CAFETERIA PLAN

FOR

THE STATE OF LOUISIANA

AN ERISA EXEMPT EMPLOYER

Current as of January 23, 2023

Established, 1993

Office of Group Benefits
Division of Administration
State of Louisiana

Article 1
INTRODUCTION

The Office of Group Benefits is administering this Internal Revenue Service qualified cafeteria plan, hereinafter referred to as the Flexible Benefits Plan (Flex Plan), in accordance with Louisiana Revised Statutes 42:802 B(9). This Flex Plan is effective as of July 1, 1993. This Flex Plan document is amended to comply with Internal Revenue Code regulations and is effective as of February 18, 2022. This Flex Plan document will remain in effect until the next Plan Year or until next amended, whichever is later.

The purpose of the Flex Plan is to allow Eligible Employees of the Employer to select among various Benefits offered by the Employer, or cash, so that the participating Employees can receive those Benefits which they have determined best meet their individual needs or the needs of their family.

It is the specific intent of the Employer that this Flex Plan be a qualified "cafeteria plan" as defined in Section 125 of the Internal Revenue Code of 1986, as amended, and that certain Benefits which an Employee may elect to receive under this Flex Plan qualify for exclusion from the Employee's income for federal income tax purposes.

Furthermore, this Flex Plan is intended to be interpreted in a manner consistent with Sections 79, 105, 106, 125, 129, 223 and 4980 of the Internal Revenue Code of 1986, as amended; all IRS Regulations thereunder; and any applicable federal law or regulation hereinafter enacted affecting qualification of a valid Section 125 Cafeteria Plan.

The Employer establishes this Flex Plan as an "exempt governmental plan" as described in Section 3(32) of the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

Article 2
DEFINITIONS

The following words and phrases as used herein shall have the following meanings, unless a different meaning is clearly required by the context. Pronouns shall be interpreted so that the masculine pronoun shall include the feminine and the singular shall include the plural.

Section 2.01 "Account" means the Health Care Flexible Spending Arrangement Account(s), or the Dependent Care Flexible Spending Arrangement Account(s) described in each respective Plan Document under separate cover.

Section 2.02 "Administrative Fee" means the required participation fee set by the Administrator to cover the cost of administering the Health Care FSA and the Dependent Care FSA. 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 the respective Benefit.

Section 2.03 "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.

Section 2.04 "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.

Section 2.05 "Appeals Panel" means the panel of at least three (3) individuals appointed by the Administrator.

Section 2.06 "Applicable Law" means the Internal Revenue Code of 1986, and the same as may be amended from time-to-time, plus all regulations promulgated with respect thereto. Reference to any section or subsection of the Code includes reference to any comparable or succeeding provisions of any legislation which amends, supplements or replaces such section or subsection.

Section 2.07 "Automatic Enrollment" means enrollment in the Premium Conversion Option upon enrollment in an OGB-offered health plan, term life on employee only, and in any other pre-tax Premium Conversion Option Qualified Benefit.

Section 2.08 "Benefit" does not include any long term disability benefit and means any of the following benefits available under the Flex Plan:

(a) Cash compensation;

(b) Conversion of eligible premiums (Accident and Health coverage, Group Term Life Insurance, Cancer Insurance, Hospital Income Insurance, Dental Insurance, Accidental Death and Dismemberment Insurance, and Vision Insurance);

(c) Dependent Care FSA reimbursements;

(d) Health Care FSA reimbursements; and

(e) HSA Contributions.

Section 2.09 "Benefit Package Option" means a qualified benefit under Code Section 125(f) that is offered under the Flex Plan, or an option for coverage under an underlying accident or health plan (such as an indemnity option, an HMO option, a High Deductible Health Plan option, or a PPO option under an accident or health plan).

Section 2.10 "COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Section 2.11 "Code" means the Internal Revenue Code of 1986, as amended.

Section 2.12 "Compensation" means the wages or salary paid to an Employee by the Employer, determined prior to (1) any Salary Reduction election under the Flex Plan, (2) any salary reduction election under any other cafeteria plan, and (3) any compensation reduction under any Code §132(f)(4) plan but is determined after salary deferral elections under any Code §§401(k), 403(b), 408(k), or 457(b) plan or arrangement.

Section 2.13 "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 selected Benefits. Unless otherwise specifically provided in writing, under the provisions of this Flex Plan, Contributions are composed entirely of the sums generated pursuant to Salary Reduction Agreements executed by the Participants pursuant to which the Participants have elected to reduce their Compensation and have such amounts contributed as Employer contributions on their behalf.

Section 2.14 "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."

Section 2.15 "Dependent Care FSA" means the Dependent Care Flexible Spending Arrangement as administered by the Office of Group Benefits and as from time-to-time amended, established pursuant to the provisions of Code §129 for reimbursement of eligible dependent care assistance expenses, as defined in Code §21(b). See the Dependent Care FSA Plan Document under separate cover.

Section 2.16 "Earned Income" means all income derived from wages, salaries, tips, self-employment, and other compensation (such as disability or wage continuation benefits), only if

such amounts are includible in gross income for the taxable year, but does not include (a) any amounts received pursuant to any Dependent Care FSA under Code §129; or (b) any other amounts excluded from Earned Income under Code §32(c)(2), such as amounts received under a pension or annuity or pursuant to workers' compensation.

Section 2.17 "Effective Date" means the date that this Flex Plan was originally effective, July 1, 1993; the Effective Date of this amendment and restatement shall be January 1, 2018.

S**ection 2.18 "Eligible Employee"** means any active, full-time Employee of the State of Louisiana whose department or agency is participating in this Flex Plan as provided in Section 3.01 of this Plan Document. Notwithstanding the foregoing, solely for purposes of determining eligibility to participate in the OGB Flex Plan, "Eligible Employee" shall include a FTE and any other Employee who is eligible to participate in an OGB-sponsored health plan.

Section 2.19 "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: (1) 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; (2) 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 (3) any employee covered under a collective bargaining agreement.

Section 2.20 "Employer" means the State of Louisiana through the respective Department or Agency employing the Eligible Employee and/or Participant(s).

Section 2.21 "Enrollment Form" means the form or forms provided to enroll in an OGB offered health plan; OGB offered term life on employee only; the Premium Conversion Option Enrollment form; or other Qualified Benefit.

Section 2.22 "Enrollment Period" means the first 30 days following each new Eligible Employee's hire date when Employees may select Benefits for the current Plan Year, and an enrollment period required by Code Section 4980H for a FTE.

Section 2.23 "ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

Section 2.24 "Flexible Benefits Plan (Flex Plan)" means this 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 42:802 B(9).

Section 2.25 "FMLA" means the Family and Medical Leave Act of 1993, as amended.

Section 2.26 "FTE" means an Employee who is determined to be a "full-time equivalent" employee for purposes of Code Section 4980H and the regulations promulgated thereunder, as established by the Patient Protection and Affordable Care Act of 2010, as amended.

Section 2.27 "General-Purpose Health Care FSA (GPFSA)" 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. A Participant who participates in the GPFSA is not an HSA-Eligible Individual. See the Health Care FSA Plan Document under separate cover.

Section 2.28 "**Grace Period**" means

- For Plan Year 2021 – the 12 months immediately following the end of a Plan Year when Participants may incur Qualifying Employment-Related Expenses to be reimbursed from their respective unused Benefits remaining as of the immediately preceding Plan Year in accordance with IRS Notice 2005-42, or any amendment thereof;
- For Plan Year 2022 – the 2 months plus 15 days immediately following the end of the Plan Year when Participants may incur Qualifying Employment-Related Expenses to be reimbursed from their respective unused Benefits remaining as of the immediately preceding Plan Year in accordance with IRS Notice 2005-42, or any amendment thereof;
- For Plan Year 2023 – 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.

