

**LOUISIANA STATE UNIVERSITY SYSTEM**  
**FLEXIBLE BENEFITS PLAN**

**ADOPTION OF**  
**LOUISIANA STATE UNIVERSITY SYSTEM**  
**FLEXIBLE BENEFITS PLAN**

(As Amended and Restated Effective as of January 1, 2011)

Pursuant to resolutions adopted by the Board of Supervisors of Louisiana State University and Agricultural and Mechanical College (the “Employer” or “Plan Sponsor”) and effective as of January 1, 2011, the undersigned officers of the Employer hereby adopt Louisiana State University System Flexible Benefits Plan (as Amended and Restated Effective as of January 1, 2011) on behalf of the Employer, in the form attached hereto.

LOUISIANA STATE UNIVERSITY SYSTEM

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## ARTICLE I

### Introduction

Section 1.1 Purpose of Plan. The Louisiana State University System Flexible Benefits Plan (the "Plan") is maintained by The Louisiana State University System (the "Employer" or "Plan Sponsor"). The purpose of the Plan is to provide Eligible Employees of the Employer a choice between cash and benefits under the Louisiana State University Flexible Benefits Plan which includes: (i) the Premiums Only Plan (POP), (ii) the "Health Care Reimbursement Program" and (iii) the "Dependent Care Reimbursement Program" all as set forth in this document.

Section 1.2 Cafeteria Plan Status. This Plan is intended to qualify as a "Cafeteria Plan" under Section 125 of the Internal Revenue Code of 1986, as amended, (the "Code") and is to be interpreted in a manner consistent with the requirements of Code Section 125 and its underlying regulations. This is a voluntary Plan established by the Employer and the Employee is responsible for 100% of the contributions to the Plan.

Section 1.3 Effective Date. The Plan was originally established by the Employer effective January 1, 1985 (the "Original Effective Date"), and was amended and restated as of July 1, 2006. The "Effective Date" of the Plan, as amended and restated, is January 1, 2011. The provisions of the Plan as amended and restated only apply to an individual employed by the Employer on or after the Effective Date. The rights and benefits, if any, of an Employee whose employment with the Employer terminated before the Effective Date will be determined in accordance with the terms of the Plan in effect as of the date of his termination. The Plan has been established by the Employer effective as of the Original Effective Date.

Section 1.4 Plan Administrator. The Plan Administrator shall be that person holding the position of Director of Employee Benefits for the LSU System, or such other person as may be appointed by or designated by Plan Sponsor. The Plan Administrator, acting on behalf of the Plan Sponsor, has overall responsibility for the Plan.

Section 1.5. FSA Administrator. The FSA Administrator may be appointed by the Plan Sponsor to perform all functions necessary to prepare, implement, operate and administer the Plan in accordance with the Plan's terms and in compliance with all legal requirements.

Section 1.6 Plan Year. The Plan Year is the twelve-month period commencing on each July 1 and ending on the next following June 30.

Section 1.7 Plan Amendments. The provisions of the Plan may be modified by amendments to the Plan. The terms and provisions of each amendment are a part of the Plan and supersede any other provisions of the Plan to the extent necessary to eliminate any inconsistencies between the amendment and any other Plan provisions.

## ARTICLE II

### Participation, Election and Enrollment

Section 2.1 Employee. Any individual the Employer classifies and treats as its own regular, common-law employee.

Section 2.2 Eligible Employee. A full-time employee of the Louisiana State University System. The term "full-time employee" means a person employed at 75% effort (average 30 hours per week) per pay period, or greater, with an appointment of more than 120 days or one Fall or Spring academic semester. No person appointed on a temporary appointment will be considered an eligible Employee. A temporary appointment means an appointment for a period of 120 consecutive calendar days or less.

Section 2.3 Participant. "Participant" means an Eligible Employee who has properly elected benefits under the Plan.

Section 2.4 Initial Enrollment Period: The "Initial Enrollment Period" is the first thirty (30) days following the date Eligibility requirements have been satisfied, as defined in Section 2.2. If an Employee does not enroll in the Plan within the Initial Enrollment Period he is deemed to be a Participant who has elected the cash option and may enroll during the designated Annual Enrollment Period as defined in Section 2.5 or within 30 days of an event that qualifies for a Mid-Year election change as defined in Section 2.14.

Section 2.5 Annual Enrollment Period: The "Annual Enrollment Period" for a Plan Year means that period beginning on April 1 and ending April 30 prior to the beginning of the next Plan Year. The FSA Administrator may shorten or lengthen this period for all Employees on a nondiscriminatory basis.

Section 2.6 Commencement of Participation for the Initial Enrollment Period; Entry Date: The Eligible Employee shall become a Participant in the Plan after providing the FSA Administrator with an executed Flexible Benefits Enrollment Form setting forth the Benefits

elected by the Eligible Employee for the remaining portion of the Plan Year, and a Salary Reduction Agreement, which authorizes the Employer to withhold from the Participant's Compensation (as defined in Section 3.4) an amount the Participant elects to have contributed to the Plan and to remit the funds withheld to the FSA Administrator Elections made by the Participant will become effective and benefits will commence on the first of the month following the Employee's first full calendar month of employment provided the Eligible Employee submits the required forms within thirty (30) calendar days of his/her date of eligibility ("Entry Date").

