LOUISIANA STATE UNIVERSITY SYSTEM
FLEXIBLE BENEFITS PLAN

(Effective January 1, 2013)
ADOPTION OF
LOUISIANA STATE UNIVERSITY SYSTEM
FLEXIBLE BENEFITS PLAN
(As Amended and Restated Effective as of January 1, 2013)

Pursuant to resolutions adopted by the Board of Supervisors of Louisiana State University and Agricultural and Mechanical College (the “Employer” or “Plan Sponsor”), the undersigned officers of the Employer hereby adopt Louisiana State University System Flexible Benefits Plan (as Amended and Restated Effective as of January 1, 2013) on behalf of the Employer, in the form attached hereto.

LOUISIANA STATE UNIVERSITY SYSTEM
# LOUISIANA STATE UNIVERSITY SYSTEM
## FLEXIBLE BENEFITS PLAN

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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 Board of Supervisors of the Louisiana State University and Agricultural and Mechanical College. 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 Premium Only Plan (POP), (ii) the "Health Care Flexible Spending Arrangement (Health Care FSA)", (iii) the “Dependent Care Flexible Spending Arrangement (Dependent Care FSA)", and (iv) the “Health Savings Account Benefit (HSA Benefit)”, 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 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, and 100% of the contributions to the Plan is derived from the Compensation Reductions, as provided for in Section 4.2, elected by the Participants.

Section 1.3 Effective Date. The "Effective Date" of the Plan is January 1, 2013. The provisions of the Plan 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.
ARTICLE II

Definitions

Section 2.1 Annual Enrollment Period. The "Annual Enrollment Period" for a Plan Year means that period beginning on October 1 and ending October 31 prior to the beginning of the next Plan Year. The Plan Administrator may shorten, lengthen, or otherwise modify this period for all Employees on a nondiscriminatory basis.

Section 2.2 COBRA. The health care continuation coverage requirements of the Consolidated Omnibus Budget Reconciliation Act of 1985 as it applies to governmental plans.

Section 2.3 Code. The Internal Revenue Code of 1986, as amended.

Section 2.4 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 2.5 Employee. Any individual the Employer classifies and treats as its own regular, common-law employee.

Section 2.6 Employer. The Board of Supervisors of Louisiana State University and Agricultural and Mechanical College is the Employer and is also the Plan Sponsor. Certain administrative duties and responsibilities may be delegated to and be performed by Employees at the respective campuses where a Participant is employed.

Section 2.7. FMLA. The Family and Medical Leave Act of 1993, as amended.

Section 2.8 FSA Administrator. The FSA Administrator may be appointed by the Plan Sponsor to perform certain functions necessary to prepare, implement, operate and administer the
Flexible Spending Arrangements in accordance with the Plan’s terms and in compliance with all legal requirements.

Section 2.9 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 2.4. 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 2.1 or within 30 days of an event that qualifies for a Mid-Year election change as provided in Section 3.9(b).

Section 2.10 Participant. “Participant” means an Eligible Employee who has properly elected benefits under the Plan.

Section 2.11 Plan. “Plan” means the Louisiana State University System Flexible Benefits Plan as established by and subject to the provisions of this document as amended and restated effective January 1, 2013.

Section 2.12 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 2.13 Plan Sponsor. The Board of Supervisors of Louisiana State University and Agricultural and Mechanical College is the Plan Sponsor and also the Employer.

Section 2.14 Plan Year. The Plan Year is the twelve-month period commencing on each January 1 and ending on the following December 31.
ARTICLE III

Participation, Enrollment and Election

Section 3.1 Commencement of Participation for the Initial Enrollment Period; Entry Date. The Eligible Employee shall become a Participant in the Premium Only Plan (POP) after providing the Employer with an executed POP enrollment election. An election to participate in the POP shall continue in effect each subsequent Plan Year until changed or terminated by the Eligible Employee during a subsequent Annual Enrollment period or as provided in Sections 3.6, 3.7, 3.9, or 3.10. The Eligible Employee shall become a Participant in a Flexible Spending Arrangement (FSA) after providing the Employer with an executed FSA enrollment election setting forth the Benefits elected by the Eligible Employee for the remaining portion of the Plan Year, and authorizing the Employer to reduce the Participant’s Compensation (as defined in Section 4.2) by the amount the Participant elects to have contributed to the FSA. An election to participate in an FSA terminates at the end of the Plan Year for which it is made. Any election under this Section must be made in the manner and on the forms established by the Plan 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 (“Entry Date”) provided the Eligible Employee submits the required forms within thirty (30) calendar days of his date of eligibility.