Section 2.29 "Health Care FSA" means the health care flexible spending arrangement, an available Benefit under this Flex Plan, which consists of two options: the General-Purpose Health Care Flexible Spending Arrangement (GPFSA) and the Limited-Purpose (dental/vision) Health Care Flexible Spending Arrangement (LPFSA). See the Health Care FSA Plan Document under separate cover.

Section 2.30 "High Deductible Health Plan (HDHP)" means the High Deductible Health Plan offered by the Employer and Office of Group Benefits that is intended to qualify as a high deductible health plan under Code Section 223(c)(2), as described in materials provided separately by the Office of Group Benefits.

Section 2.31 "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended.

Section 2.32 "HSA" means a health savings account established under Code Section 223. Such arrangements are individual trusts or custodial accounts, each separately established and maintained by the Participant with an Employer-specified HSA trustee/custodian and governed by the agreement between the Participant and the HSA trustee/custodian.

Section 2.33 "HSA-Eligible Individual" means an individual who:

(a) has elected qualifying High Deductible Health Plan coverage offered by the Employer;

(b) is not covered by any disqualifying non-High Deductible Health Plan coverage_

(c) is eligible to contribute or have contributions made on his behalf to a HSA under Code Section 223; and,

(d) has opened a HSA with the Employer-specified HSA trustee/custodian.

Section 2.34 "Limited-Purpose (dental/vision) Health Care FSA (LPFSA)" 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. See the Health Care FSA Plan Document under separate cover.

Section 2.35 "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.

Section 2.36 "OGB Plan" means the plan or plans maintained by the Office of Group Benefits for Eligible Employees (and their spouses and eligible dependents), which plan provides accident and health benefits and which qualify as accident or health plans under Code 106 (other than a long-term care insurance plan). The Office of Group Benefits may substitute, add, subtract or revise at any time the menu of such plans and/or their benefits, terms and conditions. Any such substitution, addition, subtraction or revision will be reflected on the Enrollment Form or otherwise communicated to Participants, and will automatically be incorporated by reference under this Flex Plan.

Section 2.37 "Participant" means any Eligible Employee who has elected to participate in the Flex Plan.

Section 2.38 "Period of Coverage" means that portion of the Plan Year and the Grace Period for which one is a Participant. In no event shall the Period of Coverage commence prior to, nor terminate after, the commencement and ending dates of the Plan Year, except with regard to the Grace Period.

Section 2.39 "Plan-Recognized Qualified Life Event" means one or more of the Plan-Recognized Qualified Life Events recognized by OGB from time to time. The 2021 OGB Plan-Recognized Qualified Life Events are attached hereto as Exhibit "1."

Section 2.40 "Plan Year" means the twelve-month period commencing on January 1st and ending on December 31st of each year, except in the case where the Plan Year is being changed, in which case the Plan Year shall be the entire Short Plan Year.

Section 2.41 "QMCSO" means a Qualified Medical Child Support Order, as defined in ERISA

§609(a).

Section 2.42 "Qualified Benefit" means any of those Benefits offered under this Flex Plan by the Employer and the Office of Group Benefits which qualify as qualified benefits under Section 125(f) of the Code, except for disability insurance. Disability insurance is not a qualified benefit under this Flex Plan.

Section 2.43 "Run-out Period" means the time period immediately following the Grace Period, ending on April 30, when Participants may submit Qualifying Employment-Related Expenses incurred during the proceeding Plan Year and/or Grace Period for reimbursement from their respective unused Benefits remaining at the end of the immediately preceding Plan Year,

- For Plan Year 2021 – run-out period is April 30, 2023
- For Plan Year 2022 – run-out period is April 30, 2023
- For Plan Year 2023 – run-out period is April 30, 2024

Section 2.44 "Salary Reduction" means the amount by which the Participant's Compensation is reduced and applied by the Employer under this Flex Plan to pay for selected Benefits and the Administrative Fee, before any applicable state and federal taxes have been deducted from the Participant's Compensation.

Section 2.45 "Short Plan Year" means the Period of Coverage under the Flex Plan designated by the Administrator that is less than one year.

Article 3
PARTICIPATION

Section 3.01 Eligibility to Participate.

(a) An Employee is eligible to participate in this Flex Plan if the Employee:

(1) is an active, full-time Employee as defined herein or is a FTE or is otherwise eligible for health insurance under an OGB-sponsored health plan or for whom OGB, in its sole discretion, determines should continue participation in this Flex Plan to properly administer the requirements of applicable federal and state law; and

(2) is employed by an Employer that utilizes the State of Louisiana Flex Plan.

(b) An Employee is eligible to participate in the HSA benefit only if he is a HSA-Eligible Individual and satisfies any additional requirement(s) of the Employer-specified HSA trustee/custodian.

(c) Retirees are not eligible to participate in this Flex Plan except for rehired retirees who otherwise meet the definition of an Eligible Employee. There are circumstances in which an Employee who enters retirement may be eligible for COBRA continuation coverage for a Health Care FSA in accordance to Section 3.06. However, rehired retirees are not eligible to participate in the HSA.

Section 3.02 Participation Agreement. An election by an Eligible Employee to enroll in an OGB offered health plan; OGB offered term life on employee only; the Premium Conversion Option Enrollment form; or form to enroll in any other Qualified Benefit is an agreement to the following:

(a) To pay any and all applicable Administrative Fee(s) (Failure to pay all applicable Administrative Fee(s) will result in the denial of the privilege to participate in the Flex Plan.);

(b) To be enrolled automatically in the Premium Conversion Option upon enrollment in an OGB offered health plan, or OGB offered term life on employee only;

(c) To authorize his Employer to reduce his Compensation to pay his cost of all selected Qualified Benefits pursuant to his Premium Conversion Option Enrollment form;

(d) If applicable, to certify that he is a HSA-Eligible Individual with regard to making HSA Contributions for any month; and,

(e) To agree that his Employer and Administrator will incur no liability resulting from either his participation in this Flex Plan, Dependent Care FSA, Health Care FSA, HSA, or his failure to sign and/or accurately complete an Enrollment Form.

Section 3.03 HSA Participation.

(a) *Participation.* An Eligible Employee can elect to participate in the HSA benefit by enrolling in the High Deductible Health Plan; opening a HSA with the Employer-specified HSA trustee/custodian; and electing to pay Contributions on a pre-tax basis to his HSA, pursuant to his Salary Reduction Agreement. Such election to pay Contributions can 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 that the election change was filed with his Employer.

(b) *General-Purpose Health Care FSA (GPFSA) Limitation.* The HSA benefit cannot be elected with the General-Purpose Health Care FSA option.

(c) *Limited-Purpose (dental/vision) Health Care FSA (LPFSA).* The HSA benefit can be elected with the LPFSA option.

(d) *Transition Rule.* A Participant who has an election for the General-Purpose Health Care FSA that is in effect on the day immediately preceding the first day of a Plan Year cannot make HSA Contributions for any of the first three calendar months of that same Plan Year, unless the balance in the Participant's General-Purpose Health Care FSA Account was $0.00 on the day immediately preceding the first day of that same Plan Year. For this purpose, a Participant's General-Purpose Health Care FSA Account balance is determined on a cash basis – that is without regard to any claims that have been incurred but have not yet been reimbursed (whether or not such claims have been submitted).

Section 3.04 Salary Reduction Contributions.

