

Health Care Flexible Spending Arrangement

for

The State of Louisiana
An ERISA Exempt Employer

2002

Amended as of January 1, 2015

Office of Group Benefits
Division of Administration
State of Louisiana

Article 1

INTRODUCTION

1.1 Establishment of Health Care FSA

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

This Plan Document is amended to comply with the Patient Protection and Affordable Care Act, public law no. 111-148, and the Health Care and Education Reconciliation Act of 2010, public law no. 111-152. This amendment is effective January 1, 2015.

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

1.2 Legal Status

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

1.3 HIPAA Exception

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

Article 2 DEFINITIONS and CONSTRUCTION

2.1 Definitions

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

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

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

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

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

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

“Change in Status” means the following events:

- (a) Marriage, annulment, legal separation, or divorce of the Employee;
- (b) The death of the Employee’s spouse or Dependent;
- (c) The birth, adoption or placement for adoption of a child of the Employee;
- (d) A Dependent satisfying or ceasing to satisfy eligibility requirements due to attainment of limiting age, change in student status, change in status as a Dependent, or any similar circumstance;
- (e) The switching from part-time to full-time employment status or from full-time to part-time status by the Employee, the Employee’s spouse, or the Employee’s Dependent(s);
- (f) The commencement of or return from an unpaid leave of absence by the Employee, the Employee’s spouse, or the Employee’s Dependent(s);
- (g) A change in work place of the Employee, Employee’s spouse, or Employee’s Dependent(s); and

(h) A strike or lockout, the termination of employment, or the commencement of employment of the Employee, Employee's spouse, or Employee's Dependent(s).

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

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

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

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

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

“Effective Date” means the date that this Health Care FSA was effective, January 1, 2002, as amended January 1, 2015.

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

“Employee” means an individual that the Employer classifies as active, full-time, and who is on the Employer's W-2 payroll, but does not include the following: (a) any leased employee (including, but not limited to those individuals defined as leased employees in Code §414(n)) or an individual classified by the Employer as a contract worker, independent contractor, temporary employee or casual employee for the period during which such individual is so classified, whether or

not any such individuals are on the Employer's W-2 payroll or are determined by the IRS or others to be common-law employees of the Employer; (b) any individual who performs services for the Employer but who is paid by a temporary or other employment or staffing agency for the period during which such individual is paid by such agency, whether or not such individuals are determined by the IRS or others to be common-law employees of the Employer; or (c) any employee covered under a collective bargaining agreement.

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

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

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

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

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

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

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

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

“Grace Period” means the 2 months plus 15 days immediately following the end of a Plan Year when Participants may incur Qualifying Medical Care Expenses to be reimbursed from their respective unused Benefits remaining at the end of the immediately preceding Plan Year in accordance with IRS Notice 2005-42 or any amendment thereof.

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

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

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

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

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

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

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

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

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

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

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

“Qualifying Medical Care Expenses” means expenses incurred by a Participant, or by the spouse or Dependent of such Participant, for medical care as defined in Code §213(d) and Treasury Regulations §1.213-1(e), except amounts paid for insurance premiums and amounts paid for qualified long-term care services as defined in Code §7702B(c), but only to the extent that the Participant or other person incurring the expense is not reimbursed for the expense through insurance or

otherwise. Charges for medicines or drugs, other than insulin, must be prescribed and must be purchased within the United States. Amounts paid for medicines or drugs, other than insulin, purchased outside the United States are **NOT** Qualifying Medical Care Expenses. For Participants in the Limited-Purpose (dental/vision) Health Care FSA, Qualifying Medical Care Expenses are **further limited to** expenses for vision care or dental care **ONLY**.

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

“Run-out Period” means the forty-five (45) days immediately following the Grace Period when Participants may submit Qualifying Medical Care Expenses incurred during the preceding Plan Year and/or Grace Period for reimbursement from their respective unused Benefits remaining at the end of the immediately preceding Plan Year.