Section 3.2 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 following the Annual Enrollment Period and is irrevocable and may be changed during the Plan Year only as provided in Sections 3.6, 3.7, 3.9, or 3.10. Any election under this Section must be made at the time, in the manner and on the forms established by the Plan Administrator. An election to participate in the POP in effect at the end of a Plan Year automatically renews for the next Plan Year unless changed during a subsequent enrollment period. A Participant in the POP who does not complete and file a POP election in a timely manner during an Annual Enrollment Period will be deemed to have elected to continue the last election then on file. An election to participate in an FSA terminates at the end of the Plan Year and is not automatically renewed. A
Participant in either the Health Care FSA or the Dependent Care FSA during any Plan Year who does not complete and file a new election in a timely manner during an Annual Enrollment Period will not be eligible to participate in the FSA for the Plan Year that immediately follows the Enrollment Period. A Participant of a Health Care FSA or a Dependent Care FSA must submit an FSA enrollment election to the Employer during the Annual Enrollment Period each year. Each FSA enrollment election shall specify the type and amount of benefits elected by the Participant for the Plan Year that immediately follows the Enrollment Period and authorize the Employer to reduce the Participant’s Compensation (as defined in Section 4.2) by the amount the Participant elects to have contributed to the FSA. 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 defined in Section 2.9), and (ii) Election changes permitted under Sections 3.6, 3.7 and 3.9.

Section 3.3 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 end of the month from the date the Participant ceases to be an Eligible Employee due to a reduction of employed effort below 75%, except as provided by Section 3.9(b).

d. the date as of which the Participant fails to make a required contribution; or

e. the end of the month in which the Participant chooses to stop his/her contributions due to a justified Mid-Year election change as provided in Sections 3.6, 3.7 and 3.9.

Section 3.4 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 FSA or Dependent Care FSA after such time must re-enter the FSA and reinstate his original elections.
for that Plan Year with appropriate adjustments to the prorated Compensation Reduction amount as the Employer deems necessary to prorate the Compensation Reduction 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 3.5.

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 2.9).

If an Employee is reinstated within the same Plan Year, prior contributions made to any FSA will be taken into consideration so as not to exceed Plan/IRS maximums.

Section 3.5 COBRA Continuation Elections. Notwithstanding any provision to the contrary in this Plan, to the extent required by COBRA, a Participant and his Spouse and/or Dependent(s), as applicable, whose participation in the Plan ceases 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. Although an individual who ceases to be a Participant due to a COBRA qualifying event may elect to continue coverage of certain benefits as provided by COBRA, such individual is no longer a participant in the Plan, and it shall be the sole responsibility of that individual to arrange for and pay to the Employer on an after tax basis the applicable COBRA premium. Such continuation of coverage shall be subject to all conditions and limitations under COBRA.

A Participant of the Health Care FSA whose Plan participation ceases because of a COBRA qualifying event may make an election to continue to participate in the Health Care FSA under COBRA only if, at the time immediately preceding the COBRA qualifying event, they have a credit balance in their Health Care FSA Account (as determined under Section 6.3) which exceeds the total of the Pay Period Credit Amounts (as determined under Section 4.2) payable for the remainder of the Plan Year plus any COBRA administrative fees charged by the Employer. To continue participation under COBRA, such individuals must pay to their Employer, on an after tax basis, the Pay Period Credit Amounts plus any COBRA administrative fees, due for the remainder of the Plan Year. Such COBRA coverage for the Health Care FSA
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 3.6 FMLA Leave of Absence. Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying unpaid leave under 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 Participant 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 Employer by the due date established by the Employer.

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 3.7 Non-FMLA Leave of Absence. A Participant who is on an unpaid leave of absence for greater than thirty (30) days will be required to complete a Continuation/Cancellation Form electing one of the following choices:

a. Cancel participation in their FSA 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 during the period of suspension 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 payment or reimbursement from the Health Care FSA or Dependent Care FSA. In order to remain a Participant of the Plan during the period of suspension, 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 Participant 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 Employer by the due date established by the Employer.