(a) *Salary Reductions per pay period*. Participants in this Flex Plan must pay for the cost of elected Benefits on a pre-tax basis pursuant to the Enrollment Form(s). For Participants paid monthly, the Salary Reduction for each pay period is an amount equal to the total of all Contributions plus all Administrative Fees expected to be paid during the Plan Year, divided by twelve (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 total of all Contributions plus all Administrative Fees expected to be paid during the Plan Year, divided by twenty-four (24). For Participants paid weekly, the Salary Reduction for each pay period is an amount equal to the total of all Contributions plus all Administrative Fees expected to be paid during the Plan Year, divided by fifty-two (52).

(b) *Employer Contributions.* Salary Reductions for the purpose of this Flex Plan and the Code are considered Employer contributions.

Section 3.05 Termination of Participation. An Eligible Employee will cease to be a Participant in this Flex Plan upon the earlier of:

(a) The termination of the Flex Plan;

(b) The date the Participant ceases to be an Eligible Employee; or,

(c) The date the Participant revokes the election to participate on account of and consistent with an event permitting an exception to the irrevocability of elections in accordance with Section 4.06.

Termination of an Employee's participation in this Flex Plan shall cause the Participant's elections made under this Flex Plan to be automatically revoked. Reimbursements after termination of participation will be made pursuant to applicable insurance policies and/or Plan Documents.

Section 3.06 COBRA Participation. Notwithstanding any provision to the contrary in this Plan Document, to the extent required by COBRA, a Participant and Participant's Spouse and Participant's Dependents, whose coverage terminates under the Plan because of a COBRA qualifying event, shall be given the opportunity to continue coverage in Health Care FSAs under the Plan on an after- tax basis for the periods prescribed by COBRA (subject to all conditions and limitations under COBRA). Individuals will be eligible for COBRA continuation coverage only if the Participant has a positive Health Care FSA balance (Participant contributed more funds into the account than funds spent) at the time of a COBRA qualifying event (taking into account all claims submitted before the date of the qualifying event). COBRA continuation of a Health Care FSA will be in accordance with the Health Care FSA Plan document. Such individuals will be notified if they are eligible for COBRA continuation coverage. Electing COBRA coverage for a Health Care FSA will result in the individual incurring an additional 2% monthly charge to cover administration fees.

Section 3.07 Closure of HSA. An Eligible Employee will cease to be a HSA-Eligible Individual upon the closure of his HSA with the Employer-specified trustee/custodian. Said closure will cause the HSA Contributions to cease.

Section 3.08 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. However, when this former Participant's employment is reinstated during a subsequent Plan Year, the former Participant will be permitted to enter the Flex Plan upon return from his absence.

Section 3.09 Participation Following Rehire. If a Participant terminates his or her employment with his Employer for any reason, including (but not limited to) disability, retirement, layoff, or voluntary resignation, and then is rehired within thirteen weeks (26 weeks for educational institutions) after the date of a termination of employment, then the Eligible Employee may enroll in the Flex Plan. If a former Participant is rehired more than thirteen weeks (or 26 weeks for educational institutions) following termination of employment with the Employer and is otherwise eligible to participate in the Flex Plan, then the Eligible Employee may enroll for Qualified Benefits as a new hire as described in Section 3.01 and Section 3.02. Notwithstanding the above, an HSA benefit election will only be honored or reinstated if the Eligible Employee is an HSA-Eligible Individual.

Section 3.10 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 this Flex Plan at the same level of participation as prior to the transfer.

Section 3.11 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 his coverage or discontinue his coverage. If he elects to continue, a Participant may pay his Salary Reduction in one of the following ways:

(a) by pre-paying with pre-tax dollars the monthly portion of the Salary Reduction(s) for the expected duration of the leave pursuant to the approved FMLA agreement and timely application to the OGB (i.e., GB-01). To pre-pay the Salary Reduction(s) the Participant must complete a GB-01 prior to the date that such Compensation would normally be made available (Pre-tax dollars may not be used to fund coverage during the next Plan Year) and upon return from the unpaid leave;

(b) by paying with pre-tax dollars upon his return to work on a payroll reduction schedule pursuant to the approved FMLA agreement and timely application to the OGB (i.e., GB-01). The Participant must complete a GB-01 prior to and upon return from the unpaid leave; or

(c) by paying with after-tax dollars in the form of monthly payments to the Employer by the due date established by the Employer.

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

Section 3.12 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(s) in one of the following ways:

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

(b) by paying with pre-tax dollars upon his return to work on a payroll reduction schedule pursuant to his Employer's approval of the leave and timely application to the OGB (i.e., GB-01)). The Participant must complete a GB-01 prior to and upon return from the unpaid leave; or

(c) by paying with after-tax dollars in the form of monthly payments to the Employer by the due date established by the Employer.

If a Participant goes on an unpaid leave that affects eligibility, the election change rules in Section 4.06 will apply.

Article 4
BENEFITS AND ELECTIONS

Section 4.01 Procedure. Except as otherwise provided herein, a Participant may elect Qualified Benefits in this Flex Plan by the execution of a signed Enrollment Form, and by providing such data as may be reasonably required by the Administrator in accordance with Section 4.03 and Section 4.04.

Section 4.02 Consent to Flex Plan. By the execution of an Enrollment Form each Participant who elects Qualified Benefits shall be conclusively deemed, for all purposes, to have consented to the provisions of this Flex Plan and amendments thereto.

Section 4.03 Election Effective Date.

(a) *Elections During Enrollment Period.* New Eligible Employees who want to enroll in the Flex Plan 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. Eligible Employees who want to enroll in the Flex Plan must submit the Enrollment Form and elect to pay any applicable Administrative Fee 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 Enrollment Period or the Annual Enrollment Period, he will not be considered a Participant in this Flex Plan with respect to that Plan Year, and he may not elect to participate in this Flex Plan until the next Annual Enrollment Period unless:

(1) he experiences an OGB Plan-Recognized Qualified Life Event and makes an election change on account of and consistent with the OGB Plan-Recognized Qualified Life Event pursuant to Section 4.06; or

(2) the Flex Plan adds a new Benefit Package Option, or significantly improves coverage under an existing Benefit Package Option during a Period of Coverage, and the Eligible Employee makes an election on a prospective basis for coverage under the new or improved Benefit Package Option.

Section 4.04 HSA Elections.

a) *Maximum Limits.* The annual Contribution for a Participant's HSA is equal to the annual benefit amount elected by the Participant. In no event shall the amount elected exceed the statutory maximum amount for HSA Contributions for the calendar year in which the Contribution is made. The maximum annual Contribution shall be reduced by any matching or other Employer Contribution made on the Participant's behalf. The HSA Contribution will start after the opening of a HSA with the Employer-specified HSA trustee/custodian. Upon the closure of a HSA with the Employer-specified HSA trustee/custodian, the HSA Contribution will cease in accordance with Section 3.07.

b) *Matching Contributions.* The Employer will contribute a defined dollar amount to the HSA-Eligible Individual's HSA when a Participant establishes a HSA with the Employer-specified HSA trustee/custodian. The Employer's defined contribution shall be communicated to Eligible Employees.

c) *Catch-up Contributions.* An additional catch-up Contribution of $1,000 may be made per Plan Year for Participants who are age 55 or older.

Section 4.05 Irrevocability of Elections; Not Applicable for HSA. Except as provided in Section 4.06, a Participant's election to participate in this Flex Plan is irrevocable for the duration of the Participant's Period of Coverage; therefore the Participant may not change:

(a) his participation in the Flex Plan;

(b) his elected annual benefit amount(s);or

(c) his Salary Reduction amount(s).

