in treasury regulations).

B. The following events are not considered unforeseeable emergencies under the Plan:

1. enrollment of a child in college;

2. purchase of a house;

3. purchase or repair of an automobile, except due to a casualty loss or other similar extraordinary and unforeseeable circumstances arising as a result of events beyond the control of the participant or beneficiary;

4. repayment of loans (unless the loan was the direct result of an unforeseeable emergency, as defined in section 101 of the plan);

5. payment of income taxes, back income taxes, or fines associated with back income taxes (except for income taxes which result from a distribution made in connection with an unforeseeable emergency, as defined in section 101 of the plan);

6. marital separation or divorce; or

7. bankruptcy (except when bankruptcy resulted directly from an unforeseeable emergency, as defined in section 101 of the plan).

AUTHORITY NOTE: Promulgated in accordance with IRC §457 and R.S. 42:1301-1308.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 24:1968 (October 1998), amended LR 28:1498 (June 2002), LR 32:122 (January 2006), LR 37:1621 (June 2011).

§711. Death Benefits

A. Upon the participant's death, the participant's remaining account balance(s) will be distributed to the beneficiary commencing after the administrator receives satisfactory proof of the participant's death (or on the first regular distribution commencement date thereafter as the employer or administrator may establish from time to time), unless prior to such date the beneficiary elects a deferred commencement date, in a form and manner determined pursuant to LAC 32:VII.713.A and 717.A.

B. If there are two or more beneficiaries, the provisions of this §711 and of §717.A shall be applied to each beneficiary separately with respect to each beneficiary's share in the participant's account.

C. If the participant's designated beneficiary is an eligible designated beneficiary, the designated beneficiary must take distributions over a period no longer than their life expectancy or 10 years, whichever is greater.

D. If the participant's designated beneficiary is not an eligible designated beneficiary, the designated beneficiary must take the participant's entire account balance by the end of the tenth year following the year of the participant's death.

E. If the participant's beneficiary is the surviving spouse, the surviving spouse may elect to rollover the account or be treated as the participant for required minimum distribution purposes.

F. Under no circumstances shall the commission be liable to the beneficiary for the amount of any payment made in the name of the participant before the commission receives satisfactory proof of the participant's death.

AUTHORITY NOTE: Promulgated in accordance with IRC §457 and R.S. 42: 1301-1308.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 24:1968 (October 1998), amended LR 28:1498 (June 2002), LR 32:122 (January 2006), LR 50:1012 (July 2024).

§713. Payment Options

A. A participant's or beneficiary's election of a payment option must be made at least 30 days prior to the date that the payment of benefits is to commence. If a timely election of a payment option is not made, benefits shall be paid in accordance with §715.A. Subject to applicable law and the other provisions of this plan, distributions may be made in accordance with one of the following payment options:

1. a single lump-sum payment;
2. installment payments for a period of years (payable on a monthly, quarterly, semiannual, or annual basis), which extends no longer than the life expectancy of the participant or beneficiary as permitted under the requirements of IRC §401(a)(9) using the Uniform Lifetime Table at regulation. §1.041(a)(9)-9, A-2 for the participant's age on the participant's birthday for that year. If the participant's age is less than age 70, the distribution period is 27.4 plus the number of years that the participant's age is less than age 70.

The account balance for this calculation (other than the final installment payment) is the account balance as of the end of the year prior to the year for which the distribution is being calculated;

3. installment payments for a period of years (payable on a monthly, quarterly, semiannual, or annual basis) automatically adjusted for cost-of-living increases based on the rise in the *Consumer Price Index for All Urban Consumers* (CPI-U) from the third quarter of the last year in which a cost-of-living increase was provided to the third quarter of the current year. Any increase shall be made in periodic payment checks beginning the following January;

4. partial lump-sum payment of a designated amount, with the balance payable in installment payments for a period of years, as described in Subsection A of this §713;

5. annuity payments (payable on a monthly, quarterly, or annual basis) for the lifetime of the participant or for the lifetime of the participant and beneficiary in compliance with IRC §401(a)(9);

6. such other forms of installment payments as may be approved by the commission consistent with the requirements of IRC §401(a)(9).