Section 3.8 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 suggested correction, and 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 3.9 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 provided in Sections 3.1 and 3.2 respectively), depending on when the Participant enrolled in the Plan, unless the election may be changed under one of the exceptions described in this Section 3.9. A Participant may make a new election within 30 days (or within 60 days for
3.9(a)(iii) or (iv)) of the occurrence of an event allowing the exception, as long as the election is made on account of and is consistent with the event. Elections made pursuant to this Section 3.9 shall be effective for the balance of the period of coverage following the change of election, except as provided in Section 3.9(a)(ii).

a. **HIPAA Special Enrollment Rights.** (Applies only to Premium 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 correspond 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;

ii. a new Dependent is acquired as a result of marriage, birth, adoption, or placement for adoption. An election change on account of the birth, adoption, or placement for adoption of a new Dependent child may be effective retroactively (up to 30 days);

iii. the Participant’s or Dependent’s coverage under a Medicaid plan or children’s health insurance program is terminated as a result of loss of eligibility for such coverage; or

iv. the Participant or Dependent become eligible for a state premium assistance subsidy from a Medicaid plan or through a state children’s health plan coverage with respect to coverage under the group health plan.

b. **Status Changes.** (Applies to Premium Only Plan, Health Care FSA, and Dependent Care FSA) Mid-Year election changes (changes made after the Initial Enrollment or Annual Enrollment elections have become effective) are only permitted for one of the following change of status events:

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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

v. a change in residence of the Participant, the Participant’s Spouse or Dependent when such change affects eligibility under the Plan.

If a change in status occurs, a Participant may revoke his Compensation Reduction election 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)(3) and the Participant has notified the Employer of the change within thirty (30) days from the date of the event.

A Participant in the Health Care FSA who ceases to be eligible solely because of a reduction in percent of effort, and who does not elect COBRA continuation coverage with respect to the Health Care FSA, may make a Mid-Year election change and continue as a Participant in the Health Care FSA only if, under Section 6.3, they have a credit balance in the account for such program, and provided the Participant continues to have sufficient compensation throughout the continuation period to fully cover the Compensation Reduction required for the election. Participation in the Health Care FSA will cease at the end of the Plan Year and cannot be continued for the next Plan Year.

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 3.9 (c), such judgment or order must be final, non-appealable, and executory in the State of Louisiana or in the state where the Participant is domiciled and employed.

d. Entitlement to Medicare or Medicaid. (Applies to Premium Only Plan and Health Care FSA) If a Participant, his Spouse or Dependent who is enrolled in the Premium Only Plan (other than group term life insurance) or Health Care FSA 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 Dependent (the individual(s) entitled to Medicare or Medicaid coverage) under 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 Premium Only Plan (other than group term life insurance) and the Health Care FSA to pay for the cost of any added coverage under those plans for the effected individual.

e. Changes in Cost. (Applies to Premium Only Plan and Dependent Care FSA)

(1) Insignificant Cost Changes – When there has been an Insignificant Cost Change to a Premium Only Plan benefit, the Employer will automatically increase or decrease the Participant’s Compensation Reduction amount, on a prospective basis, as appropriate to implement the change.

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

(a) increase their Compensation Reduction 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,
   
   (a) Participants will be allowed to:
       
       (i) decrease their Compensation Reduction for the benefit that has decreased in cost; or
       
       (ii) change their elections to the option that has decreased in cost;
       
   and

   (b) Eligible Employees who are not Participants may commence participation in the Plan to 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 Participant. For purposes of this section, a relative of a Participant is an individual who, with respect to the Participant, is:

   (a) a child or a descendant of a child, a stepchild, a child placed with the Participant by an authorized placement agency for legal adoption by the Participant, and a foster child if such child has as his principal place of residence, for the Participant’s taxable year, the home of the Participant and is a member of the Participant's household;

   (b) a brother, sister, including those by the half-blood, stepbrother, or stepsister;

   (c) the father or mother, or an ancestor of either;

   (d) a stepfather or stepmother;

   (e) a son or daughter of a brother or sister of the Participant;

   (f) a brother or sister of the father or mother of the Participant; or

   (g) a son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or sister-in-law.
(5) The Plan Administrator, at its sole discretion on a uniform and consistent basis, will determine whether a Significant Cost Increase or Significant Cost Decrease has occurred based on all the surrounding facts and circumstances and in accordance with prevailing IRS guidance.

f. Changes in Coverage. (Applies to Premium Only Plan and Dependent Care FSA 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, in lieu thereof, elect to receive on a prospective basis coverage under another benefit package option providing 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, in lieu thereof, elect to receive on a prospective basis coverage under another benefit package option providing 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 3.6.

h. HSA Elections under CDHP-HSA Option. To the extent otherwise allowed by the Louisiana Office of Group Benefits, a Participant may at any time during the Plan Year revoke or revise any participation or contribution election made by the Participant during any Plan Year that was made with respect to a Health Savings Account established in connection with the Participant’s election of the CDHP-HSA health care insurance option offered by the Louisiana Office of Group Benefits. HSA election changes shall be made on a prospective basis only, may not be made more than once in any calendar month, and shall be effective for the calendar month following the date of the election change.