Section 4.06 Events Permitting Exception to the Irrevocability of Elections. Elections under the Flex Plan may only be revoked or changed if and as provided in the OGB Plan-Recognized Qualified Life Events document, attached hereto.

Section 4.07 Automatic Change in Election. Any event that results in a Participant or eligible Dependents becoming ineligible for health coverage will result in an automatic corresponding change of enrollment for health coverage. A Participant's election is deemed to have changed automatically as of the date of the event that caused the loss of eligibility.

Section 4.08 Election Modifications Required by Administrator. The Administrator may, at any time, require any Participant or class of Participants to amend his/their enrollment in Qualified 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 Flex Plan;

(b) prevent any Employee or class of Employees from having to recognize more income for federal income tax purposes from the receipt of Benefits hereunder than would otherwise be recognized; or

(c) maintain the qualified status of Benefits received under this Flex Plan.

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

Section 4.09 Change in Applicable Law. In the event that changes in Applicable Law result in a Qualified Benefit offered under the Flex Plan becoming a non-qualified benefit, any Participant electing such Benefit may, if permissible under Applicable Law, be allowed to enroll in another Qualified Benefit in lieu of the non-qualified benefit. Such enrollment may be made at times not provided for under the Flex Plan but in accordance with the rules adopted by the Administrator.

Article 5
OPTIONAL BENEFITS

Section 5.01 Benefits. Participants shall be permitted to choose among available Benefits. The terms and conditions of each covered Benefit are set forth in the appropriate insurance policies and Plan Documents providing the selected Benefits. Cash or Benefits treated as cash are intended to be the only taxable Flex Plan Benefits.

Section 5.02 Selection of Benefits. As provided in Section 4.03, each Eligible Employee must first enroll in his desired Benefits. By the enrollment in selected Benefits, the Eligible Employee has elected to receive Compensation as Cash and Benefits pursuant to his Enrollment Form(s).

Section 5.03 Flexible Spending Arrangements. The Employer has, by separate Plan Document(s), established a Dependent Care FSA and a Health Care FSA.

Section 5.04 HSA. As established under Code Section 223, an HSA is an individual trust or custodial account, separately established and maintained by the Participant with a HSA trustee/custodian. The HSA benefit under this Flex Plan consists solely of the ability to make Contributions on a pre-tax Salary Reduction basis to the Participant's HSA that is established and maintained outside this Flex Plan by the Employer-specified HSA trustee/custodian. The Employer and the Office of Group Benefits will forward Contributions to the Employer-specified HSA trustee/custodian pursuant to the Participant's HSA payroll deduction form. This funding feature constitutes the entirety of the HSA benefit offered under this Flex Plan. Distributions from a Participant's HSA and all other matters related to the Participant's HSA are outside this Flex Plan and are to be handled by the Participant and the Employer-specified HSA trustee/custodian in accordance with the contract between the Participant and the HSA trustee/custodian. The Flex Plan and its service providers, other than the Employer-specified HSA trustee/custodian, are not considered custodians or trustees and shall not be held responsible for any use of the Participants' funds. The Employer and Office of Group Benefits have no authority over the funds deposited in a HSA.

Article 6
APPEALS PROCEDURES

Section 6.01 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 Flex Plan. The purpose of the review procedure as set forth herein is to provide a procedure by which a denial under this Flex Plan may receive a full and fair review by the Appeals Panel.

Section 6.02 Eligibility and Premium Conversion Appeals. OGB retains the authority to make all determinations regarding Premium Conversion and eligibility in relation to this Flex Plan. To obtain review of a Flex Plan eligibility or Premium Conversion 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.

Section 6.03 Appeal of Denial of Claim for Reimbursement. To obtain a review of a denial of a claim for reimbursement of expenses for Plan Year 2020 and 2021, 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 Wex, 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. To obtain a review of a denial of a claim for reimbursement of expenses for Plan Year 2022 for the months January through May, 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 DataPath Administrative Services, ATTN: DPAS OGB Customer Service, 1601 Westpark Drive, Suite 9, Little Rock, AR 72204, within sixty (60) days after receipt by the applicant of written notice of the denial. In connection with this request for review, the applicant may review pertinent Plan documents and submit issues and/or comments in writing to the address in this Section. To obtain a review of a denial of a claim for reimbursement of expenses for Plan Year 2022 for the months June through December and Plan year 2023, 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 Optum Financial, ATTN: Claims Department, PO Box 622317, Orlando, FL 32862-2317, 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.

Section 6.04 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 6.04, the claim shall be deemed denied on review.

ADMINISTRATION

Section 7.01 Administrator. The administration of the Flex Plan shall be under the supervision of the Administrator. It is the principal duty of the Administrator to see that the terms of this Flex Plan are carried out, in accordance with the terms of this Plan Document for the exclusive benefit of persons entitled to participate in this Flex Plan without discrimination among them.

Section 7.02 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 the provisions of the Flex Plan including all possible ambiguities, inconsistencies, and omissions in this Plan Document and related documents, to decide all questions of fact, questions relating to eligibility and participation, and questions of Benefits (provided that, notwithstanding the first paragraph in this Section 7.02, the Appeals Panel shall exercise such exclusive power with respect to an appeal of an administrative decision or action under Article 6);

(b) to prescribe procedures to be followed and the forms to be used by Eligible Employees and Participants to enroll in Qualified Benefits under this Flex Plan;

(c) to prepare and distribute information explaining this Flex Plan and the Benefits under this Flex Plan in such manner as the Administrator determines to be appropriate;

(d) to request and receive from all Employer(s), Employees and Participants such information as the Administrator shall determine to be necessary for the proper administration of this Flex Plan;

(e) to furnish each Participant with such reports with respect to the administration of this Flex Plan 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 Flex Plan;

(f) to receive, review and keep on file such reports and information concerning the Benefits covered by this Flex Plan 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 Flex Plan as it determines to be necessary or advisable;

(h) to sign documents for the purpose of administering this Flex Plan, or to designate an individual or individuals to sign documents for the purposes of administering this Flex Plan;

(i) to file or cause to be filed all such annual reports, returns, schedules, descriptions,

financial statements and other statements as may be required by Applicable Law, agency, or authority within the time prescribed by Applicable Law for filing such documents;

(j) to determine the amount, manner, and time of payment of Benefits hereunder, subject to the provisions and limitations of the policies providing the Benefits selected;

(k) to forward the Eligible Employees' HSA Contributions on a pre-tax Salary Reduction basis to each employee's HSA established and maintained outside the Flex Plan by the Employer-specified trustee/custodian;

(l) to communicate to any insurer or other contract supplier of Benefits under this Flex Plan, in writing, all information required to carry out the provisions of the Flex Plan;

(m) to notify the Participants of the Flex Plan, in writing, of any amendment or termination of the Flex Plan; and

(n) to do such other acts as it deems reasonably required to manage the Flex Plan in accordance with its provisions or as may be provided for by Applicable Law.

Section 7.03 Reliance on Participant, Tables, etc. The Administrator may rely upon the direction, information or enrollment by a Participant as being proper under the Flex Plan 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.

Section 7.04 Fiduciary Liability. To the extent permitted by law, the Administrator shall incur no liability for any acts or failure to act except for his own willful misconduct or willful breach of this Flex Plan.

Section 7.05 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 made 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 Flex Plan. Such action by the Administrator may include withholding of any amounts due this Flex Plan or the Employer from Compensation paid by the Employer.

Article 8
GENERAL PROVISIONS

Section 8.01 Expenses. All reasonable expenses incurred in administering the Flex Plan are currently paid by Office of Group Benefits, FSA Administrative Fees and by forfeitures in the FSA Accounts.