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:1301-1308 and IRC §457.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 24:1968 (October 1998), amended LR 28:1498 (June 2002), LR 32:123 (January 2006).

§715. Default Distribution Option

A. In the absence of an effective election by the participant, beneficiary or other payee, as applicable, as to the commencement and/or form of benefits, distributions shall be made in accordance with the applicable requirements of IRC §§401(a)(9) and 457(d), and proposed or final treasury regulations thereunder. In the absence of an effective election by the beneficiary or alternate payee as to the commencement and/or form of benefits, distribution shall be made in a lump sum.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:1301-1308 and IRC §457.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 24:1969 (October 1998), amended LR 28:1499 (June 2002), LR 32:123 (January 2006).

§717. Limitations on Distribution Options

A. No distribution option may be selected by a participant or beneficiary under this §717 unless it satisfies the requirements of IRC §§401(a)(9) and 457(d) and proposed or final treasury regulations thereunder.

B. If installment payments are designated as the method of distribution, the minimum distribution shall be no less than \$100 per check and the payments made annually must be no less than \$600.

AUTHORITY NOTE: Promulgated in accordance with IRC §457 and R.S. 42:1301-1308.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 24:1969 (October 1998), amended LR 28:1499 (June 2002).

§719. Taxation of Distributions

A. To the extent required by law, income and other taxes shall be withheld from each benefit payment, and payments shall be reported to the appropriate governmental agency or agencies.

AUTHORITY NOTE: Promulgated in accordance with IRC §457 and R.S. 42:1301-1308.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 24:1969 (October 1998), amended LR 28:1499 (June 2002).

§721. Transfers and Rollovers Catch-Up

A. Transfers Into the Plan. At the direction of the employer, the administrator may permit a class of participants who are participants in another eligible governmental plan under code §457(b) to transfer assets to the plan. Such a transfer is permitted only if the other plan provides for the direct transfer of each participant's interest therein to the plan. The administrator may require in its sole discretion that the transfer be in cash. The administrator may require such documentation from the other plan as it deems necessary to effectuate the transfer in accordance with code §457(e)(10) and treasury regulation §1.457-10(b) and to confirm that the other plan is an eligible governmental plan as defined in treasury regulation §1.457-2(f). The amount so transferred shall be credited to the participant's account balance and shall be held, accounted for, administered and otherwise treated in the same manner as an annual deferral by the participant under the plan, except that the transferred amount shall not be considered an annual deferral under the plan in determining the maximum deferral under article III.

B. In-Service Transfers from the Plan. If a participant becomes a participant in another governmental eligible deferred compensation plan, and provided that payments under this plan have not begun, such participant may request a transfer of his or her account to the other eligible deferred compensation plan. Requests for such transfers must be made in writing to the commission and shall be granted in the sole discretion of the commission. If an amount is to be transferred pursuant to this provision, the commission shall transfer such amount directly to the other eligible governmental deferred compensation plan. Amounts transferred to another eligible governmental deferred compensation plan shall be treated as distributed from this plan and this plan shall have no further responsibility to the participant or any beneficiary with respect to the amount transferred.

C. Section 3121 Participant Transfers. If a participant was formerly a section 3121 participant, then the plan shall accept assets representing amounts deferred under §323 of this plan, provided the participant remains an employee.

D. Rollovers to the Plan

1. The plan shall accept a rollover contribution on behalf of a participant or employee who may become a participant. A rollover contribution, for purposes of this

Subsection, is an eligible rollover contribution (as defined in IRC §402(f)(2)) from any:

- a. plan qualified under IRC §401(a) or 403(a);
- b. tax-sheltered annuity or custodial account described in IRC §403(b);
- c. individual retirement account or annuity described in IRC §408;
- d. eligible deferred compensation plan described in IRC §457(b).

2. Prior to accepting any rollover contribution, the commission must reasonably conclude, after a good faith effort, that the amount to be rolled over to the plan is a valid rollover within the meaning of the Internal Revenue Code. A participant's rollover contribution shall be held in a separate rollover account or accounts, as the commission shall determine from time to time. If, at any time, a rollover contribution is determined to be invalid, the commission shall distribute to the participant any such amount determined to be invalid within a reasonable period of time after such a determination is made.