Section 3.10 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.
Section 3.11 Notice of Privacy Practices. The Employer shall, at each Annual Enrollment and at each Initial Enrollment, deliver or cause to be delivered a HIPAA-compliant Notice of Privacy Practices approved by Employer to each Participant electing benefits under the Plan.
ARTICLE IV
Plan Benefits, Funding and Fees

Section 4.1 Benefits Offered. When first eligible for participation (as provided in Section 2.4), a Participant will be given the opportunity to elect one or more of the following benefits under the Plan:

a. Premium Only Plan as provided in Article V.
b. Health Care FSA as provided in Article VI.
c. Dependent Care FSA as provided in Article VII.
d. HSA Benefit as provided in Article VIII.

Section 4.2 Compensation Reduction for Elected Benefits. During each Enrollment Period (as defined in Sections 2.1 and 2.9), 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. The prorated Compensation Reduction amount determined under the preceding sentence may be referred to herein as the “Pay Period Credit Amount.” For purposes of this Section 4.2, 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. Compensation Reductions are applied by the Employer to pay for the Participant’s share of the contributions for benefits elected under the Plan, and for purposes of this Plan and the Internal Revenue Code, are considered Employer contributions.

a. Premium Only Plan. The Compensation Reduction for any of the benefits elected in the Premium 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 changes during the Plan Year, the Plan Administrator may change the Participant’s Compensation Reduction to cover the new premium cost, in accordance with Section 3.9 (e) of the Plan. The Compensation Reduction attributable to the Premium Only Plan benefits shall be applied each pay period by the Employer to the payment of the Participant’s share of the insurance premium cost.

b. **Health Care FSA.** The Compensation Reduction for participation in the Health Care FSA 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 6.2. The full amount of the Participant’s annualized Compensation Reduction (“Annual Target”) for the Health Care FSA shall be credited to the Participant’s Health Care FSA Account as provided in Section 6.3.

c. **Dependent Care FSA.** The Compensation Reduction for participation in the Dependent Care FSA 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 income exclusion limit for expenses incurred for Qualifying Dependent Care services as provided in Section 7.5. The Participant’s Dependent Care FSA 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 FSA. The prorated amount shall be the Compensation Reduction attributable to the Participant’s election to participate in the Dependent Care FSA divided by the number of pay periods in the Plan Year remaining after the effective date of the election to participate.

d. **HSA Benefit.** The Compensation Reduction for participation in the HSA Benefit shall be such amount as elected by the Participant not to exceed the maximum amount permitted the Louisiana Office of Group Benefits for the CDHP-HSA option or by the Code for HSA contributions for the
Plan Year. The maximum permitted Compensation Reduction shall be reduced by the amount of Employer contributions to be made to the HSA as provided by the Office of Group Benefits for the CDHP-HSA option. The Compensation Reduction amount for the HSA Benefit may be increased, decreased, or revoked prospectively at any time during the Plan Year, effective no later than the first day of the second month following the date the election change is filed with the Employer.

Section 4.3  Funding. Employer shall remit funds for the payment of premiums due under the Premium Only Plan and shall remit funds to the FSA Administrator as necessary to pay claims. Unless otherwise required by law, contributions to the Plan need not be placed in trust, reserved or dedicated to a specific Participant, account or benefit. Unless otherwise required by law, nothing herein shall be construed to require the Employer or the Plan Administrator to maintain any fund or segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account or asset of the Employer from which any payment under the Plan may be made.

Section 4.4  Administrative Fees. A Participant shall be responsible for payment of all administrative fees chargeable to the Participant for the elected benefits. Administrative fees shall not be included in the Compensation Reduction amount and shall be payable in the manner directed by the Employer. The Employer shall inform the Participant of all administrative fees for the elected benefits and the manner of payment at the time of enrollment.
ARTICLE V

Premium Only Plan

Section 5.1 Purpose. The Employer has established the Premium Only Plan to permit Eligible Employees a choice between cash and benefits for coverage under certain group insurance coverage in accordance with this Article V, the Plan and Code Section 125.