#### Section 2.7 Commencement of Participation for the Annual Enrollment Period

An election made under this Section will be effective as of the first day of the Plan Year and will continue in effect until changed during a subsequent Enrollment Period or as provided in Sections 2.12, 2.14, or 2.15. Any election under this Section must be made at the time, in the manner and on the forms established by the FSA Administrator. A Participant who does not complete and file an election with the FSA Administrator in a timely manner during an Annual Enrollment Period will be deemed to have elected to continue the last election then on file with the FSA Administrator, except for his election under the Health Care Reimbursement Program and Dependent Care Reimbursement Program, both of which will be reduced to zero. A Participant of a Health Care and Dependent Care Reimbursement Program must submit a Flexible Spending Enrollment Form to the FSA Administrator during the Annual Enrollment Period each year. Each Flexible Spending Enrollment Form shall specify the type and amount of benefits elected by the Participant for the Plan Year that immediately follows the Enrollment Period. All elections to participate in the Plan shall be made prior to the first day of the Plan Year for which the elections are to be effective except for (i) Elections made during the Initial Enrollment Period (as provided in Section 2.4), and (ii) Election changes permitted under Section 2.14.

Section 2.8 Cessation of Participation . A Participant shall be a Participant in the Plan for the entire Plan Year or the portion of the Plan Year remaining after the Participant's Entry Date, if later than the first day of the Plan Year. A Participant shall cease to be a Participant in the Plan on the earliest of:

- a. the date on which the Plan terminates;
- b. the end of the month from the date the Participant dies, resigns or terminates employment with the Employer;
- c. the date as of which he fails to make a required contribution; or
- d. the end of the month in which the Participant chooses to stop his/her contributions due to a justified Mid-Year election change as defined in Section 2.14

Section 2.9 Reinstatement of Former Participant. An Employee whose participation terminates and returns to an eligible status less than thirty (30) days later may re-enroll within thirty (30) days of returning to an eligible status with a commencement date of the first of the month following the adjusted eligibility date. An Employee who re-enrolls in a Health Care or Dependent Care Reimbursement Program after such time must re-enter the Plan and reinstate his/her original elections for that Plan Year with adjustments to the Annual Target as the FSA Administrator deems necessary to prorate the Annual Target over the remainder of the Plan Year. Expenses incurred by the employee during the time that the employee was not a Participant will not be covered expenses unless COBRA was elected pursuant to Section 2.10.

An employee who terminates employment and is rehired into an eligible status after thirty (30) days from the date of termination will be treated as a new enrollee under the Plan (see Section 2.4). If such employee returns within the same Plan Year, prior contributions made to any Reimbursement Program will be taken into consideration so as not to exceed Plan/IRS maximums.

Section 2.10 COBRA Continuation Provisions. Notwithstanding any provision to the contrary in this Plan, to the extent required by Consolidated Omnibus Reconciliation Budget Reconciliation Act 1986 (“COBRA”), a Participant and his Spouse and/or Dependent(s), as applicable, whose health insurance coverage terminates because of a COBRA qualifying event, shall be given an opportunity to continue the same health insurance coverage that he had the day before the qualifying event for the periods prescribed by COBRA. It shall be the sole responsibility of the Participant electing COBRA to arrange for and pay the applicable COBRA premium. Such continuation of coverage shall be subject to all conditions and limitations under COBRA.

A Participant whose COBRA coverage arises because the Participant ceases to be eligible solely because of a reduction in percent of effort may make a Mid-Year election change and continue as a Participant solely for health insurance coverage under the Premiums Only Plan. Unless such Participant elects otherwise during the Annual Enrollment Period, such Participant will be automatically re-enrolled during the Annual Enrollment Period as provided by Section 2.7 solely for health insurance coverage under the Premiums Only Plan for a period not to exceed the period of COBRA coverage. Contributions may not be prepaid in one Plan Year to provide coverage that extends into a subsequent Plan Year.

A Participant in the Health Care Reimbursement Program and/or Dependent Care Reimbursement Program who ceases to be eligible solely because of a reduction in percent of effort may make a Mid-Year election change and continue as a Participant in the Health Care Reimbursement Program and Dependent Care Reimbursement Program only if, under Section 9.2 and Section 10.4, they have a credit balance in the account for such programs. Participation in the Health Care Reimbursement Program and/or the Dependent Care Reimbursement Program will cease at the end of the Plan Year and cannot be continued for the next Plan Year.

A Participant of the Health Care Reimbursement Program whose coverage terminates because of a COBRA qualifying event may make an election to continue to participate in the Health Care Reimbursement Program. However, such individuals will be eligible to continue Health Care Reimbursement Program coverage under COBRA only if, under Section 9.2, they have a credit balance in their Health Care Reimbursement Account at the time of the COBRA qualifying event. Such COBRA coverage for the Health Care Reimbursement Program will cease at the end of the Plan Year in which the qualifying event occurred, and cannot be continued for the next Plan Year.

Section 2.11 FMLA Leave of Absence. Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying unpaid leave under the Family and Medical Leave Act of 1993 (FMLA) and elects to continue coverage while on leave, to the extent required by the FMLA, Employer will continue to maintain the Participant's elected benefits on the same terms and conditions as though he were still an active Employee provided, however, the Participant timely contributes the Compensation Reduction amount. If the Participant elects to continue his coverage during the leave, the Participant shall pay the Compensation Reduction amount plus

related administrative fees for the duration of the leave on an after-tax basis by sending monthly payments to the FSA Administrator by the due date established by the FSA Administrator.