AUTHORITY NOTE: Promulgated in accordance with IRC §457 and R.S. 42:1301-1308.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 24:1969 (October 1998), amended LR 28:1499 (June 2002), LR 37:1621 (June 2011), LR 40:2281 (November 2014), LR 50:1012 (July 2024).

§723. Eligible Rollover Distributions

A. General. Notwithstanding any provision of the plan to the contrary that would otherwise limit a distributee's election under this §723, a distributee may elect, at the time and in the manner prescribed by the employer, to have any portion of an eligible rollover distribution paid directly to an eligible retirement plan specified by the distributee in a direct rollover.

B. Notice. The commission shall, within a reasonable period of time before making an eligible rollover distribution, provide a written explanation to the distributee explaining the following, as amended from time to time by applicable changes to the law:

1. the provisions under which the distributee may have the distribution directly transferred to an eligible retirement plan and that the automatic distribution by direct transfer applies to certain distributions in accordance with §401(a)(31)(B) of the Internal Revenue Code;
2. the provision which requires the withholding of tax on the distribution if it is not directly transferred to an eligible retirement plan;
3. the provisions under which the distribution will not be subject to tax if transferred to an eligible retirement plan within 60 days after the date on which the recipient received the distribution;
4. the provisions under which distributions from the eligible retirement plan receiving the distribution may be

subject to restrictions and tax consequences which are different from those applicable to distributions from the plan making such distribution.

C. Definitions. For purposes of this §723, the following definitions shall apply.

Direct Rollover—a payment by the plan to the eligible retirement plan specified by the distributee.

Distributee—includes an employee or former employee, the employee's or former employee's surviving spouse and the employee's or former employee's spouse or former spouse who is the alternate payee under a *qualified domestic relations order*, as defined in IRC §414(p), are distributees with regard to the interest of the spouse or former spouse.

Eligible Retirement Plan—an eligible retirement plan is an individual retirement account described in IRC §408(a), an individual retirement annuity described in IRC §408(b), an annuity plan described in IRC §403(a) that accepts the distributee's eligible rollover distribution, a qualified trust described in IRC §401(a) (including §401(k)) that accepts the distributee's eligible rollover distribution, a tax-sheltered annuity described in IRC §403(b) that accepts the distributee's eligible rollover distribution, or another eligible deferred compensation plan described in IRC §457(b) that accepts the distributee's eligible rollover distribution. However, in the case of an eligible rollover distribution to the surviving spouse, an eligible retirement plan is an individual retirement account or individual retirement annuity.

Eligible Rollover Distribution—any distribution of all or any portion of the balance to the credit of the distributee, except that an eligible rollover distribution does not include any distribution that is one of a series of substantially equal periodic payments (not less frequently than annually) made for the life (or life expectancy) of the distributee or the joint lives (or joint life expectancies and the distributee's designated beneficiary, or for:

- a. a specified period of 10 years or more;
- b. any distribution to the extent such distribution is required under IRC §401(a)(9);
- c. any distribution that is a deemed distribution under the provisions of IRC §72(p);
- d. the portion of any distribution that is not includable in gross income; and
- e. any hardship distribution or distribution on account of unforeseeable emergency.

Reasonable Period of Time—shall have the meaning assigned to it under §401(a)(31) of the Internal Revenue Code and the regulations thereunder.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:1301-1308 and IRC §457.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 24:1969 (October 1998), amended LR 28:1499 (June 2002), LR 32:123 (January 2006), LR 37:1621 (June 2011).

§725. Elections

A. Elections under this Chapter 7 shall be made in such form and manner as the commission may specify from time to time. To the extent permitted by and in accordance with the Internal Revenue Code, any irrevocable elections as to the form or timing of distributions executed prior to January 1, 2002, are hereby revoked.

AUTHORITY NOTE: Promulgated in accordance with IRC §457 and R.S. 42:1301-1308.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 24:1970 (October 1998), amended LR 28:1500 (June 2002).

§727. Practices and Procedures

A. The commission may adopt practices and procedures applicable to existing and new distribution elections.

AUTHORITY NOTE: Promulgated in accordance with R.S. §42:1301-1308 and IRC §457.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 28:1500 (June 2002).