Section 5.2 Benefits. During each Enrollment Period (as defined in Sections 2.1 and 2.9), an Eligible Employee may elect to participate in and receive one or more of the benefits offered under the Premium Only Plan. For purposes of this Plan, participation in the Premium 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 Premium 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, including, the health plan options offered by the Louisiana Office of Group Benefits which include, without limitation, the Consumer Driven Health Plan with Health Savings Account (CDHP-HSA) option with Employer contributions to the Employee’s Health Savings Account in such amounts as periodically determined by the Louisiana Office of Group Benefits;

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 through the Office of Group Benefits, Division of Administration, State of Louisiana.
ARTICLE VI

Health Care Flexible Spending Arrangement

Section 6.1  Purpose.  The Employer has established the Louisiana State University Health Care Flexible Spending Arrangement (the "Health Care FSA") to permit Eligible Employees, to pay or be reimbursed for certain Qualifying Medical Expenses in accordance with this Article VI, the Plan and Code Section 105.

Section 6.2  Maximum Contribution.  During each Enrollment Period (as defined in Sections 2.1 and 2.9), an Eligible Employee who has not elected to participate in the CDHP-HSA health care insurance option offered by the Louisiana Office of Group Benefits may elect to participate in and receive the benefits of the Health Care FSA as provided by this Article VI.  The minimum contribution to participate in this Program is $100 per Plan Year.  The maximum contribution to participate in this program is $4,000 for Plan Year 2012.  Effective for the Plan Year beginning January 1, 2013, the maximum contribution shall be $2,500 per twelve month Plan Year, or such other amount as may be established by law from time to time.  In the event of a short Plan Year consisting of less than twelve months, the Plan Administrator may reduce the maximum contribution for such short Plan Year for all Employees on a nondiscriminatory basis. Employees shall be informed of any reduction in the amount of the maximum contribution during the Enrollment Period (as defined in Sections 2.1 and 2.9) for such short Plan Year. Employees who elect to participate in the CDHP-HSA health care insurance option offered by the Louisiana Office of Group Benefits and who have opened a health savings account under that option are not eligible to participate in the Health Care FSA.

Section 6.3  Payments or Reimbursements.  Subject to the limitations of Section 9.4, Qualifying Medical Expenses (as defined in Section 6.5) 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 paid or reimbursed from the Participant's Health Care FSA Account to the extent the Participant has a Credit Balance in his Health Care FSA Account, but not to exceed the maximum set forth in Section 6.2.  For purposes of determining the Credit Balance under the preceding sentence as of any date during the Plan
Year, the Participant's Health Care FSA Account will be deemed to be credited as of the first day of the Plan Year with the full Annual Target amount for the entire year elected by the Employee pursuant to Section 4.2(b) and shall be reduced by the sum of all reimbursable claims submitted to the Health Care FSA Account to such date. A claim must be submitted in accordance with Article IX along with supporting documentation as defined in Section 6.4.

Section 6.4  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 Participant for care of the Participant, Participant’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.

Over-the-counter drugs shall not be reimbursable unless such drug was prescribed by a physician and a copy of the prescription is submitted with the claim.

Section 6.5  Qualifying Medical Expenses. A "Qualifying Medical Expense" means any medical expense (as defined in Code Section 213 and regulations thereunder) incurred by the Participant on behalf of himself, his Spouse, or his Dependents (as defined in Code 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.

Section 6.6  Limitation on Participation. A Participant in the Louisiana Office of Group Benefits CDHP-HSA health care insurance coverage program who has opened a healthcare savings account is not eligible to participate in the Health Care FSA, and a participant in the Health Care FSA may not make an election to contribute to a healthcare savings account offered as an option to the CDHP-HSA health care insurance coverage program offered by the Louisiana Office of Group Benefits at any time while still a participant in the Health Care FSA, or at any time the Transition Rule as provided in Section 8.5 applies.
ARTICLE VII

Dependent Care Flexible Spending Arrangement

Section 7.1 Purpose. The Employer has established the Louisiana State University System Dependent Care Flexible Spending Arrangement (“Dependent Care FSA”) to permit its Eligible Employees, to pay or be reimbursed for certain Qualifying Dependent Care Expenses in accordance with this Article VII, the Plan and Code Section 129.