If a Participant elects not to continue participation in the Plan during FMLA leave, then upon returning from such leave during the same Plan Year, the Participant shall be permitted to re-enter the Plan on the same basis the Participant was participating in the Plan prior to this leave, or as otherwise required by the FMLA.

Section 2.12 Non-FMLA Leave of Absence. An Employee who is on an unpaid leave of absence for greater than thirty (30) days will be sent a Continuation/Cancellation Form when the FSA Administrator is advised of their leave period. The Employee will then be required to elect one of the following choices:

- a. Cancel participation in their Flexible Spending Account which would not allow a re-enrollment during the same Plan Year.
- b. Suspend participation and resume contributions upon return from leave without pay during the same Plan Year, missed contributions will not be made up through payroll deduction. Election of this option will reduce the Annual Target by the number of deductions missed while on leave. Claims for expenses incurred during this leave period will not be eligible for reimbursement from the Health Care Reimbursement Program or Dependent Care Reimbursement Program. In order to remain a member of the Plan, the Participant will be responsible for the monthly administrative fee which will be collected in one payroll deduction upon the Participant's return to a paid status. If a Participant returns during the next Plan Year, he must re-enroll within thirty (30) days of returning to a paid status.
- c. Continue elected benefits on the same terms and conditions as though he were still an active Employee provided, however, the Participant shall timely contribute the Compensation Reduction amount. If the Participant elects to continue his coverage during the leave, the Participant shall pay the Compensation Reduction amount plus related administrative fees for the duration of the leave on an after-tax basis by sending monthly payments to the FSA Administrator by the due date established by the FSA Administrator.

Section 2.13 Changes to comply with non-discrimination rules. The FSA Administrator shall determine for each Plan Year, if the Plan satisfies, for that Plan Year, all non-discrimination requirements imposed by the Code or any limitation on benefits provided to "Key Employees" (as determined under Code Section 416(i)(1)) or "Highly Compensated Participants" (as determined under Code Section 125(e)). The FSA Administrator shall advise the Plan Administrator of any action appropriate, under rules uniformly applicable to similarly situated Participants, to assure compliance with such requirements or limitations. The Plan Administrator may take any action it deems appropriate, under rules uniformly applicable to similarly situated participants, to ensure compliance with such requirements or limitations. An action under the preceding sentence may include, without limitation, a modification of any elections under the Plan by Participants who are Highly Compensated Participants or Key Employees, with or without the consent of those Participants.

Section 2.14 Irrevocability of Election by the Participant During the Plan Year. Confirmation statements will be sent to each Participant after the Initial Enrollment or Annual Enrollment period has lapsed. A Participant will be allowed an opportunity to change his election if an error has occurred or an amendment to his initial election is needed; such a change must occur prior to the first day of participation in the Plan Year for which the elections are effective. Elections made under the Plan shall be irrevocable by the Participant once such elections have become effective (as defined in Sections 2.4 and 2.5 respectively), depending on when the Participant enrolled in the Plan, unless the election may be changed under one of the following exceptions:

- a. HIPAA Special Enrollment Rights. (Applies only to Premiums Only Plan) If a Participant or his Spouse and/or Dependent(s) is entitled to special enrollment rights under a group health plan, as required by HIPAA under Code Section 9801(f), then a Participant may revoke a prior election for group health plan coverage and make a new election, provided that the election changes corresponds with such HIPAA special enrollment rights. As required by HIPAA, a special enrollment right will arise if:
  - i. a Participant or his Spouse and/or Dependent(s) declined to enroll in group health coverage because of coverage under another policy or plan,

and eligibility for such other coverage is subsequently lost for reasons designated by HIPAA; or

- ii. a new Dependent is acquired as a result of marriage, birth, adoption, or placement for adoption. Such elections MUST be made within thirty (30) days of the HIPAA-related event to be considered a Special Enrollment.

b. Status Changes. (Applies to Premiums Only Plan, and Health and Dependent Care Reimbursement Programs) Mid-Year election changes (changes made after the Initial Enrollment Period) are only permitted for one of the following change of status events:

- i. change in legal marital status (includes marriage, death of Spouse, divorce, legal separation or annulment);
- ii. change in employment status of the Participant or the Participant's Spouse or Dependent (includes start or end of employment, a strike or lockout, commencement of or return from an unpaid leave of absence and a change in worksite);
- iii. change in number of Dependent(s) (includes birth, death, adoption and placement for adoption);
- iv. a Dependent satisfies or ceases to satisfy eligibility requirements (includes attainment of age that would make Dependent ineligible under the Plan or change in student status): or
- v. a change in residence of the Participant, the Participant's Spouse or Dependent when such change affects eligibility under the Plan.
- vi. If a change in status occurs, a Participant may revoke his compensation conversion and file a new election to be effective for the balance of the Plan Year, provided that the election change satisfies the consistency rules of Treasury Regulation Section 1.125-4(c) and the Participant has notified the Administrator of the change within thirty (30) days from the date of the event.