Chapter 9. Leave of Absence

§901. Paid and Unpaid Leave of Absence

A. Paid Leave of Absence. If a participant is on an approved leave of absence from the employer with compensation, or on approved leave of absence without compensation that does not constitute a severance from employment within the meaning of IRC §402(d)(4)(A)(iii) which under the employer's current practices is generally a leave of absence without compensation for a period of one year or less, said participant's participation in the plan may continue.

B. Unpaid Leave of Absence. If a participant is on an approved leave of absence without compensation and such leave of absence continues to such an extent that it becomes a severance from employment within the meaning of IRC §402(e)(4)(A)(iii), said participant shall have severed employment with the employer for purposes of this plan. Upon termination of leave without pay and return to active status, the participant may execute a new participation agreement to be effective when permitted by LAC 32:VII.313.B of the plan.

AUTHORITY NOTE: Promulgated in accordance with IRC §457 and R.S. 42:1301-1308.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 24:1970 (October 1998), amended LR 28:1500 (June 2002).

Chapter 11. Participant Loans

§1101. Authorization of Loans

A. The commission may direct the administrator to make loans to participants on or after the effective date of treasury regulations or other guidance under IRC §457 and to the extent allowable under and in accordance with IRC §457. Such loans shall be made on the application of the participant in a form approved by the administrator and on

such terms and conditions as are set forth in this Chapter 11, provided, however, that the administrator may adopt rules or procedures specifying different loan terms and conditions, if necessary or desirable, to comply with or conform to such treasury regulations or other guidance and other applicable law.

AUTHORITY NOTE: Promulgated in accordance with IRC §457 and R.S. 42:1301-1308.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 28:1500 (June 2002).

§1103. Maximum Loan Amount

A. In no event shall any loan made to a participant be in an amount which shall cause the outstanding aggregate balance of all loans made to such participant under this plan exceed the lesser of:

1. \$50,000, reduced by the excess (if any) of:
 - a. the highest outstanding balance of loans from the plan to the participant during the one-year period ending on the day before the date on which the loan is made;
 - b. over the outstanding balance of loans from the plan to the participant or the beneficiary on the date on which the loan is made; or
2. one-half of the participant's account balance.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:1301-1308 and IRC §457.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 28:1500 (June 2002), amended LR 32:123 (January 2006).

§1105. Repayment of Loan

A. Each loan shall mature and be payable, in full and with interest, within five years from the date such loan is made, unless:

1. the loan is used to acquire any dwelling unit that within a reasonable time (determined at the time the loan is made) will be used as the principal residence of the participant; or
2. loan repayments are, at the employer's election, suspended as permitted by IRC §414(u)(4) (with respect to qualified military service).

AUTHORITY NOTE: Promulgated in accordance with R.S. §42:1301-1308 and IRC §457.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 28:1500 (June 2002).

§1107. Loan Terms and Conditions

A. In addition to such rules as the administrator may adopt, which rules are hereby incorporated into this plan by reference, all loans to participants shall comply with the following terms and conditions.

1. Loans shall be available to all participants on a reasonably equivalent basis.
2. Loans shall bear interest at a reasonable rate to be fixed by the administrator based on interest rates currently

being charged by commercial lenders for similar loans. The administrator shall not discriminate among participants in the matter of interest rates, but loans granted at different times may bear different interest rates based on prevailing rates at the time.

3. Each loan shall be made against collateral, including the assignment of no more than one-half of the present value of the participant's total amount deferred as security for the aggregate amount of all loans made to such participant, supported by the participant's collateral promissory note for the amount of the loan, including interest.

4. The participant shall be required, as a condition to receiving a loan, to enter into an irrevocable agreement authorizing the employer to make payroll deductions from his or her compensation as long as the participant is an employee and to transfer such payroll deduction amounts to the trustee in payment of such loan plus interest. Repayments of a loan shall be made by payroll deduction of equal amounts (comprised of both principal and interest) from each paycheck, with the first such deduction to be made as soon as practicable after the loan funds are disbursed; provided, however, a participant may prepay the entire outstanding balance of his loan at any time; and provided, further, that if any payroll deductions cannot be made in full because a participant is on an unpaid leave of absence or is no longer employed by a participating employer (that has consented to make payroll deductions for this purpose) or the participant's paycheck is insufficient for any other reason, the participant shall pay directly to the plan the full amount that would have been deducted from the participant's paycheck, with such payment to be made by the last business day of the calendar month in which the amount would have been deducted.