Section 8.02 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.

Section 8.03 Amendment and Termination. This Flex Plan has been established with the intent of being maintained for an indefinite period of time. Nonetheless, the Administrator may amend or terminate this Flex Plan 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 Flex Plan.

Section 8.04 Governing Law. This Flex Plan 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.

Section 8.05 Code Compliance. It is intended that this Flex Plan meets all applicable requirements of the Code, and all of the regulations issued thereunder. This Flex Plan 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.

Section 8.06 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 Flex Plan 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 Flex Plan 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.

Section 8.07 Indemnification of Employer. If a Participant receives one or more payments or reimbursements under this Flex 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.

Section 8.08 Non-Assignability of Rights. The right of any Participant to receive any reimbursement under this Flex Plan 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.

Section 8.09 Limitation of Rights. Neither the establishment of the Flex Plan nor any amendment thereof will be construed as giving to any Participant or other person any legal or equitable right against the Administrator nor the Employer, except as expressly provided herein. Nothing herein will be construed to require the Employer or the 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 Flex Plan may be made.

Section 8.10 Plan Document Provisions Controlling. In the event the terms or provisions of any summary or description of this Flex Plan, 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.

Section 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.

Section 8.12 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.

Section 8.13 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 Flex Plan document or as indicating or controlling the meaning or construction of any provision.

EXHIBIT “1”

OGB PLAN-RECOGNIZED QUALIFIED LIFE EVENTS

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

QLE Code	Plan Recognized Qualified Life Event	Enrollee change request to OGB plan ADD or DROP	Deadline to submit request and provide proof document	Proof or document required	Enrollee allowed to change (who meets the eligibility definition)	Effective Date of Change	ADD Dependent YES or NO	DROP Dependent YES or NO	DROP Self YES or NO	ADD or DROP Medical Coverage	CHANGE Health Plan YES or NO	COBRA Event YES or NO	Flexible Spending Plan – Health Care	Flexible Spending Plan - Dep. Care
BIRTH/ADOPTION														
A-1	Birth	ADD	Application must be made within 30 days of change in status	Birth Certificate or Birth Letter which includes newborn data, and eligibility data for any newly-eligible persons	Employee, new baby. Spouse may be added as a result of this event, but only if baby is added.	Baby's date of birth if Application for enrollment is timely made	YES	NO	NO	ADD	YES	NO	May enroll or can increase amount	May enroll or increase amount
A-2	Adoption or placement for adoption	ADD	30 days from the effective date of adoption/placement for adoption	Adoption or placement for adoption legal document, and eligibility data for any newly-eligible persons	Employee and adopted child; spouse may be added as a result of this event but only if child is added.	Effective date of adoption or placement for adoption if Application for enrollment is timely made	YES	NO (but may drop dependent if dependent is placed for adoption)	NO	ADD	YES	NO	May enroll or can increase amount	May enroll or increase amt if dependent care expenses increased

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

QLE Code	Plan Recognized Qualified Life Event	Enrollee change request to OGB plan ADD or DROP	Deadline to submit request and provide proof document	Proof or document required	Enrollee allowed to change (who meets the eligibility definition)	Effective Date of Change	ADD Dependent YES or NO	DROP Dependent YES or NO	DROP Self YES or NO	ADD or DROP Medical Coverage	CHANGE Health Plan YES or NO	COBRA Event YES or NO	Flexible Spending Plan – Health Care	Flexible Spending Plan - Dep. Care
DEATH														
B-1	Death of covered dependent	DROP	60 days from the date of death (OGB has the discretion to retroactively terminate coverage if correct premium is not timely paid and Application for disenrollment is not timely made)	Copy of certified death certificate or other official document	Dependent who died. If spouse dies, stepchildren must be terminated and offered COBRA coverage.	End of the month in which the death occurs	NO	DROP the deceased and any stepchildren who are not adopted by the enrollee	NO	DROP for the deceased dependent or any stepchildren only	NO	Only for step-children if parent is the dependent who died	May decrease amount	May drop or decrease amount if dependent is child; May increase amount if event or death of spouse will increase dependent care expenses
B-2	Employee Deceased	DROP	30 days from the date of death (OGB has the discretion to retroactively terminate coverage if correct premium is not timely paid and Application for disenrollment is not timely made)	Copy of certified death certificate or other official document	Employee and eligible dependents (Eligible dependents will be offered survivor coverage)	End of month in which Employee's death occurred	N/A	YES	YES	DROP	NO	YES	Automatic Cancel on date of death	Automatic Cancel on date of death

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

QLE Code	Plan Recognized Qualified Life Event	Enrollee change request to OGB plan ADD or DROP	Deadline to submit request and provide proof document	Proof or document required	Enrollee allowed to change (who meets the eligibility definition)	Effective Date of Change	ADD Dependent YES or NO	DROP Dependent YES or NO	DROP Self YES or NO	ADD or DROP Medical Coverage	CHANGE Health Plan YES or NO	COBRA Event YES or NO	Flexible Spending Plan – Health Care	Flexible Spending Plan - Dep. Care
	DIVORCE													
C-1	Divorce, Annulment and Legal Separation (legal separation and annulment are qualified events only if recognized by law of state of the separation or annulment)	ADD	Application must be made within 30 days of change in status	Copy of divorce, annulment, or legal separation order and eligibility data for any newly-eligible persons	Self; children	Date of divorce order if Application for Enrollment is timely made	YES	N/A	N/A	ADD	YES	NO	May enroll or can increase amount if loss of coverage on spouse's health plan	Yes, if change affects the amount of time the child needs to be in dependent care and increases expenses OR lose coverage under spouse's Dep Daycare Flex Plan
C-2	Divorce, Annulment and Legal Separation (where annulment and legal separation are recognized by law of the state of the separation or annulment)	DROP	Application must be made within 30 days of change in status (OGB has the discretion to retroactively terminate coverage to the end of the month of the change in status if correct premium is not timely paid and application is not timely made)	Copy of official divorce, annulment or legal separation decree	Ex-spouse and ex-stepchildren	End of the Month of the divorce, annulment or legal separation if application is timely made	N/A	YES for Ex-Spouse and Ex-Stepchildren	NO	DROP	NO	YES	May decrease election	May decrease if divorce, annulment or legal separation lowers dependent daycare expenses

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

QLE Code	Plan Recognized Qualified Life Event	Enrollee change request to OGB plan ADD or DROP	Deadline to submit request and provide proof document	Proof or document <u>required</u>	Enrollee allowed to change (who meets the eligibility definition)	Effective Date of Change	ADD Dependent YES or NO	DROP Dependent YES or NO	DROP Self YES or NO	ADD or DROP Medical Coverage	CHANGE Health Plan YES or NO	COBRA Event YES or NO	Flexible Spending Plan – Health Care	Flexible Spending Plan - Dep. Care
GAIN OF OTHER COVERAGE														
D-1	Gain Medicaid or state CHIP (Children's Health Insurance Program) coverage	DROP	Application <u>must</u> be made within 60 days from date Medicaid became effective	Official state document indicating who, when Medicaid /SCHIP coverage began	Self and dependents who gained such coverage (dependents cannot remain on the OGB plan without the Employee being covered)	The end of the month preceding the first full month in which other coverage became effective if application is timely made	N/A	YES	YES	DROP	NO	NO	May decrease or deactivate deductions if gain of Medicaid; no change if gain of SCHIP	No change
D-2	Dependent gains coverage under another group or individual health plan	DROP	Application <u>must</u> be made within 30 days from date other coverage becomes effective	Proof of other coverage, for whom, and the effective date of the coverage	Dependent who gained other coverage	The end of the month preceding the first full month in which other coverage became effective if application is timely made	N/A	YES	NO	DROP	NO	NO	No change	No change