c. Judgment or Order Unless otherwise prohibited by applicable laws and regulations, a Participant may change benefit elections pursuant to and consistent with a judgment, decree, or order resulting from a divorce, legal separation, annulment or change in legal

custody, including a qualified medical child support order, or a qualified domestic relations order. To qualify under this Section 2.14 (c), such judgment or order must be final, non-appealable, and executory in the State of Louisiana.

d. Entitlement to Medicare or Medicaid. (Applies to Premiums Only Plan and Health Care Reimbursement Program) If a Participant, his Spouse or Dependent who is enrolled in the Premiums Only Plan (other than group term life insurance) or Health Care Reimbursement Program becomes entitled to coverage under Medicare or Medicaid, the Participant may modify his elections under these plans in order to reflect the canceled coverage of the Participant or that of his Spouse or Dependant (the individual(s) entitled to Medicare or Medicaid coverage) under the these plans. If an Eligible Employee, his Spouse or his Dependent lose Medicare or Medicaid coverage, the Eligible Employee may increase his contributions to his account for the Premiums Only Plan (other than group term life insurance) and the Health Care Reimbursement Program to pay for the cost of any added coverage under those plans for the effected individual.

e. Changes in Cost. (Applies to Premiums Only Plan and Dependent Care Reimbursement Program)

(1) Insignificant Cost Changes – When there has been an Insignificant Cost Change, Participants will be required to increase or decrease their compensation conversion amounts to reflect insignificant cost changes. The FSA Administrator will automatically implement this change to affected employees' elections on a prospective basis.

(2) Significant Cost Increases – When there has been a Significant Cost Increase, Participants will be allowed to:

- (a) increase their compensation conversion election;
- (b) revoke their election for that coverage and select another benefit option with similar coverage; or
- (c) drop coverage if there is no benefit option with similar coverage.

(3) Significant Cost Decreases – Where there has been a Significant Cost Decrease, Participants will be allowed to:

- (a) change their elections to the option that has decreased in cost; and;
- (b) Eligible Employees may elect the benefit option that has decreased in cost, subject to the terms and limitations of the benefit option.

(4) Limitation on Cost Changes for Dependent Care – When there has been a Cost Change for Dependent Care, the Change in Cost provisions apply only if the cost change is imposed by a Dependent Care provider that is not a relative of the Employee.

(5) The Plan Administrator, at its sole discretion on a uniform and consistent basis, will determine whether a cost increase or decrease is insignificant or significant based on all the surrounding facts and circumstances and in accordance with prevailing IRS guidance.

f. Changes in Coverage. (Applies to Premiums Only Plan and Dependent Care Only). If there is a significant change in coverage, Participants may change their elections under the Plan as indicated below. The Plan Administrator, in its sole discretion, on a uniform and consistent basis, will decide, in accordance with prevailing IRS guidance, whether a significant change in coverage, or whether a Loss of Coverage has occurred.

(1) Significant Curtailment Without Loss of Coverage – When there has been a significant curtailment without loss of coverage, Participants may revoke their election for the affected coverage and select another benefit option with similar coverage.

(2) Significant Curtailment With a Loss of Coverage – When there has been a significant curtailment with a loss of coverage, Participants may:

- a) revoke their election for the affected coverage and select another benefit option with similar coverage; or
- b) drop coverage if there is no benefit option with similar coverage.

(3) Addition/Improvement of Benefit Option – When there has been an addition or improvement of a benefit option, Eligible Employees may elect the newly-added or newly-improved benefit option, subject to the terms and limitations of the benefit option.

(4) Change in Coverage Under Another Employer Plan – When there has been a change in coverage under another employer plan, a Participant may make a prospective change that is on account of and corresponds with a change made under another employer plan. The Plan Administrator, in its sole discretion, on a uniform and consistent basis, will decide, in accordance with prevailing IRS guidance, whether a requested change is on account of and corresponds with a change made under another employer plan.

(5) Dependent Care Coverage Changes – When there has been a Dependent Care coverage change, a Participant may make a prospective change that is on account of and corresponds with a change by the Participant in the Dependent Care service provider.

g. Family and Medical Leave. If a Participant takes an unpaid leave under the FMLA, a Participant may revoke his election or a Participant may continue his coverage under the Plan during the FMLA leave as provided in Section 2.11.

Section 2.15 Automatic Termination of Election. Elections made under this Plan will automatically terminate on the date on which the Participant ceases to be a Participant in the Plan.

## ARTICLE III

### Plan Benefits

Section 3.1 Premium Only Plan. During each Enrollment Period (as defined in Sections 2.4 and 2.5), a Participant may elect to participate in and receive one or more of the benefits offered under the Premiums Only Plan. For purposes of this Plan, participation in the Premiums Only Plan means coverage under one or more of the group insurance policies described herein below and offered by the Employer. The types and amounts of insurance benefits available under each of the respective group insurance policies, the requirements and qualifications for participating therein, and the other terms and conditions of coverage and benefits are as set forth from time to time in the group insurance contracts that constitute those benefits. The group insurance policies offered by the Employer under the Premiums Only Plan are:

- a. Health Insurance with such coverage and benefits as described in the policy or policies offered by the Employer to its employees;
- b. Dental Insurance with such coverage and benefits as described in the policy or policies offered by the Employer to its employees;
- c. Vision Insurance with such coverage and benefits as described in the policy or policies offered by the Employer to its employees;
- d. Group Term Life Insurance with such coverage and benefits as described in the policy or policies offered by the Employer to its employees.
- e. Accidental Death and Dismemberment Insurance with such coverage and benefits as described in the policy or policies offered by the Employer to its employees;
- f. Long Term Disability Insurance with such coverage and benefits as described in the policy or policies offered by the Employer to its employees;

Section 3.2 Health Care Reimbursement Program. During each Enrollment Period (as defined in Sections 2.4 and 2.5), a Participant may elect to participate in and receive the benefits of the Health Care Reimbursement Program as provided under Article IX of this Plan. The minimum contribution to participate in this Program is \$100.00 per Plan Year. The maximum

contribution to participate in this Program is \$4,000.00 per Plan Year. Effective for the Plan Year beginning July 1, 2012, the maximum contribution shall be \$2,500 or such other amount as may be established by law from time to time.