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

"Short Plan Year" means the period of coverage under the Health Care FSA designated by the Administrator that is less than one year.

2.2 Gender and Number

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

2.3 Headings

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

Article 3

PARTICIPATION

3.1 Eligibility to Participate

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

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

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

3.2 Participation for HSA-Eligible Individuals

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

3.3 Election to Participate; Commencement of Participation

- (a) *Elections During Enrollment Period.* New Eligible Employees who want to enroll in the Health Care FSA must submit the Enrollment Form and elect to pay any applicable Administrative Fee within the Enrollment Period. The applicant becomes a Participant effective the first of the month following the first full calendar month of eligibility.
- (b) *Elections During Annual Enrollment Period.* During each Annual Enrollment Period with respect to a Plan Year, the Administrator shall make available an Enrollment

Form upon request. The Enrollment Form shall be completed and returned to the Employer on or before the last day of the Annual Enrollment Period. If an Eligible Employee elects to participate during an Annual Enrollment Period, he becomes a Participant on the first day of the applicable Plan Year.

- (c) *Eligible Employee Who Fails to File an Enrollment Form.* If an Eligible Employee fails to file (or fails to timely file) an Enrollment Form with respect to a Plan Year with his Employer during the Annual Enrollment Period, he will not be considered a Participant in this Health Care FSA with respect to the Plan Year and he may not elect to participate in this Health Care FSA until the next Annual Enrollment Period, unless he experiences an event as outlined in Section 4.5, and makes an election change on account of and consistent with the event pursuant to Section 4.5.

3.4 Participation Agreement

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

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

3.5 Termination of Participation

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

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

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

3.6 Reinstatement of Former Participants by Reason of Civil Service Appeal

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

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

3.7 Participation Following Rehire

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

3.8 Participation Following Transfer

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

3.9 FMLA Leaves of Absence

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

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

- (a) by pre-paying with pre-tax all or a portion of the Salary Reduction for the expected duration of the leave pursuant to a prior to commencement of FMLA leave agreement with his Employer. To pre-pay the Salary Reduction, the Participant must make a special election to that effect prior to the date that such Compensation would normally be made available (Pre-tax dollars may not be used to fund coverage during the next Plan Year);
- (b) by paying with pre-tax dollars upon his return to work on a payroll reduction schedule pursuant to a prior to commencement of FMLA leave agreement with his Employer; or
- (c) by paying with after-tax dollars in the form of monthly payments to the Employer by the due date established by the Employer.

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

3.10 Non-FMLA Leaves of Absence

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

- (a) by pre-paying with pre-tax dollars all or a portion of the Salary Reduction for the expected duration of the leave pursuant to a prior to commencement of unpaid leave agreement with his Employer. To pre-pay the Salary Reduction the Participant must make a special election to that effect prior to the date that such Compensation would normally be made available (Pre-tax dollars may not be used to fund coverage during the next Plan Year);
- (b) by paying with pre-tax dollars upon his return to work on a payroll reduction schedule pursuant to a prior to commencement of unpaid leave agreement with his Employer; or
- (c) by paying with after-tax dollars in the form of monthly payments to the Employer by the due date established by the Employer.

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

Article 4

BENEFITS and ELECTIONS

4.1 Administrative Fee

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

4.2 Maximum and Minimum Benefits

(a) *Plan Years.* The maximum annual Benefit amount that a Participant may elect to receive under this Health Care FSA in any Plan Year and/or Grace Period shall be \$2,550. The minimum annual Benefit amount that a Participant may elect to receive under this Health Care FSA in any Plan Year and/or Grace Period shall be \$600.

(b) *Short Plan Years.* The maximum annual Benefit amount that a Participant may elect to receive under this Health Care FSA in any Short Plan Year and/or Grace Period shall be \$2,550. The minimum annual Benefit amount that a Participant may elect to receive under this Health Care FSA in any Short Plan Year and/or Grace Period shall be \$600.