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

QLE Code	Plan Recognized Qualified Life Event	Enrollee change request to OGB plan ADD or DROP	Deadline to submit request and provide proof document	Proof or document required	Enrollee allowed to change (who meets the eligibility definition)	Effective Date of Change	ADD Dependent YES or NO	DROP Dependent YES or NO	DROP Self YES or NO	ADD or DROP Medical Coverage	CHANGE Health Plan YES or NO	COBRA Event YES or NO	Flexible Spending Plan – Health Care	Flexible Spending Plan - Dep. Care
D-3	Gain new coverage through Medicare Part A or Part B	Continue with OGB coverage as secondary (employee would be retired)	Application must be made within 30 days from date other coverage becomes effective	Official documentation of active enrollment on Medicare Part A or Part B; must show effective dates	Self and dependents	OGB coverage will remain primary until the last day of the month preceeding the first full month of Part A/B	N/A	Yes	N/A	N/A	YES	NO	N/A	N/A
D-4	Gain coverage through Medicare Part A or Part B, or coverage under spouse's group health plan or other group or individual health plan, or by court order releasing the employee from covering a dependent and ordering someone else to cover dependent	DROP	Application must be made within 30 days from date new coverage became effective	Official documentation of active enrollment on new plan; must show effective dates of each named dependent	Self and dependents who gained such coverage (dependents cannot remain on the OGB plan without the Employee/Retiree being covered)	The end of the month preceding the first full month in which other coverage became effective if application is timely made	N/A	YES	YES	DROP	NO; but any Health Savings Account contributions should cease once gain Medicare	NO	May decrease or deactivate amount	No change

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

QLE Code	Plan Recognized Qualified Life Event	Enrollee change request to OGB plan ADD or DROP	Deadline to submit request and provide proof document	Proof or document required	Enrollee allowed to change (who meets the eligibility definition)	Effective Date of Change	ADD Dependent YES or NO	DROP Dependent YES or NO	DROP Self YES or NO	ADD or DROP Medical Coverage	CHANGE Health Plan YES or NO	COBRA Event YES or NO	Flexible Spending Plan – Health Care	Flexible Spending Plan - Dep. Care
COURT-ORDERED LEGAL GUARDIANSHIP OR COURT-ORDERED CUSTODY; QMCSO														
E-1	Qualified Medical Child Support Order (QMCSO)	ADD	30 days from date of the QMCSO or as otherwise specified by law	Copy of QMCSO and eligibility data for newly-eligible persons	Eligible Child dependent(s) covered by Order (and eligible employee if not currently enrolled)	1st of month following OGB receipt of application or as otherwise specified in the Order	Yes, only for the dependent(s) required by Order (and employee if not currently enrolled)	N/A	NO	only changes consistent with Order	YES	NO	May enroll or can increase amount	No change allowed
E-2	Court-Ordered Legal Guardianship or Court-Ordered Custody	ADD	Application must be made within 30 days from the date of the court-ordered legal guardianship or court-ordered custody	Certified copy of the signed court order granting custody or guardianship, and eligibility data for any newly-eligible persons	Newly Acquired Dependent(s)	The date of the court-ordered legal guardianship or custody or the effective date specified in the court order, if Application for enrollment is timely made	YES for newly-acquired dependent only	NO	NO	ADD	YES	NO	May enroll or can increase amount	May enroll or increase amount if dependent care expenses increased

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

QLE Code	Plan Recognized Qualified Life Event	Enrollee change request to OGB plan ADD or DROP	Deadline to submit request and provide proof document	Proof or document required	Enrollee allowed to change (who meets the eligibility definition)	Effective Date of Change	ADD Dependent YES or NO	DROP Dependent YES or NO	DROP Self YES or NO	ADD or DROP Medical Coverage	CHANGE Health Plan YES or NO	COBRA Event YES or NO	Flexible Spending Plan – Health Care	Flexible Spending Plan - Dep. Care
E-3	Qualified Medical Child Support Order (QMCSO)	DROP	30 days from date of the Order releasing you from covering child or as otherwise specified by law.	Copy of QMCSO	Dependent child covered by Order, or Self and dependent child who was added as a result of the Order	End of month following OGB receipt of application, if application is timely made	NO	YES	YES	DROP	YES	YES, for child	May decrease or disenroll	No change allowed
E-4	Court-Ordered Legal Guardianship or Court-Ordered Custody	DROP	Application must be made within 30 days from date of the Order removing custody or guardianship	Copy of Order	Dependent child for whom custody or guardianship was lost	End of month following OGB receipt of timely application	NO	YES	NO	DROP	YES	YES, for child	May decrease amount or disenroll	May decrease amount if dependent care expenses decreased, or disenroll

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

QLE Code	Plan Recognized Qualified Life Event	Enrollee change request to OGB plan ADD or DROP	Deadline to submit request and provide proof document	Proof or document <u>required</u>	Enrollee allowed to change (who meets the eligibility definition)	Effective Date of Change	ADD Dependent YES or NO	DROP Dependent YES or NO	DROP Self YES or NO	ADD or DROP Medical Coverage	CHANGE Health Plan YES or NO	COBRA Event YES or NO	Flexible Spending Plan – Health Care	Flexible Spending Plan - Dep. Care
LOSS OF OTHER COVERAGE														
F-1	Lose coverage on spouse's employer-provided health insurance for any of the following reasons: 1) Spouse deceased, 2) Employment of Spouse terminated, 3) COBRA coverage under Spouse's plan terminated or expired, 4) Spouse loses employer's insurance due to no fault of the spouse, 5) Spouse terminates coverage on his/her plan during annual enrollment	ADD	Application <u>must</u> be made within 30 days from the date the health insurance ended	Documents from prior plan confirming coverage date and for whom, termination and eligibility data for any newly-eligible persons	Self and other dependent(s) who lost coverage	Date immediately following loss of previous coverage if Application for enrollment is timely made	YES to Add self and eligible dependents who lost coverage	N/A	N/A	ADD	YES	NO	May enroll or can increase amount	No change
F-2	Eligible Dependent loses current coverage under another employment-based group health plan or individual health plan	ADD	Application <u>must</u> be made within 30 days from the date the health insurance ended (except when other coverage is Medicaid, then member has 60 days to apply)	Documents from prior plan confirming coverage termination and eligibility data for any newly-eligible persons	Self and other dependent(s) who lost coverage	Date immediately following loss of previous coverage if Application for enrollment is timely made	YES to Add eligible dependents who lost coverage or self and eligible dependent who lost coverage	N/A	N/A	ADD	YES	NO	May enroll or can increase amount	No change