Section 3.3 Dependent Care Reimbursement Program. During each Enrollment Period (as defined in Sections 2.4 and 2.5), a Participant may elect to participate in and receive the benefits of the Dependent Care Reimbursement Program as provided under Article X of this Plan. The minimum contribution to participate in this Program is \$100.00 per Plan Year. The maximum contribution to participate in this Program is \$5,000.00 per Plan Year (see Section 10.4 for specific maximums based on tax filing status).

Section 3.4 Compensation Reduction for Elected Benefits. During each Enrollment Period (as defined in Sections 2.4 and 2.5), a Participant who elects any of the above described benefits shall also elect to reduce his Compensation in such amount described below as required to fund payment of the cost of the elected benefits. The amount by which the Employee elects to reduce his Compensation is referred to herein as the "Compensation Reduction." The Employer shall prorate the Compensation Reduction over the number of pay periods for the Employee for the Plan Year, or remainder thereof, and shall withhold such prorated amount from the Employee's remuneration for each pay period. For purposes of this Section 3.4, a Participant's "Compensation" means all annualized cash remuneration that would be payable to him by the Employer for the Plan Year for which the Participant is enrolling prior to any reductions made pursuant to this Section.

- a. Premiums Only Plan. The Compensation Reduction for any of the benefits elected in the Premiums Only Plan shall be an amount equal to the premium cost for the insurance benefits elected. The Employer shall inform the Participant of the premium cost at the time of enrollment. If the premium cost of elected insurance benefits increases during the Plan Year, the Plan Administrator may increase the Participant's Compensation Reduction to cover the increased premium cost, in accordance with Section 2.14 (e) of the Plan. The Compensation Reduction attributable to the Premiums Only Plan benefits shall be applied each pay period by the

FSA Administrator to the payment of the Participant's share of the insurance premium cost.

- b. Health Care Reimbursement Program. The Compensation Reduction for participation in the Health Care Reimbursement Program shall be such amount as elected by the Participant not to exceed the lesser of (i) the Participant's Compensation, less the Compensation Reduction for all other benefits elected by the Participant, or (ii) the Plan Year limitation for contributions as set forth in Section 3.2. The full amount of the Participant's annualized Compensation Reduction ("Annual Target") for the Health Care Reimbursement Program shall be credited to the Participant's Health Care Reimbursement Account as provided in Article IX.
- c. Dependent Care Reimbursement Program. The Compensation Reduction for participation in the Dependent Care Reimbursement Program shall be such amount as elected by the Participant not to exceed the lesser of (i) the Participant's Compensation, less the Compensation Reduction for all other benefits elected by the Participant, or (ii) the limitation for reimbursement of expenses incurred for Qualifying Dependent Care services. The Participant's Dependent Care Reimbursement Account shall be credited each pay period in an amount equal to the prorated Compensation Reduction attributable to the Participant's election to participate in the Dependent Care Reimbursement Program.

## ARTICLE IV

### Benefit Payments

Section 4.1    Payment Procedures. Any Compensation Reduction Amount allocated to the benefits of the Premium Only Plan will be applied by the FSA Administrator to pay those premiums at the times and in the amounts required by the underlying plans. Any amounts in the Participant's Health Care Reimbursement Account or Dependent Care Reimbursement Account will be applied to reimburse qualifying expenses for a Plan Year under those programs upon the FSA Administrator's receipt and approval of a written claim submitted by the Participant. To receive a reimbursement, the written claim must be filed with the FSA Administrator no later than October 31<sup>st</sup> after the end of the Plan Year in which the expense was incurred. A Participant who terminates during a Plan Year must submit claims incurred during employment before the earlier of 120 days from the end of the month in which he terminates or October 31<sup>st</sup> after the end of the Plan Year (unless COBRA is elected). An expense will be incurred on the date in which the service was provided.

Section 4.2    Grace Period. The grace period is defined as the two and one-half month period after the end of the Plan Year. This grace period allows a Participant with unused benefits or contributions in his/her Health Care or Dependent Care Reimbursement Account, relating to a particular qualified benefit from the immediately preceding Plan Year, to be reimbursed for expenses incurred during the Grace Period. The effect of the Grace Period is that a Participant has as long as 14 months and 15 days to use the benefits or contributions for the Plan Year before those amounts are "forfeited" under the "use-it-or-lose-it" rule, as explained in Section 4.6.

In addition, if a Participant submits a claim that was incurred during the Grace Period and the Participant also has elected a Health Care Reimbursement Account for the immediately following Plan Year, the amount of the claim will be reimbursed, to the extent allowed, first, from any balance remaining in the preceding Plan Year's Account, and then from the immediately following Plan Year's Account.