5. A loan to a participant or beneficiary shall be considered a directed investment option for such participant's account balance.

6. No distribution shall be made to any participant, or to a beneficiary of any such participant, unless and until all unpaid loans, including accrued interest thereon, have been satisfied. If a participant terminates employment with the employer for any reason, the outstanding balance of all loans made to him shall become fully payable and, if not paid within 30 days, any unpaid balance shall be deducted from any benefit payable to the participant or his beneficiary. In the event of default in repayment of a loan or the bankruptcy of a participant who has received a loan, the note will become immediately due and payable, foreclosure on the note and attachment of security will occur, the amount of the outstanding balance of the loan will be treated as a distribution to the participant, and the defaulting participant's accumulated deferrals shall be reduced by the amount of the outstanding balance of the loan (or so much thereof as may be treated as a distribution without violating the requirements of the Internal Revenue Code).

7. The loan program under the plan shall be administered by the administrator in a uniform and

nondiscriminatory manner. The administrator shall establish procedures for loans, including procedures for applying for loans, guidelines governing the basis on which loans shall be approved, procedures for determining the appropriate interest rate, the types of collateral which shall be accepted as security, any limitations on the types and amount of loans offered, loan fees and the events which shall constitute default and actions to be taken to collect loans in default.

8. Security for Loan. Any loan to a participant under the plan shall be secured by the pledge of the portion of the participant's interest in the plan invested in such loan.

9. Default

a. In the event that a participant fails to make a loan payment under this Article IV by the end of the calendar quarter following the calendar quarter in which such payment was due, a default on the loan shall occur. In the event of such default:

i. all remaining payments on the loan shall be immediately due and payable;

ii. interest will continue to accrue on the unpaid balance until the loan is repaid in full; and

iii. the participant shall be permanently ineligible for any future loans from the plan unless, in the administrator's sole discretion, the participant is deemed to be credit worthy and agrees to repay the loan through payroll deduction.

b. In the case of any default on a loan to a participant, the administrator shall apply the portion of the participant's interest in the plan held as security for the loan in satisfaction of the loan on the date of severance from employment. In addition, the administrator shall take any legal action it shall consider necessary or appropriate to enforce collection of the unpaid loan, with the costs of any legal proceeding or collection to be charged to the account balance of the participant.

c. Notwithstanding anything elsewhere in the plan to the contrary, in the event a loan is outstanding hereunder on the date of a participant's death, his or her estate shall be his or her beneficiary as to the portion of his or her interest in the plan invested in such loan (with the beneficiary or beneficiaries as to the remainder of his or her interest in the plan to be determined in accordance with otherwise applicable provisions of the plan).

10. Loans shall not be available for a period of 30 days following the repayment of a previous loan from the plan.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:1301-1308 and IRC §457.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 28:1500 (June 2002), amended LR 32:123 (January 2006), LR 37:1622 (June 2011).

Chapter 13. Plan Amendment or Termination

§1301. Termination

A. The commission may at any time terminate this plan; provided, however, that no termination shall affect the amount of benefits, which at the time of such termination shall have accrued for participants or beneficiaries. Such accrued benefits shall include any compensation deferred before the time of the termination and income thereon accrued to the date of the termination.

B. Upon such termination, each participant in the plan shall be deemed to have revoked his agreement to defer future compensation as provided in LAC 32:VII.311.A as of the date of such termination. Each participant's full compensation on a non-deferred basis shall be restored.

AUTHORITY NOTE: Promulgated in accordance with R.S. §42:1301-1308 and IRC §457.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 24:1970 (October 1998), amended LR 28:1501 (June 2002).

