

**Williamson County
Government**

FLEXIBLE SPENDING ACCOUNT
SAMPLE SUMMARY PLAN
DESCRIPTION *
Health Care

EFFECTIVE DATE: July 1, 2015

FSA003
3334791

This document printed in July, 2015 takes the place of any documents previously issued to you which described your benefits.

*Employer Please Read: This document is a sample Flexible Spending Account Summary Plan Description. Please be sure to review the document with your own legal counsel in order to make sure this document meets your needs.

ERISA and the Internal Revenue Code impose certain obligations on the plan sponsor which must be reviewed with your counsel. This document is a sample and it is only one part of the documentation needed to meet your requirements under federal regulations.

Printed in U.S.A.

Table of Contents

Your Flexible Spending Account (FSA) At-A-Glance.....	4
About This Summary Plan Description.....	5
Who To Contact.....	5
Eligibility.....	5
Enrolling.....	5
Cost and Contributions.....	6
Covered Expenses.....	7
Coordination With Your Medical Plan Option.....	8
Claims For Reimbursement.....	8
How To Appeal A Denial Of Reimbursement.....	10
Administrative Information.....	10
Plan Administration Information.....	10
Definitions.....	12

Your Flexible Spending Account (FSA) At-A-Glance	
Date my FSA begins:	07/01/2015
Date my FSA ends:	06/30/2016
Plan Year:	Calendar
Date of my first contribution :	01/09/2015
What is the maximum that I can contribute to my FSA?	\$2,500
What is the maximum amount that I can carry over to the new Plan Year?	\$500
What will happen if there is no activity on my account?	If your Flexible Spending Account has no activity for a full year following the prior Plan Year, it will be automatically terminated and any remaining unused funds will no longer be carried over and will be subject to forfeiture.
What is the last date I can send in claims to Cigna for reimbursement?	In order for claims to be paid back from your FSA, Cigna must receive claims within 90 days of the Date my FSA ends.
How often will payments be made?	Daily
What can my FSA pay?	Your FSA pays eligible expenses as defined in IRS Code Section 213d. (See section titled “Covered Expenses, What Expenses Are Covered” for more detail.)
What can I do to get paid more quickly?	If you sign up for Direct Deposit, you will receive your payments more quickly. You can sign up for this feature by visiting www.myCigna.com.

About This Summary Plan Description

This is the Summary Plan Description (SPD) for the Williamson County Government, (hereinafter referred to as your Employer), Health Care Flexible Spending Account Plan, referred to as the Plan or the Health Care FSA plan. This SPD is also the Health Care FSA plan document.

A Flexible Spending Account (FSA), also known as a flexible spending arrangement, is a tax-advantaged financial account set up by your employer. An FSA allows you to set aside a portion of your earnings to pay for qualified expenses as established in the Plan, most commonly for medical expenses. Money deducted from your pay into an FSA is not subject to payroll taxes resulting in tax savings.

You will be notified of any changes to the Health Care FSA through SPD updates or announcements. If you have any questions about the Plan, see information in the “Who To Contact” section.

Explanation of Terms

You will find terms starting with capital letters throughout your SPD. To help you understand your benefits, most of these terms are defined in the “Definitions” section of your SPD.

HC-FSA2

vi

Who To Contact

For more information about the topics listed below, contact your Plan Administrator:

- Eligibility
- Enrollment
- Payroll Contributions
- Life Status Changes
- COBRA Continuation
- Covered Expenses
- Claims (call the number on the back of your ID card or 1-800-Cigna24)

HC-FSA3

Eligibility

Enrolling in the Flexible Spending Account (FSA) is optional. You are not automatically covered by the Plan. You are

eligible to enroll in the FSA if you are a full-time, non-temporary employee of your Employer, its divisions or its subsidiaries in the United States. Please contact your Plan Administrator for additional details.

HC-FSA4

Enrolling

When and How You Can Enroll

There are limited periods (described below) when you can choose whether or not to participate in the Plan. You cannot change your enrollment decision or your coverage amount until the next annual enrollment period, unless you have a Life Status Change, as described below.