To the extent any unused contributions from the immediately preceding Plan Year exceed the expenses for the qualified benefit incurred during the Grace Period, those remaining unused contributions may not be carried forward to any subsequent period and are forfeited under section 4.6 ( the “Use-it-or-lose-it Rule”).

If a Participant ceases to be a Participant on the last day of the Plan Year he may take advantage of the Grace Period. However, if a Participant ceases to be a Participant any time prior to the end of the Plan Year, he is not eligible to take advantage of the Grace Period.

Section 4.3    Supporting Documentation. Supporting documentation must accompany the Reimbursement Form at the time a claim is filed. See Article IX for a definition of Supporting Documentation and how it applies to the Health Care Reimbursement Program and Article X for a definition of Supporting Documentation and how it applies to the Dependent Care Reimbursement Program. The FSA Administrator will make the initial determination whether or not the expenses to be reimbursed under this Section are qualifying expenses under the Health Care or Dependent Care Reimbursement Programs and whether or not sufficient documentation has been submitted to support the payment of the claim. The Plan Administrator may review, and, if appropriate, reverse the initial determination made by the FSA Administrator. Approved claims will be paid as soon as practicable by the FSA Administrator following approval. Deficient claims will be returned to the Participant by the FSA Administrator with an explanation of what is required to process the claim (see Section 6.4 for details of the review procedures).

Section 4.4    Claim Limitations. Notwithstanding the provisions of Section 4.1, no payment will be made under the Health Care Reimbursement Plan to reimburse any expense that has been or will be reimbursed under any of the group insurance policies elected under the Premiums Only Plan, or from any other source available to the Participant or his dependents. In signing the Health Care or Dependent Care Reimbursement Form, the Employee certifies that such expense has not been and will not be reimbursed from any other source.

Section 4.5 Claim Review. The FSA Administrator, in accordance with the provisions of Article VI, will determine the timing and the amount of any payment to be made under the Plan. However, a Participant may seek a review of any benefit determination made by the FSA Administrator as provided in Section 6.4.

Section 4.6 Forfeiture of Account Balances. Any amount in a Participant's Flexible Benefit Accounts, either Health Care or Dependent Care Reimbursement Programs, at the end of Plan Year (including the Grace Period), or upon termination of employment, that is not used to pay claims or premiums for that year will be forfeited. Forfeitures will be used to offset the Plan Sponsors' expenses under the Plan. Forfeiture under this paragraph is sometimes referred to as the "Use-it-or-lose-it Rule".

## **ARTICLE V**

### **Plan Administrator Responsibilities**

Section 5.1    Establishment of Plan. Plan Sponsor shall establish and maintain the Plan in accordance with all applicable laws and regulations.

Section 5.2    Responsibility and Authority. The Plan Administrator shall exercise the fiduciary responsibility and claims authority of the Plan Sponsor.

Section 5.3    Claim Disposition. In the event a claim for reimbursement is denied or pending, the Plan Administrator shall have final review of and authority for disposition of disputed claims.

## ARTICLE VI

### FSA Administrator Duties and Responsibilities

Section 6.1 FSA Administrator Responsibilities. The administration of the Plan will be under the supervision of the Plan Administrator. Subject to applicable requirements of law and subject to review and approval by the Plan Administrator, the FSA Administrator shall exercise all power to administer the Plan in all of its details. The FSA Administrator shall advise the Plan Administrator of such action as may be necessary to assure that the Plan complies with the requirements of Section 125 of the Code and applicable regulations.

Section 6.2 Examination of Records. The FSA Administrator will make the Plan records that pertain to a Participant available to that Participant for examination at reasonable times during normal business hours.

Section 6.3 Administrator Rules and Decisions. All rules and decisions of the FSA Administrator will be consistent with the terms of the Plan and will be uniformly and consistently applied to all Participants in similar circumstances. When making a determination or calculation the FSA Administrator may rely upon information furnished by an Employee or the Plan Administrator. The FSA Administrator will make any adjustments it considers equitable and practicable to correct a mistake of fact once the mistake becomes known.

Section 6.4 FSA Administrator Review Procedures. In cases where the FSA Administrator denies a claim under this Plan of any Participant, Spouse or Dependent, the FSA Administrator shall furnish in writing to inform the party the reasons for the denial. The written denial shall be provided to the party within 30 days of the date the benefit was denied by the FSA Administrator. The written denial shall refer to any section of the Plan, Code, Treasury Regulation or Internal Revenue Service ruling upon which the FSA Administrator relied in making such denial. The denial may include a request for any additional data or material needed to properly complete the claim and explain why such data or material is necessary, and explain the Plan's claim review procedures. If requested in writing, and within 30 days of the claim denial, the FSA Administrator shall afford any claimant whose request for claim was denied a

review of the FSA Administrator's decision, and within 30 days of the request for review of the denied claim, the FSA Administrator shall notify the claimant and the Plan Administrator in writing of his final decision on the reviewed claim. The FSA Administrator shall date the final decision to correspond to the reasonably expected delivery date of the written decision to the Participant.

Section 6.5 Extensions of Time. In any case where the FSA Administrator determines special circumstances apply, the FSA Administrator may extend the amount of time any Participant, Spouse, Dependent or designated beneficiary may need to appeal a claim, upon proper application to the FSA Administrator.