§1303. Amendments to the Plan

A. The commission may also amend the provisions of this plan at any time; provided, however, that no amendment shall affect the amount of benefits which at the time of such amendment shall have accrued for participants or beneficiaries, to the extent of compensation deferred before the time of the amendment and income thereon accrued to the date of the amendment, calculated in accordance with LAC 32:VII.505.A and the terms and conditions of the investment options hereunder; and provided further, that no amendment shall affect the duties and responsibilities of the trustee unless executed by the trustee.

B. Copies of Amendments. The administrator shall provide a copy of any plan amendment to any trustee or custodian and to the issuers of any investment options.

AUTHORITY NOTE: Promulgated in accordance with R.S. §42:1301-1308 and IRC §457.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 24:1970 (October 1998), amended LR 28:1501 (June 2002).

Chapter 15. Taxes, Nonassignability and Disclaimer

§1501. Tax Treatment of Amounts Deferred

A. It is intended that pursuant to IRC §457, the amount of deferred compensation shall not be considered current compensation for purposes of federal and state income taxation. This rule shall also apply to state income taxation unless applicable state laws provide otherwise. Such amounts shall, however, be included as compensation to the extent required under the Federal Insurance Contributions Act (FICA). Payments under this plan shall supplement retirement and death benefits payable under the employer's group insurance and retirement plans, if any.

AUTHORITY NOTE: Promulgated in accordance with R.S. §42:1301-1308 and IRC §457.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 24:1970 (October 1998), amended LR 28:1501 (June 2002).

§1503. Nonassignability

A. It is agreed that neither the participant, nor any beneficiary, nor any other designee shall have any right to commute, sell, assign, transfer, or otherwise convey the right to receive any payments hereunder, which payments and right thereto are expressly declared to be nonassignable and nontransferable; and in the event of attempt to assign or transfer, the commission shall have no further liability hereunder, nor shall any unpaid amounts be subject to attachment, garnishment or execution, or be transferable by operation of law in event of bankruptcy, or insolvency, except to the extent otherwise required by law.

B. Qualified domestic relations orders approved by the commission shall be administered as follows.

1.a. To the extent required under a final judgment, decree, or order made pursuant to a state domestic relations law, herein referred to as a Qualified Domestic Relations Order (QDRO) which is duly filed upon the commission, any portion of a participant's account may be paid or set aside for payment to an alternate payee.

NOTE: For purposes for this §1503, an alternate payee is a person or persons designated by a domestic relations order who may be a spouse, former spouse, or a child of the participant.

b. Where necessary to carry out the terms of such a QDRO, a separate account shall be established with respect to the alternate payee, and such person(s) shall be entitled to make investment selections with respect thereto in the same manner as the participant. All costs and charges incurred in carrying out the investment selection shall be deducted from the account created for the alternate payee making the investment selection.

2. Any amounts so set aside for an alternate payee shall be paid out immediately in a lump sum, unless the QDRO directs a different form of payment or later payment date. Nothing in this §1503.B shall be construed to authorize any amounts to be distributed under the employer's plan at a time or in a form that is not permitted under IRC §457. Any payment made to a person other than the participant pursuant to this §1503.B shall be reduced by required income tax withholding. Such withholding and income tax reporting shall be done under the terms of the Internal Revenue Code as amended from time to time.

3. The commission's liability to pay benefits to a participant shall be reduced to the extent that amounts have been paid or set aside for payment to an alternate payee pursuant to this §1503.B. No amount shall be paid or set aside unless the commission, or its agents or assigns, has been provided with satisfactory evidence releasing them from any further claim by the participant with respect to these amounts. The participant shall be deemed to have released the commission from any claim with respect to such

amounts in any case in which the commission has been notified of or otherwise joined in a proceeding relating to a QDRO, which sets aside a portion of the participant's account for an alternate payee, and the participant fails to obtain an order of the court in the proceeding relieving the employer from the obligation to comply with the QDRO.