Section 7.2 Maximum Contribution. During each Enrollment Period (as defined in Sections 2.1 and 2.9), an Eligible Employee may elect to participate in and receive the benefits of the Dependent Care FSA as provided under this Article VII. The minimum contribution to participate in this Program is $100 per Plan Year. The maximum contribution shall not exceed the income exclusion limit as provided in Section 7.5. In the event of a short Plan Year consisting of less than twelve months, the Plan Administrator may reduce the maximum contribution for such short Plan Year for all Employees on a nondiscriminatory basis. Employees shall be informed of any reduction in the amount of the maximum contribution during the Enrollment Period (as defined in Sections 2.1 and 2.9) for such short Plan Year.

Section 7.3 Qualifying Individuals. Dependent care expenses must be provided for a “qualifying individual” under Code 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 7.4 Qualifying Dependent Care Services. Qualifying Dependent Care Services means those services for which dependent care assistance, as defined in Code Section 129 (e) (1) and regulations thereunder, may be provided by an employer to an employee under Code Section 129(a)(1) without being included in the employee’s taxable income.
Section 7.5 Payments or Reimbursements. Subject to the limits of this Section 7.5 and Section 9.4, Qualifying Dependent Care Services (as defined in Section 7.4) incurred by a Participant will be paid or reimbursed from the Participant's Dependent Care FSA Account only to the extent the Participant has a Credit Balance in his Dependent Care FSA 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 credited each pay period as provided in Section 4.2(c), and shall be reduced by the sum of all reimbursable claims submitted to the Dependent Care FSA. A claim must be submitted in accordance with Section 9.1, together with supporting documentation as defined in Section 7.6 (all reimbursements will be made in accordance with Article IX of the Plan).

Payment or reimbursement for expenses incurred for Qualifying Dependent Care Services shall be limited to the income exclusion limit as provided by Code section 129(a)(2) as it may be amended from time to time (which amount as of January 1, 2013, for any twelve-month Plan Year, is 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 Code Section 32(c)(2)) for the Plan Year or (ii) the Participant’s spouse’s earned income for the Plan Year), or a lesser amount as determined by the Plan Administrator for a short Plan Year of less than twelve months). 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 is single.

Section 7.6 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.

Section 7.7 Reporting of Reimbursements. The FSA Administrator will provide each Participant with a written statement showing the total reimbursements made under the Dependent Care FSA for each calendar year in the form and at the time required by law.
ARTICLE VIII

Health Savings Account Benefit

Section 8.1.  Purpose.  A Health Savings Account Benefit ("HSA Benefit") is provided to permit Eligible Employees who have elected to participate in the Consumer Driven Health Plan with Health Savings Account (CDHP-HSA) offered by the Louisiana Office of Group Benefits to make contributions on a pre-tax basis to a health savings account under Code Section 223.

Section 8.2  HSA Benefit.  The HSA Benefit offered by this Plan consists solely of the ability to make contributions on a pre-tax basis, via Compensation Reduction as provided in Section 4.2(d), to an individual trust or custodial account that qualifies as a health savings account under Code Section 223.  Such health savings account shall be separately established and maintained outside of this Plan by the Participant with a health savings account trustee or custodian specified by the Louisiana Office of Group Benefits.  The Employer will forward the Compensation Reduction amount allocated by the Participant for the HSA Benefit to the health savings account trustee or custodian.  This pre-tax funding feature constitutes the entirety of the HSA Benefit offered under this Plan.  Distributions from a Participant’s health savings account and all other matters related to the health savings account are outside of this Plan and are to be handled exclusively by the Participant and the health savings account custodian or trustee.  Employer has no responsibility or authority over Participant funds deposited in a health savings account.  Neither Employer nor Plan Administrator are custodians or trustees of any health savings account established by the Participant and shall not be held responsible for any use of the Participant’s funds deposited in the health savings account,

Section 8.3  Participation.  During each Enrollment Period (as defined in Sections 2.1 and 2.9), an Eligible Employee who has elected to participate in the Consumer Driven Health Plan with Health Savings Account option (CDHP-HSA) offered by the Louisiana Office of Group Benefits may elect to establish a health savings account in the manner determined by the Office of Group Benefits to which the Participant may make pre-tax contributions and to which Employer
contributions and Employer matching contributions will be made in such amounts as periodically determined by the Office of Group Benefits.