4.3 Salary Reduction Contributions

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

4.4 Irrevocability of Elections: Not Applicable for HSA

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

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

4.5 Events Permitting Exception to the Irrevocability Rule

The exceptions to the irrevocability requirement are as follows:

- (a) *Change in Status.* A Participant may change or terminate his election under this Health Care FSA upon the occurrence of a Change in Status (see Section 2.1), and only if such election change or termination is because of and consistent with the Change in Status. An election change is "consistent" if the Change in Status event affects eligibility for coverage and the change in the election corresponds with the effect on eligibility. The Administrator (in its sole discretion and on a uniform and consistent basis) shall determine, based upon prevailing IRS guidance, whether a requested change is consistent with and attributable to a Change in Status.
- (b) *Certain Judgments, Decrees, and Orders.* If a judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in legal custody (including NMSN) requires accident or health coverage (including an election for Health Care FSA Benefits) for a Participant's Dependent (including a foster child who is a Dependent of the Participant), a Participant may:
 - (1) change his election to provide coverage for the Dependent (provided that the Order requires the Participant to provide coverage), or
 - (2) change his election to revoke coverage for the Dependent if the Order requires that another individual (including the Participant's spouse or former spouse) provide coverage under the individual's plan and such coverage is actually provided.
- (c) *Medicare and Medicaid.* If a Participant or his spouse or Dependent who is enrolled in a health or accident plan under the Flex Plan becomes entitled to Medicare or Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act providing for pediatric vaccines), the Participant may prospectively cancel or reduce his Health Care FSA coverage. Further, if a Participant or his spouse or Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, the Participant may prospectively change his enrollment to commence or increase his Health Care FSA coverage.
- (d) *FMLA.* A Participant may change an election under the Health Care FSA with regard to FMLA leave in accordance with Section 3.9.

Effective Date of New Election. Elections made pursuant to this Section shall be effective for the balance of the Plan Year unless a subsequent Change in Status event allows for another election change. All election changes shall be made on a prospective basis effective for the pay period in which the documents are received by the Employer.

4.6 Election Modifications Required by Administrator

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

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

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

Article 5

REIMBURSEMENT PROCEDURE

5.1 Reimbursable Expenses

- (a) *Qualifying Medical Care Expenses.* A Participant may receive reimbursement for Qualifying Medical Care Expenses incurred during the Plan Year and/or Grace Period for which an election is in force. A Qualifying Medical Care Expense is incurred at the time the medical care or service giving rise to the expense is furnished, and not when the Participant is formally billed, is formally charged, or pays for the medical care.
- (b) *Prescription Medicines/Drugs.* The Plan Administrator (in its sole discretion and on a uniform and consistent basis) shall determine, based upon prevailing IRS guidance, whether a particular item is a medicine or drug, and whether the prescription requirement has been satisfied. Items such as crutches, bandages, and blood sugar test kits are not medicines or drugs.
- (c) *Coordination of Benefits with HSA.* The Health Care FSA shall not be considered to be a group health plan and Health Care FSA Benefits shall not be taken into account for coordination of benefits purposes. In the event an expense is eligible for reimbursement under both the Health Care FSA and the HSA, the Participant may choose to seek reimbursement from either the Health Care FSA or the HSA, but not both.