4. The commission shall not be obligated to comply with any judgment, decree or order which attempts to require the plan to violate any plan provision or any provision of §457 of the Internal Revenue Code. Neither the commission nor its agents or assigns shall be obligated to defend against or set aside any judgment, decree, or order described herein or any legal order relating to the division of a participant's benefits under the plan unless the full expense of such legal action is borne by the participant. In the event that the participant's action (or inaction) nonetheless causes the commission, its agents or assigns to incur such expense, the amount of the expense may be charged against the participant's account and thereby reduce the commission's obligation to pay benefits to the participant. In the course of any proceeding relating to divorce, separation, or child support, the commission, its agents and assigns shall be authorized to disclose information relating to the participant's individual account to the participant's spouse, former spouse or child (including the legal representatives of the alternate payee), or to a court.

5. Any Conforming Equitable Distribution Order (CEDO), filed prior to January 2002, may be amended to comply with this §1503.B, pursuant to a Qualified Domestic Relations Orders (QDRO), which is duly filed upon the commission.

AUTHORITY NOTE: Promulgated in accordance with R.S. §42:1301-1308 and IRC §457.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 24:1970 (October 1998), amended LR 28:1502 (June 2002).

§1505. Disclaimer

A. The commission makes no endorsement, guarantee or any other representation and shall not be liable to the plan or to any participant, beneficiary, or any other person with respect to:

1. the financial soundness, investment performance, fitness, or suitability (for meeting a participant's objectives, future obligations under the plan, or any other purpose) of any investment option in which amounts deferred under the plan are actually invested; or

2. the tax consequences of the plan to any participant, beneficiary or any other person.

AUTHORITY NOTE: Promulgated in accordance with R.S. §42:1301-1308 and IRC §457.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 24:1971 (October 1998), amended LR 28:1502 (June 2002).

Chapter 17. Employer Participation

§1701. Additional Compensation Deferred

A. Notwithstanding any other provisions of this plan, the employer may add to the amounts payable to any participant under the plan additional deferred compensation for services to be rendered by the participant to the employer during a payroll period, provided:

1. the participant has elected to have such additional compensation deferred, invested, and distributed pursuant to this plan, prior to the payroll period in which the compensation is earned; and

2. such additional compensation deferred, when added to all other compensation deferred under the plan, does not exceed the maximum deferral permitted by LAC 32:VII.303.A.

AUTHORITY NOTE: Promulgated in accordance with R.S. §42:1301-1308 and IRC §457.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 24:1971 (October 1998), amended LR 28:1502 (June 2002).

Chapter 19. Applicable Terms

§1901. Interpretation

A. Governing Law. This plan shall be construed under the laws of the state of Louisiana.

B. Section 457. This plan is intended to be an eligible deferred compensation plan within the meaning of §457 of the Internal Revenue Code, and shall be interpreted so as to be consistent with such Section and all regulations promulgated thereunder.

C. Employment Rights. Nothing contained in this plan shall be deemed to constitute an employment agreement between any participant and the employer and nothing contained herein shall be deemed to give a participant any right to be retained in the employ of the employer.

D. Days and Dates. Whenever time is expressed in terms of a number of days, the days shall be consecutive calendar days, including weekends and holidays, provided, however, that if the last day of a period occurs on a Saturday, Sunday or other holiday recognized by the employer, the last day of the period shall be deemed to be the following business day.

E. Word Usage. Words used herein in the singular shall include the plural and the plural the singular where applicable, and one gender shall include the other genders where appropriate.

F. Headings. The headings of articles, sections or other subdivisions hereof are included solely for convenience of reference, and if there is any conflict between such headings and the text of the plan, the text shall control.

G. Entire Agreement. This plan document shall constitute the total agreement or contract between the commission and the participant regarding the plan. No oral statement regarding the plan may be relied upon by the participant. This plan and any properly adopted amendment, shall be binding on the parties hereto and their respective heirs, administrators, trustees, successors, and assigns and on all designated beneficiaries of the participant.

AUTHORITY NOTE: Promulgated in accordance with R.S. §42:1301-1308 and IRC §457.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 24:1972 (October 1998), amended LR 28:1503 (June 2002).

Title 32
EMPLOYEE BENEFITS

Part VII. Public Employee Deferred Compensation

Subpart 2. Nominations and Elections

Chapter 101. Nomination and Election of Participant Members

§10101. Election Procedures

A. The Louisiana Deferred Compensation Commission (the "commission") developed the following procedures for the election of participant members to the commission, revised August 16, 2005. These procedures shall remain in effect until amended.