Section 8.4  Limitation on Participation. A Participant in the Louisiana Office of Group Benefits CDHP-HSA health care insurance coverage program who has opened a health savings account is not eligible to participate in the Health Care FSA, and a Participant in the Health Care FSA may not make an election to contribute to a health savings account offered as an option to the Louisiana Office of Group Benefits CDHP-HSA health care insurance coverage program at any time while still a participant in the Health Care FSA, or at any time the Transition Rule as provided in Section 8.5 applies.

Section 8.5  Transition Rule. A Participant who has an election to participate in the Health Care FSA that is in effect on the day immediately preceding the first day of the Plan Year cannot make a contribution to a health savings account for any of the first three months of that Plan Year, unless the balance in the Participant’s Health Care FSA account was $0.00 on the day immediately preceding the first day of that same Plan Year. For purposes of this Transition Rule, the balance of the Participant’s Health Care FSA account shall be determined on a cash basis, without regard to any claims that have been incurred but which have not yet been reimbursed (regardless of whether or not such claims have been submitted for reimbursement.)
ARTICLE IX

Benefit Payments

Section 9.1 Payment Procedures. Any Compensation Reduction Amount allocated to the benefits of the Premium Only Plan will be applied by the Employer to pay those premiums at the times and in the amounts required by the underlying plans. Any amounts in the Participant’s Health Care FSA Account or Dependent Care FSA Account will be applied to pay or 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 or submitted through debit card or other means established by the FSA Administrator. To receive a payment or reimbursement, a claim for a qualifying expense incurred during a Plan Year and its subsequent Grace Period must be filed with the FSA Administrator no later than April 30 after the end of the Plan Year. 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 April 30 after the end of the Plan Year (unless COBRA is elected). A qualifying expense for which payment or reimbursement is sought is incurred on the date on which the service was provided.

Section 9.2 Grace Period. The Grace Period is defined as the two and one-half month period after the end of the Plan Year. For each Plan Year that closes on December 31, the Grace Period will close on March 15 of the immediately following calendar year. This Grace Period allows a Participant with unused benefits or contributions in his Health Care or Dependent Care FSA Account, relating to a particular qualified benefit from the immediately preceding Plan Year, to pay or be reimbursed for expenses incurred during the Grace Period. The effect of the Grace Period is that in any regular twelve-month Plan Year 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 9.6

In addition, if a Participant submits a claim that was incurred during the Grace Period and the Participant also has elected a Health Care or Dependent Care FSA Account for the immediately following Plan Year, the amount of the claim will be paid or reimbursed, to the extent allowed, first, from any balance remaining in the preceding Plan Year’s Health Care or
Dependent Care FSA Account, and then from the immediately following Plan Year’s Health Care or Dependent Care FSA 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 and for which a claim for reimbursement was made on or before April 30, those remaining unused contributions may not be carried forward to any subsequent period and are forfeited under Section 9.6 (the “Use-it-or-lose-it Rule”).

The Grace Period is available to individuals who (i) were Participants in the FSA as of the last day of the preceding Plan Year, (ii) were covered by a COBRA continuation election with respect to the Health Care FSA as of the last day of the preceding Plan Year, or (iii) had a status change due to a reduction in percent of effort and who as of the last day of the preceding Plan Year were covered by an election to continue participation as provided in Section 3.9(b).

Section 9.3 Supporting Documentation. Supporting documentation must accompany a FSA claim at the time the claim is filed. See Section 6.3 for a definition of Supporting Documentation and how it applies to the Health Care FSA and Section 7.6 for a definition of Supporting Documentation and how it applies to the Dependent Care FSA. The FSA Administrator will make the initial determination whether or not the expenses to be paid or reimbursed under this Section are qualifying expenses under the Health Care FSA or Dependent Care FSA and whether or not sufficient documentation has been submitted to support the payment of the claim. 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 9.5 for details of the review procedures).

Section 9.4 Claim Limitations. Notwithstanding the provisions of Section 9.1, no payment will be made under the Health Care FSA for any expense that has been or will be paid or reimbursed under any of the group insurance policies elected under the Premium Only Plan, or from any other source available to the Participant or his dependents. No payment will be made
under the Dependent Care FSA for any expense that has been or will be used by the Participant or any other person to claim a tax credit. By submitting a claim for reimbursement from the Health Care FSA or Dependent Care FSA, the Participant certifies that such expense has not been and will not be paid or reimbursed from insurance or from any other source nor will such expense be claimed for any tax credit.