Section 6.6 Plan Administrator Review Procedures. Within 30 days after the date of the final decision of the FSA Administrator, a Participant may request review of a denied claim by the Plan Administrator by giving written notice of his intent to seek further review to the Plan Administrator and the FSA Administrator, and shall submit with such notice to the Plan Administrator any additional data or material the Participant believes may be necessary for the Plan Administrator to properly review the claim. Upon receipt of such notice, the FSA Administrator shall promptly deliver to the Plan Administrator all documents, writings, or other material pertaining to the denied claim including any materials and authorities relied upon by the FSA Administrator in denying the claim. The Participant may request a meeting with the Plan Administrator. The Plan Administrator shall provide to the Participant and to the FSA Administrator written notice of the final decision within 30 days of the Participant's notice seeking review if no meeting has been requested, or within 30 days of the Plan Administrator's meeting with the Participant, whichever is later.

Section 6.7 Notice of Privacy Practices. The FSA Administrator shall, at each Annual Enrollment and for each new hire deliver or cause to be delivered, a HIPAA-compliant Notice of Privacy Practices approved by LSU to each Participant electing benefits under the Plan.

**ARTICLE VII**

**Amendment and Termination of Plan**

The Plan may at any time be amended, in whole or in part, or terminated by the Employer.

**ARTICLE VIII**  
**Miscellaneous Provisions**

Section 8.1 Information to be Furnished. Participants must provide the Employer and/ or the FSA Administrator with any information and evidence, and sign any document, as may reasonably be requested from time to time, for the purpose of administering the Plan.

Section 8.2 Limitation of Rights. Neither the establishment of the Plan, nor any amendment thereof, nor the payment of any benefits, may be construed as giving to any Participant or other person any legal or equitable right against the Employer or the FSA Administrator, except as specifically provided in the Plan.

Section 8.3 Governing Law. To the extent not superseded by the laws of the United States, this Plan shall be construed, administered and enforced according to the laws of the State of Louisiana, without regard to that state's choice of law principles.

Section 8.4 Non-Guarantee of Employment. Nothing contained in this Plan may be construed as a contract of employment between an Employer and the Employee, or as a right to be engaged or continued in the employment of an Employer or as a limitation of the right of the Employer to discharge any of its Employees, with or without cause.

Section 8.5 Non-Alienation of Benefits. Except as may be required by law, benefits payable under this Plan are not subject in any manner to sale, transfer, assignment, pledge, encumbrance, garnishment, or levy of any kind, either voluntary or involuntary, prior to actually being received by the person entitled to the benefit under the terms of the Plan; and any attempt to sell, assign, pledge, encumber, or otherwise - dispose of any right to benefits payable hereunder will be void. The Employer will not be liable for, or subject to, the debts, contracts, liabilities, engagements or torts of any person entitled to benefits hereunder.

Section 8.6 Illegal or Invalid Provisions. The Employer intends that the Plan be legally enforceable and in the event any provision of this Plan is held illegal or invalid for any reason,

any illegality or invalidity will not affect the remaining part of this Plan, and the Plan will be construed and enforced as if the illegal or invalid provision had never been inserted.

Section 8.7 Gender and Number. Words in the masculine gender are to be construed to include the feminine gender in all cases where appropriate and words in the singular or plural are to be construed as being in the plural or singular where appropriate.

Section 8.8 Notice. Any notice to be given or required pursuant to the Plan or law shall be made in writing addressed as follows:

If to the Participant: To the Participant's last known address of record with Employer.

If to the Employer, Plan Administrator, or Plan Sponsor:

Plan Sponsor  
Louisiana State University System  
Flexible Benefits Plan  
3810 West Lakeshore Drive, Suite 123  
Baton Rouge, LA 70808

If to the FSA Administrator: To such address as stated in the Plan Document, or to such other address as may be obtained by contacting the Plan Sponsor.

Section 8.9 Waiver of Notice. Any notice required under the Plan may be waived by the party entitled to such notice.

Section 8.10 Funding. Other than remitting to the FSA Administrator the Compensation Reductions on a prorated basis as described in Section 3.4, the Employer is not required to segregate any funds or establish any funding procedure for any benefit or amount credited or to be credited to a Participant's Flexible Spending Account.

## **ARTICLE IX**

### **Health Care Reimbursement Program**

**Section 9.1 Purpose.** The Employer has established the Louisiana State University Health Care Flexible Spending Reimbursement Program (the "Health Care Reimbursement Program") to permit Eligible Employees, to be reimbursed for certain Qualifying Medical Expenses in accordance with this Article IX, the Plan and Code Section 105.

**Section 9.2 Reimbursements.** Qualifying Medical Expenses (as defined in Section 9.4) incurred by a Participant, Participant's Spouse or the Participant's Dependent as defined under Code Section 105(b), and the Participant's child as defined under Code Section 105(b), will be reimbursed by payments from the Participant's Health Care Reimbursement Account to the extent the Participant has a credit balance in his Health Care Reimbursement Account, but not to exceed the maximum set forth in Section 3.2. For purposes of determining the credit balance under the preceding sentence for any Plan Year, the Participant's Health Care Reimbursement Account will be deemed to be credited with the Compensation Reduction amount elected by the Employee pursuant to Section 3.4 attributable to participation in the Health Care Reimbursement Program, this being the total credits expected to be made for the entire Plan Year (the Participant's "Annual Target") and will be reduced by any amounts previously paid from the Health Care Reimbursement Account for that year. A claim for reimbursement must be submitted in accordance with Article IV along with supporting documentation as defined in Section 9.3.