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

QLE Code	Plan Recognized Qualified Life Event	Enrollee change request to OGB plan ADD or DROP	Deadline to submit request and provide proof document	Proof or document required	Enrollee allowed to change (who meets the eligibility definition)	Effective Date of Change	ADD Dependent YES or NO	DROP Dependent YES or NO	DROP Self YES or NO	ADD or DROP Medical Coverage	CHANGE Health Plan YES or NO	COBRA Event YES or NO	Flexible Spending Plan – Health Care	Flexible Spending Plan - Dep. Care
F-3	Lose Medicaid or state CHIP (Children's Health Insurance Program) coverage because no longer eligible	ADD	Application must be made within 60 days from the date the Medicaid/CHIP health coverage ended	Official state document indicating for whom and when Medicaid/ CHIP coverage ended and eligibility data for any newly-eligible persons	Self and dependent(s) who lost coverage	Date immediately following end of Medicaid/CHIP coverage if Application is timely made	YES to add eligible dependents who lost coverage or self and eligible dependent who lost coverage	N/A	N/A	ADD	YES	N/A	May enroll or can increase amount if loss of Medicaid; no change if loss of CHIP coverage	No change
F-4	Lose another group or individual health plan sponsored by government or educational institution, including Indian Tribal government and foreign government, or other individual coverage	ADD	Application must be made within 30 days from the date the health insurance ended	Proof of loss of insurance on other plan, for whome and date of loss of coverage, and eligibility data for any newly-eligible persons	Self and dependent(s) who lost coverage	Date immediately following loss of previous coverage if application is timely made	YES	N/A	N/A	ADD	YES	N/A	No change	No change

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

QLE Code	Plan Recognized Qualified Life Event	Enrollee change request to OGB plan ADD or DROP	Deadline to submit request and provide proof document	Proof or document required	Enrollee allowed to change (who meets the eligibility definition)	Effective Date of Change	ADD Dependent YES or NO	DROP Dependent YES or NO	DROP Self YES or NO	ADD or DROP Medical Coverage	CHANGE Health Plan YES or NO	COBRA Event YES or NO	Flexible Spending Plan – Health Care	Flexible Spending Plan - Dep. Care
F-5	Member moves residence and becomes ineligible under current OGB plan	Transfer to another OGB Plan including Medicare Advantage plans	Application must be made within 30 days from date coverage ended under prior plan because of change in residence	Documentation proving date of change in residence (examples include voter registration card, homestead exemption, copy of water or electric bill, notarized attestation, etc)	Self; self and current covered dependents	First of the month following change in residence if Application is timely made	N/A (can only add persons who were previously covered)	NO	NO	CHANGE	YES	NO	No change	No change
MARRIAGE														
G-1	Marriage	ADD	Application must be made within 30 days of date of marriage	Copy of certified marriage certificate and eligibility data for any newly-eligible persons	Self and new spouse and/or new stepchildren; employee may add child only if child was immediately previously covered under new spouse's insurance.	Date of the marriage if Application is timely made	YES (New Spouse and/or New Step-Children)	N/A	NO	ADD	YES	NO	May enroll or increase amount	May enroll or increase amount

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

QLE Code	Plan Recognized Qualified Life Event	Enrollee change request to OGB plan ADD or DROP	Deadline to submit request and provide proof document	Proof or document required	Enrollee allowed to change (who meets the eligibility definition)	Effective Date of Change	ADD Dependent YES or NO	DROP Dependent YES or NO	DROP Self YES or NO	ADD or DROP Medical Coverage	CHANGE Health Plan YES or NO	COBRA Event YES or NO	Flexible Spending Plan – Health Care	Flexible Spending Plan - Dep. Care
G-2	Marriage	DROP	Application must be made within 30 days from the marriage	Copy of certified marriage certificate and proof of active enrollment on spouse's health plan	Self and current covered dependents	Coverage will be cancelled at the end of the month of marriage if timely Application for disenrollment is made	N/A	YES	YES	DROP	N/A	NO	May decrease if become covered under spouse's health plan	May decrease if spouse has Dependent FSA through his/her employer
MILITARY LEAVE AND UNPAID LEAVE														
H-1	Employee who dropped coverage while on unpaid leave returning to work with pay from unpaid leave in same capacity	Reinstate coverage	Application must be made within 30 days of return to work with pay	Signed GB-01 from Employer	Can only reinstate prior election coverage	Date returns to work with paid status if Application is timely made	ADD (may add newly-acquired dependents only)	NO	N/A	Reinstate prior coverage	NO	NO	May re-enroll either: (a) at same level of benefits as before leave, which requires increased deduction amount for catch-up, or b) continue same deduction as before unpaid leave with no catch-up.	May re-enroll either: (a) at same level of benefits as before leave, which requires increased deduction amount for catch-up, or b) continue same deduction as before unpaid leave with no catch-up.

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

QLE Code	Plan Recognized Qualified Life Event	Enrollee change request to OGB plan ADD or DROP	Deadline to submit request and provide proof document	Proof or document required	Enrollee allowed to change (who meets the eligibility definition)	Effective Date of Change	ADD Dependent YES or NO	DROP Dependent YES or NO	DROP Self YES or NO	ADD or DROP Medical Coverage	CHANGE Health Plan YES or NO	COBRA Event YES or NO	Flexible Spending Plan – Health Care	Flexible Spending Plan - Dep. Care
H-2	Employee on unpaid leave	DROP	Application must be made within 30 days of taking unpaid leave	Signed GB-01 from Employer	Self; self and current covered dependents	End of month unpaid leave begins if Application is timely made	N/A	DROP	YES	DROP	NO	NO	May pre-pay, decrease or deactivate deductions	May pre-pay, decrease or deactivate deductions
H-3	Employee on unpaid leave; elects to maintain coverage (may maintain for 12 months while on LWOP)	Retain coverage	Agency must immediately notify OGB of employee's LWOP status	Documentation (e.g., leave slip, letter on agency letterhead, or etc.) evidencing LWOP status	Self and covered dependents	N/A	NO	YES	NO	N/A	YES	NO, unless drop dependent	May pre-pay, decrease or deactivate deductions	May pre-pay, decrease or deactivate deductions
H-4	Military Employee goes on USERRA leave	DROP	Application must be made within 30 days of beginning USERRA leave	Signed GB-01 from Employer and any military orders, indicating when USERRA service begins	Self; self and current covered dependents	End of month that USERRA leave begins if Application is timely made	N/A	DROP	YES	DROP	NO	NO, unless drop dependent	May pre-pay, decrease or deactivate deductions	May pre-pay, decrease or deactivate deductions
H-5	Military Employee returns from USERRA leave to full-time status.	Reinstate coverage	Application must be made within 30 days from re-employment or from date that Employee's active duty military health benefits end, whichever is later	Documentation of military orders and of military health coverage end date	Can reinstate coverage for self; self and dependents who were covered prior to taking USERRA leave	Date returns to full-time active status from USERRA leave or the date that Employee's active duty military health coverage ends, whichever is later, if Application is timely made	ADD (may only add newly acquired dependents)	N/A	N/A	Reinstate prior coverage; may also allow for a change in health plan	YES	NO	May re-enroll either; (a) at same level of benefits as before leave, which requires increased deduction amount for catch-up, or (b) continue same deduction as before military leave with no catch-up.	May re-enroll either; (a) at same level of benefits as before leave, which requires increased deduction amount for catch-up, or (b) continue same deduction as before military leave with no catch-up.