Section 9.5 Claim Review and Appeal Procedures. The FSA Administrator, in accordance with the provisions of Article XI, 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 this Section 9.5.

a. 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.

b. 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.
c. **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 9.6 Forfeiture of FSA Account Balances.** Any amount in a Participant's Health Care FSA Account or Dependent Care FSA Accounts, at the end of Plan Year (including the Grace Period), or upon termination of employment, that is not used to pay claims 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”.

**Section 9.7 Effect of Mistake.** In the event of a mistake as to eligibility or participation of an Employee, the allocations made to the account of any Participant, or the amount of benefits paid or to be paid to a Participant, the Plan Administrator, through the Employer, shall cause to be allocated or otherwise make adjustment of such amounts to the extent it deems administratively possible and permissible under the Internal Revenue Code. Such action may include withholding of any amounts due to the Plan or the Employer from Compensation paid by the Employer.
ARTICLE X

Plan Administrator Responsibilities

Section 10.1 Establishment of Plan. Plan Sponsor shall establish and maintain the Plan in accordance with all applicable laws and regulations.

Section 10.2 Responsibility and Authority. The Plan Administrator shall exercise the fiduciary responsibility and claims authority of the Plan Sponsor. The Plan Administrator shall have the exclusive right to interpret the Plan and to decide all matters under the plan. Determinations of the Plan Administrator shall be conclusive and binding.

Section 10.3 Claim Disposition. In the event a claim is denied or pending, the Plan Administrator shall have final review of and authority for disposition of disputed claims.

Section 10.4 Provision for Third-Party Service Provider. The Plan Administrator may employ the services of such persons as it deems necessary or desirable in connection with the operation of the Plan.
ARTICLE XI

FSA Administrator Duties and Responsibilities

Section 11.1  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 in accordance with its management agreement with the Plan Sponsor. 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 and other applicable law and regulations.

Section 11.2  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 11.3  FSA 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.
ARTICLE XII

Amendment and Termination of Plan

Section 12.1  Plan Amendments.  The provisions of the Plan may be modified by the Employer, at any time, in whole or in part, 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.

Section 12.2  Termination of Plan.  The Plan may at any time be terminated by the Employer.
ARTICLE XIII

Miscellaneous Provisions

Section 13.1 Information to be Furnished. Participants must provide the Employer, the Plan Administrator 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 13.2 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, the Plan Administrator, or the FSA Administrator, except as specifically provided in the Plan.

Section 13.3 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 13.4 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 13.5 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 13.6  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 13.7  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 13.8  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 may be obtained by contacting the Plan Administrator.  The Plan Administrator shall provide contact information for the FSA Administrator at the time of enrollment.

Section 13.9  Waiver of Notice.  Any notice required under the Plan may be waived by the party entitled to such notice.

Section 13.10  Indemnification of Employer.  If any Participant receives one or more payments or reimbursements under this Plan on a tax-free basis and if such payments do not qualify for such treatment under the Code, then such Participant shall indemnify and reimburse the
Employer for any liability that it may incur for failure to withhold federal income taxes, social security taxes, or other taxes from such payment or reimbursement.

Section 13.11 Headings. The headings of the various Articles, sections and paragraphs are for convenience of reference and are not intended to be and shall not be regarded as part of the Plan or as indicating or controlling the meaning or construction of any provision.

Section 13.12 No Guarantee of Tax Consequences. The Plan Administrator, the FSA Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Plan will be excludable from the Participant’s gross income for federal, state, or local income tax purposes. The determination of tax consequences is the responsibility and obligation of the Participant and Participant’s tax advisor.

Section 13.13 Code Compliance. It is intended that this Plan shall meet all applicable requirements of the Code, and all of the regulations issued thereunder. This Plan shall be construed, operated, and administered accordingly, and in the event of any conflict between any part, clause, or provision of this Plan and the Code, the provisions of the Code shall be deemed controlling and any conflicting part, clause, or provision of this Plan shall be deemed superseded to the extent of the conflict.

IN WITNESS WHEREOF, Employer has caused this Plan to be executed this _____day of__________, 2012, to become effective January 1, 2013.

Board of Supervisors of Louisiana State University and Agricultural and Mechanical College

By: ________________________________

William L. Jenkins, Interim President