5.2 Maximum and Minimum Reimbursement

- (a) *Maximum Reimbursement Available.* Reimbursement for Qualifying Medical Care Expenses of the maximum dollar amount elected by the Participant for a Short Plan Year or Plan Year (reduced by prior reimbursements and Qualified Reservist Distribution(s) during the Short Plan Year or Plan Year) shall be available at all times during the Plan Year and/or Grace Period, regardless of the actual amounts credited to the Participant's Health Care FSA Account pursuant to Section 5.3. Notwithstanding the foregoing, no reimbursements will be available for expenses incurred after coverage under this Health Care FSA has terminated, unless the Participant has elected COBRA as provided in Section 5.7. Payment shall be made to the Participant in cash as reimbursement for Qualifying Medical Care Expenses incurred during the Short Plan Year or Plan Year and/or Grace Period for which the Participant's election is effective, provided that the Participant has complied with all other requirements of this Plan Document.
- (b) *Maximum and Minimum Annual Benefit Amounts.*
 - (1) *Short Plan Year.* The maximum Benefit amount that a Participant may elect to receive under this Health Care FSA in any Short Plan Year and/or Grace Period shall be \$2,550, subject to Section 5.3(c), below. The minimum Benefit amount that a Participant may elect to receive under this Health Care FSA in any Short Plan Year and/or Grace Period shall be \$600. Reimbursements due

for Qualifying Medical Care Expenses incurred by the Participant, Participant's Spouse or Participant's Dependents as well as any Qualified Reservist Distribution(s) shall be charged against the Participant's Health Care FSA Account.

(2) *Plan Year.* The maximum annual Benefit amount that a Participant may elect to receive under this Health Care FSA in any Plan Year and/or Grace Period shall be \$2,550, subject to Section 5.3(c), below. The minimum annual Benefit amount that a Participant may elect to receive under this Health Care FSA in any Plan Year and/or Grace Period shall be \$600. Reimbursements due for Qualifying Medical Care Expenses incurred by the Participant, Participant's spouse or Participant's Dependents as well as any Qualified Reservist Distribution(s) shall be charged against the Participant's Health Care FSA Account.

(c) *Changes; No Proration.* For subsequent Plan Years, the maximum and minimum annual Benefit amount may be changed by the Administrator and shall be communicated to Employees through the Enrollment Form or another document. If a Participant wishes to increase an election mid-year as permitted under Section 4.5, the Participant may elect coverage up to the maximum annual Benefit amount, as applicable.

(d) *Effect on Maximum Benefits if Election Change Permitted.* Any change in an election under Section 4.5 affecting the maximum annual Benefit amount for a Participant's Health Care FSA Account also will change the maximum reimbursement of Benefits for the balance of the Plan Year commencing with the election change. Such maximum reimbursement of Benefits for the balance of the Plan Year shall be calculated by adding the Contributions made by the Participant (if any) as of the end of the portion of the Plan Year immediately preceding the change in election to the total Contributions scheduled to be made by the Participant during the remainder of such Plan Year to the Health Care FSA Account, reduced by all reimbursements and distributions made during the entire Plan Year.

5.3 Establishment of Account

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

(a) *Crediting of Accounts.* A Participant's Health Care FSA Account will be credited periodically during each Plan Year with an amount equal to the Participant's maximum annual Benefit amount elected to be allocated to such Account. The Administrative Fee is not credited to the Account.

(b) *Debiting of Accounts.* A Participant's Health Care FSA Account will be debited during each Plan Year for any reimbursement of Qualifying Medical

Care Expenses incurred, or Qualified Reservist Distribution(s) during the Plan Year and/or the Grace Period.

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

5.4 Qualified Reservist Distribution (QRD)

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

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

The amount of the QRD shall be no more than the Participant's Contributions to his Health Care FSA Account for the Plan Year as of the date of the QRD request, minus the reimbursements he has received from his Account for the Plan Year as of the date of the request. Notwithstanding any other provision of the Plan to the contrary, this portion of the Participant's balance may be distributed without regard to whether Qualifying

Medical Care Expenses have been incurred. The QRD is subject to employment taxes and will be reported as wages on the Participant's employee Form W-2 for the year in which the QRD is paid.

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

The Qualified Reservist Distribution will be made as soon as practicable not to exceed sixty (60) days, or the Administrator will notify the Participant that his distribution was denied within a reasonable time not to exceed sixty (60) days after receipt of the QRD request in accordance with Section 6.1.