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

QLE Code	Plan Recognized Qualified Life Event	Enrollee change request to OGB plan ADD or DROP	Deadline to submit request and provide proof document	Proof or document required	Enrollee allowed to change (who meets the eligibility definition)	Effective Date of Change	ADD Dependent YES or NO	DROP Dependent YES or NO	DROP Self YES or NO	ADD or DROP Medical Coverage	CHANGE Health Plan YES or NO	COBRA Event YES or NO	Flexible Spending Plan – Health Care	Flexible Spending Plan - Dep. Care
NEW HIRES AND TERMINATIONS, ACA REQUIREMENTS, AND CHANGE IN CLASSIFICATION														
I-1	New Full-Time Employee	ADD	Application must be made within 30 days from date of full-time employment	Signed GB-01 from Employer and eligibility data for any newly-eligible persons	Employee; employee and eligible dependent(s)	Based upon date of employment (Hire Date - 1st Day of the Month - Coverage effective on First day of the following month; Hire Date - 2nd day of the month or after - Coverage effective on the first day of the second month following employment) if Application is timely made	YES	N/A	N/A	ADD	N/A	NO	May Enroll	May Enroll
I-2	Non-Full-Time (variable, seasonal, part-time) Employee who is determined to be Full-Time at end of the Initial Measurement Period	ADD	Application must be made within 30 days of date of eligibility	Signed GB-01 from Employer and eligibility data for any newly-eligible persons	Employee; employee and eligible dependent(s)	First of the month following the end of the 30-day enrollment period if Application is timely made	YES	N/A	N/A	ADD	N/A	NO	May Enroll	May Enroll

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I-3	Non-Full-Time (variable, seasonal, part-time) Employee who is determined to be Full-Time at end of the Standard Measurement Period	ADD	Application must be made within 30 days of date of eligibility	Signed GB-01 from Employer and eligibility data for any newly-eligible persons	Employee; employee and eligible dependent(s)	January 1 of following plan year if application is timely made	YES	N/A	N/A	ADD	N/A	NO	May Enroll	May Enroll
I-4	Non-Full-Time (variable, seasonal, part-time) Employee who experiences a Change in Classification to permanent Full-Time in any measurement or stability period (this requires a deliberate documented employer decision to make the employee a full-time employee)	ADD	Application must be made within 30 days of date of change in classification	Signed GB-01 from Employer and eligibility data for any newly-eligible persons	Employee; employee and eligible dependent(s)	First of the month following the end of the 30-day enrollment period if Application is timely made	YES	N/A	N/A	ADD	N/A	NO	May Enroll	May Enroll

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QLE Code	Plan Recognized Qualified Life Event	Enrollee change request to OGB plan ADD or DROP	Deadline to submit request and provide proof document	Proof or document required	Enrollee allowed to change (who meets the eligibility definition)	Effective Date of Change	ADD Dependent YES or NO	DROP Dependent YES or NO	DROP Self YES or NO	ADD or DROP Medical Coverage	CHANGE Health Plan YES or NO	COBRA Event YES or NO	Flexible Spending Plan – Health Care	Flexible Spending Plan - Dep. Care
I-5	Full-Time Employee returning full-time or part-time with less than 13 weeks (or less than 26 weeks for educational institutions) since Separation (this would include retirees who are rehired as WAEs)	ADD	Application must be made within 30 days following the return to work	Signed GB-01 from Employer and eligibility data for any newly-eligible persons	Employee; employee and eligible dependent(s)	Effective first of the month following the return of work.	YES	N/A	N/A	ADD	YES	NO	May Enroll	May Enroll
I-6	Employee changes from Full-Time status to non-Full-Time (requires deliberate documented decision to reduce hours below full time) (not in stability period)	Employee must continue coverage	Application must be made within 30 days of change in status confirming change in hours from Full-Time to non-Full-Time	Signed GB-01 from Employer	Employee; Employee and eligible dependent(s) would be dropped at the end of the plan year	Coverage terminates at the end of the plan year	N/A	N/A	N/A	N/A	NO	YES at the end of the plan year	Auto drop at the end of the plan year	Auto drop at the end of the plan year

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

QLE Code	Plan Recognized Qualified Life Event	Enrollee change request to OGB plan ADD or DROP	Deadline to submit request and provide proof document	Proof or document required	Enrollee allowed to change (who meets the eligibility definition)	Effective Date of Change	ADD Dependent YES or NO	DROP Dependent YES or NO	DROP Self YES or NO	ADD or DROP Medical Coverage	CHANGE Health Plan YES or NO	COBRA Event YES or NO	Flexible Spending Plan – Health Care	Flexible Spending Plan - Dep. Care
I-7	Employee determined to be Full-Time during previous Measurement Period changes to Non-Full-Time under corresponding Stability Period	Employee must continue coverage	Application must be made within 30 days of change in status	Signed GB-01 from Employer	Employee; employee and eligible dependent(s) would be dropped at the end of the stability period on the last day f that month	Coverage terminates at the end of the stability period on the last day of that month	N/A	N/A	N/A	N/A	N/A	Upon termination of coverage	Auto drop at the end of the plan year health coverage ends	Auto drop at the end of the plan year health coverage ends
I-8	Full-time to Full-Time Transferring	Moving coverage from one OGB Participant Employer to another OGB Participant Employer (Employee may not Add or Drop coverage but may change health plans)	Transferring Participant Employer- Application to remove should be received within 30 days of transfer; New Participant Employer - Application to Add must be received within 30 days of hire	Signed GB-01 from the hiring Participant Employer	Employee; employee and eligible dependents	Continuous coverage, no gap. Hiring Participant's employer will assume coverage based upon date of hire. If hired the first day of the month, hiring Participant's employer will assume responsibility for plan member immediately. If hired the second day of the month, or after, the hiring Participant's employer will assume responsibility on the first of the second month following hire.	NO	NO	NO	N/A	YES	NO	May Enroll if transferring from a Non-Flex Participant Employer	May Enroll if transferring from a Non-Flex Participant Employer

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I-9	Employee Terminated/separation of service (other than retirement)	DROP	30 days from the date of termination (OGB has the discretion to retroactively drop if correct premium is not timely paid and Application for disenrollment is not timely made)	GB-01 or it's electronic equivalent, signed by participant employer	Employee and all covered dependents	The end of the month in which Employee's termination is effective	N/A	YES	YES	DROP	NO	YES	Automatic Cancel on date of termination of employment	Automatic Cancel on date of termination of employment
I-10	Annual Enrollment	ADD OR DROP	Annual Enrollment period designated by OGB	GB-01 or its electronic equivalent (LaGov) signed by participant employer. Retirees ONLY may submit a signed written request or enrollment form	Employee; employee and eligible dependents	January 1 of following plan year if Application is timely made	YES	YES	YES	ADD or DROP	YES	N/A	Changes allowed	Changes allowed

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

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RETIREMENT														
L-1	Retirement (without gaining Medicare)	Continuation of Coverage under current plan	Application must be made within 30 days from the date of retirement	Application	Continuation of Coverage only for Current Covered Dependents	First of the month following date of retirement	N/A	N/A	N/A	N/A	YES	N/A	Yes, if FSA account has a positive balance	N/A
L-2	Retirement (without gaining Medicare)	DROP	Application must be made within 30 days from the date of retirement	Application	Self and covered dependents	End of month of retirement date	NO	YES	YES	DROP	YES, if drop dependent only	YES, for person dropped	Yes, if FSA account has a positive balance	N/A
L-3	Retirement (without gaining Medicare)	ADD	Application must be made within 30 days from the date of retirement	Application	Eligible dependents	First of month following the date of retirement	YES (may not add Self)	N/A	N/A	N/A	YES	N/A	Yes, if FSA account has a positive balance	N/A
N/A	Retirement with Medicare - refer to Gain of Other Coverage	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	YES	N/A	Yes, if FSA account has a positive balance	N/A

Note: OGB reserves the right to supplement or amend the QLE chart at any time. Revised January 30, 2023

STATE OF LOUISIANA

DIVISION OF ADMINISTRATION

OFFICE OF GROUP BENEFITS

Cafeteria Plan

Adoption of Amendments to the Cafeteria Plan Document

On February 1, 2023, the Cafeteria Plan Document was amended. As the Chief Executive Office of the Office of Group Benefits, on behalf of OGB, the Plan as amended is adopted.

David W. Couvillon 2/2/23

David W. Couvillon — Date