1. On or before the first day of January of each year, the commission shall appoint a nominating committee consisting of three to five participants, no two of whom are employed by the same department of state government and none of whom are members of the commission. Public notice of the appointment of the nominating committee shall be given in the same manner as that required for giving public notice of meetings of the commission. All participants shall be notified by means of a notice mailed to them by either the fourth quarter statements or via direct mail that an election will be held, and the method by which the election will be held.

2. The nominating committee shall submit to the commission the name of at least one participant for each vacancy that has occurred and the name of at least one participant for each term that is about to expire. Only participants who have been participants for more than two years prior to the date on which the term begins may be nominated.

3. Upon the receipt of the report of the nominating committee, the commission shall notify personnel officers of the receipt of the said report and shall request personnel officers to notify participants (by posting a notice in appropriate places or by other means) that the said report has been received and that additional nominations may be made by petition.

4. A participant may be nominated by petition if the petition contains the signatures of 12 participants and is received by the commission chairman or his/her designee prior to the deadline set forth in the notice supplied to personnel officers pursuant to Paragraph 3 above. Only participants who have been participants for more than two years prior to the date on which the term begins may be nominated by petition. Petitioning participants' signatures must be accompanied by a statement signed by the nominee in which the nominee expresses his or her willingness to serve if elected.

5. In the event two or more participants are nominated for a position on the commission, the commission chairman shall conduct a drawing to determine the order in which candidates' names will appear on the ballot. All nominees for a position shall be invited by the chairman to attend the drawing. Each ballot shall contain, in addition to the name of the nominee(s), a statement containing no more than 200 words, which statement shall be prepared by the nominee and shall contain biographical information and/or a statement concerning the nominee's position on one or more issues pertinent to the deferred compensation program. If and when the commission determines that the use of photographs of the nominees on the ballots will be feasible, the chairman shall provide all nominees with the opportunity to submit suitable photographs of themselves for use in preparation of the ballots.

6. A participant shall be eligible to participate in an election if that participant receives a first quarter statement of his account with the Louisiana Deferred Compensation plan during the year in which the election is held. The commission may elect to distribute the ballots to the eligible participants via the first quarter statement, or via direct mail. The commission may also contract through a third party vendor to provide vote collection services, including electronic votes utilizing an Interactive Voice Response ("IVR") telephone voting system, electronic votes utilizing the Internet and also paper ballot votes. Election services include the production of election materials, mailing services, barcode system services, election ballot processing and counting using automated scanning, and other related services. If the voting process is sent via the statement or mail, each ballot shall be accompanied by a ballot envelope (clearly marked with instructions that the completed ballot shall be placed therein and the envelope sealed), a mailing envelope on which is printed the name and address of the commission's designated return address, and a signature slip.

7. The commission may require that the participant's signature appear on the signature slip together with the last four digits of the participant's Social Security number. The signature slip and the ballot envelope shall be placed in the mailing envelope. The signature slip must not be placed in the ballot envelope. The mailing envelope shall be mailed or delivered to the commission at the address printed on the mailing envelope.

8. The commission or the commission chairman, if authorized by the commission, shall appoint a ballot counting committee and the commission chairman shall invite all nominees to be present for the ballot counting.

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9. The deadline for return of ballots and the date on which ballots will be counted shall both be fixed by the commission or by the commission chairman, if authorized by the commission.

10. Prior to counting the ballots, the ballot counting committee shall make such verification as is deemed appropriate. The committee shall verify that each ballot has been submitted correctly. Any ballot not submitted correctly will be deemed invalid. If a third party vendor is contracted for vote collection services, the ballot counting committee shall examine and verify the database representing the final vote tally.

11. No nominee shall be required to receive a majority of the votes in order to be elected. The nominee receiving a

plurality of the votes cast shall be declared elected. In the event two or more nominees receive the same number of votes, the winner shall be chosen by the toss of a coin.

12. Upon completion of its work, the ballot counting committee shall submit a written report to the chairman concerning the result of the election. The chairman shall make public the result of the election at the next commission meeting.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:1301-1308 and IRC §457.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 32:124 (January 2006), amended LR 50:1012 (July 2024).