5.5 Procedure for Claiming Reimbursement

A Participant who has elected to receive Benefits for a Plan Year may apply for reimbursement by submitting an application in writing to the Administrator in such form as the Administrator may prescribe no later than forty-five (45) days following the close of the Grace Period for the Plan Year in which the Qualifying Medical Care Expenses were incurred, setting forth:

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

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

5.6 Timing of Reimbursement

As soon as practicable after the Participant submits a reimbursement claim to the Administrator, the Administrator will reimburse the Participant for his Qualifying Medical Care Expenses, or will notify the Participant that his claim has been denied within a reasonable period of time not to exceed sixty (60) days after receipt of a claim in accordance with Section 6.1.

5.7 Termination of Benefits

When a Participant ceases to be a Participant under Section 3.5, the Participant's Salary Reduction will terminate, as will the Participant's election to receive reimbursements. The Participant will not be able to receive reimbursements for Qualifying Medical Care Expenses incurred after his participation terminates. However, such Participant (or the Participant's estate) may claim reimbursement for any Qualifying Medical Care Expenses incurred during the Plan Year and/or the Grace Period prior to termination, provided that the Participant (or the Participant's estate) files a claim no later than forty-five (45) days following the close of the Grace Period for the Plan Year in which the expense arose.

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

5.8 Use or Lose Rule; Forfeiture of Accounts

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

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

Article 6

APPEALS PROCEDURE

6.1 Review of Administrative Decisions

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

6.2 Eligibility Appeals

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

6.3 Appeal of Denial of Claim for Reimbursement

To obtain a review of a denial of a claim for reimbursement of expenses, and for any appeals not covered under Section 6.2, one shall request a review by filing a written application for review by the Appeals Panel with Discovery Benefits, Inc., ATTN: APPEALS, 4321 20th Avenue S, Fargo, ND 58103, within sixty (60) days after receipt by the applicant of written notice of the denial. In connection with this request for review, the applicant may review pertinent Plan documents and submit issues and/or comments in writing to the address in this Section.

6.4 Decision on Review

Decisions on review shall be made in the following manner:

(a) The decision on review shall be made by the Appeals Panel. The Appeals Panel shall make its decision promptly, and not later than sixty (60) days after the Appeals Panel receives the request for review, unless special circumstances require an extension of time for processing. In such case, a decision shall be rendered as soon as possible, but not later than one hundred twenty (120) days after receipt of the request for review. If such an extension of time for review is required, written notice of the extension shall be furnished to the Participant prior to the commencement of the extension.

(b) The decision on review shall be in writing and shall set forth the following in the event of a denial:

(1) Information to identify the Participant's request;

(2) Specific reason(s) for the decision; and,

(3) Specific reference to pertinent Plan provisions on which the denial is based.

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

Article 7

ADMINISTRATION

7.1 Administrator

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

7.2 Powers of the Administrator

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

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

- (g) to appoint and employ such individuals or entities to assist in the administration of this Health Care FSA as it determines to be necessary or advisable;
- (h) to sign documents for the purpose of administering this Health Care FSA, or to designate an individual or individuals to sign documents for the purposes of administering this Health Care FSA; and
- (i) to maintain the books of accounts, records, and other data in the manner necessary for the proper administration of this Health Care FSA and to meet any applicable disclosure and reporting requirements.

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

7.3 Reliance on Participant, Tables, etc.

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

7.4 Fiduciary Liability

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

7.5 Inability to Locate Payee

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

7.6 Effect of Mistake

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

Article 8

GENERAL PROVISIONS

8.1 Expenses

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

8.2 No Contract of Employment

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

8.3 Amendment and Termination

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

8.4 Governing Law

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

8.5 Code Compliance

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

8.6 No Guarantee of Tax Consequences

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

8.7 Indemnification of Employer

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

8.8 Non-Assignability of Rights

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

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

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

8.10 Plan Document Provisions Controlling

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

8.11 Severability

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