**Section 9.3 Supporting Documentation.** Supporting documentation is defined as bills, and receipts (only if accompanied by a fully itemized bill(s) including dates of service, name of claimant, type of service, etc. or an explanation of benefits statement indicating the deductible, co-payment, or co-insurance amounts due), written statements from a physician stating the medical necessity, or explanation of benefits (EOBs) that demonstrate the out-of-pocket expense incurred by the Employee for care of the Employee, Employee's Spouse or Dependent, and such other information or documentation reasonably required by the FSA Administrator on a uniform and consistent basis for all similarly situated Employees.

In the case of over-the-counter drugs, Participants will be required to provide a dated receipt, complete with store/pharmacy name, name of drug, and the price of drug. For stores/pharmacies that do not include full drug names on their receipts, the drug box with the name of the drug and the UPC code that matches the UPC code on the receipt will suffice. Actual store receipts will be required; credit card statements will not be sufficient documentation. Participants will be required to provide a letter from a physician indicating a diagnosis and the proposed treatment, as well as dated receipts as indicated above for any drugs which have a “dual purpose”. Over-the-counter drugs purchased on or after January 1, 2011 shall not be reimbursable unless such drug was prescribed by a physician and a copy of the prescription is submitted with the claim for reimbursement.

Section 9.4 Qualifying Medical Expenses. A "Qualifying Medical Expense" means any medical expense (as defined in IRC Section 213 and regulations thereunder) incurred by the Participant on behalf of himself, his Spouse, or his Dependents (as defined in IRC Section 105(b), but only to the extent the expense is incurred while a Participant and is not reimbursable through any other health or supplemental plan coverage.

## **ARTICLE X**

### **Dependent Care Reimbursement Program**

**Section 10.1 Purpose.** The Employer has established the Louisiana State University System Dependent Care Reimbursement Program to permit its Eligible Employees, to be reimbursed for certain Qualifying Dependent Care Expenses in accordance with this Article X, the Plan and IRC Section 129.

**Section 10.2 Qualifying Individuals.** Dependent care expenses must be provided for a “qualifying individual” under IRC Section 21(b)(1), as amended. The status of a qualifying individual is determined on a daily basis; therefore, if a Dependent or Spouse of the taxpayer ceases to be a qualifying individual Mid-Year, then the Spouse or Dependent is treated as a qualifying individual only until the day before the change in status occurs.

**Section 10.3 Qualifying Dependent Care Services.** Qualifying Dependent Care Services means those services defined in IRC Section 129 (e) (1) and regulations thereunder.

**Section 10.4 Reimbursements.** Subject to the limits of this Section 10.4, Qualifying Dependent Care Services (as defined in Section 10.3) incurred by a Participant will be reimbursed by payments from the Participant's Flexible Spending Account only to the extent the Participant has a credit balance in his Dependent Care Reimbursement Account . For purposes of determining the credit balance under the preceding sentence for any Plan Year, the Participant's Dependent Care Reimbursement Account will be deemed to be credited with the Compensation Reduction amount elected by the Employee pursuant to Section 3.4 attributable to participation in the Dependent Care Reimbursement Program, this being the total credits expected to be made for the entire Plan Year (the Participant’s “Annual Target”) and will be reduced by any amounts previously paid from the Dependent Care Reimbursement Account for that year. A claim for reimbursement must be submitted in accordance with Section 4.1, together with supporting documentation as defined in Section 10.5 (all reimbursements will be made in accordance with Article IV of the Plan).

Reimbursement for expenses incurred for Qualifying Dependent Care Services shall be limited as provided by law (currently the lesser of (a) \$5,000 (\$2,500 for a married Participant who files a separate federal income tax return) or (b) the lesser of (i) the Participant's earned income (as determined under IRC Section 32(c) (2)) for the Plan Year or (ii) the Participant's Spouse's earned income for the Plan Year). The FSA Administrator may require the Participant to certify as to his marital status and, if applicable, to his Spouse's earned income. If the Participant fails to supply a proper certification, the FSA Administrator may assume the Participant's requested reimbursement would exceed the limits of this Section.

Section 10.5 Supporting Documentation. Supporting Documentation is defined as a written statement from an independent third party stating that the expense has been incurred and providing the total amount of the expense. The statement should include all information and supporting documentation as may be reasonably required by the FSA Administrator on a uniform and consistent basis for all similarly situated Employees.

This information must be accompanied by a Flexible Spending Account Reimbursement Form which states that the Dependent Care expenses have not been reimbursed or are not reimbursable under any other Dependent Care coverage. This form may be obtained from the FSA Administrator.

Section 10.6 Reporting of Reimbursements. The FSA Administrator will provide each Participant with a written statement showing the total reimbursements made under the Dependent Care Reimbursement Program for each calendar year in the form and at the time required by law.

This Plan is adopted effective January 1, 2011 pursuant to resolutions adopted by the Board of Supervisors of Louisiana State University and Agricultural and Mechanical College.

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John Lombardi, President