If You Are Newly Eligible

You have 30 days from the date you become eligible (by hire, rehire, or job status change) to enroll in the FSA. If you enroll:

- Your Plan coverage starts on the date you enroll and remains effective for the rest of the Plan Year.
- The amount you elect to contribute will be divided by the number of pay periods remaining in the year. Your Employer will begin deducting Pre-tax Contributions from your pay in the next paycheck processed after you enroll.
- Only Covered Expenses that you incur on or after the date your coverage starts will be eligible for reimbursement from your FSA.

During the Annual Enrollment Period

If you are eligible, you can enroll in the FSA during the annual enrollment period. You will be told how to enroll before the enrollment period starts. If you enroll:

- Your Plan coverage starts at the beginning of the following Plan Year and remains in effect for the entire Plan Year.
- The amount you elect to contribute will be divided by the number of pay periods in the year. Your Employer will begin deducting your Pre-tax Contributions from your pay in the first paycheck of the Plan Year.
- Only Covered Expenses that you incur during the Plan Year will be eligible for reimbursement from your FSA.

If you have funds remaining at the end of the Plan Year which meet the criteria established by your Plan for Carryover (i.e., your year-end FSA balance is greater than the minimum and less than the maximum amount allowed to carry over), you will automatically be enrolled in the FSA for the new Plan Year and your new balance will be equal to the amount allowed to be carried over based on your Plan’s criteria for Carryover. If you have elected to participate in a qualified

high deductible health plan with a Health Savings Account (HSA) for the new Plan Year and your Plan offers a Limited Purpose FSA option, your automatic enrollment resulting from FSA Carryover will be placed into the Limited Purpose FSA for the new Plan Year.

You have the right to opt out of this Carryover. Notification must be given to your Plan Administrator prior to the end of the Plan Year that you do not want the Plan Year's unused Health Flexible Spending Account funds to be carried over. Any unused funds remaining in your Health Flexible Spending Account after all claims have been processed for that Plan Year will be forfeited.

When You Have a Life Status Change

You are allowed to change your enrollment elections during a Plan Year if you have a Life Status Change. You have 30 days after a Life Status Change to enroll in the FSA if enrolling is consistent with the Life Status Change event and you are Actively-at-Work when you elect to enroll. In other words, you may only change your election if the Life Status Change causes you, your Spouse or your child to gain or lose eligibility for coverage under this or another plan. The election change must correspond with the nature of the status change.

To add or delete coverage, notify your Employer. Complete the enrollment requirements, including providing proof, and paying any required contributions within 30 days of the Life Status Change event. The plan administrator will use its discretion to determine if changes are consistent, and will also determine what information will be required to provide proof of any change in status. If you don't meet the 30-day deadline, you will not be allowed to enroll in the FSA until the next annual enrollment period.

If you enroll:

- Your Plan coverage starts on the date of the Life Status Change or the date you tell the Plan about it – whatever date is later.
- The amount that you elect to contribute will be divided by the number of pay periods remaining in the year. Your Employer will begin deducting Pre-tax Contributions from your pay with the next available pay cycle after you complete your enrollment.
- Only Covered Expenses that you incur on or after the date your coverage starts will be eligible for reimbursement from your FSA.

Cost and Contributions

Cost

Typically you pay the entire cost of the Health Care FSA. These contributions are free from federal income and Social Security taxes, as well as most state and local income taxes. The contributions are deducted from your pay and deposited into a trust fund that holds Health Care FSA contributions. Your Employer may contribute to your FSA but in most cases the FSA is funded solely by making Pre-tax Contributions each pay period through payroll deductions. Generally, your Employer makes no contributions to your Health Care FSA.

Health Care FSA administrative expenses are paid for by Williamson County Government and by contributions that participants forfeit under the Use-It-or-Lose-It Rule. See the "Definitions" section for more information.

How Much You Can Contribute

The amount you can contribute into your Health Care FSA is limited for each Plan Year. Refer to the "Your Flexible Spending Account (FSA) At-A-Glance" section of this document to view your maximum contribution amount.

Health Care FSA Reimbursement Account Limitations

Reimbursements for outlined expenses will only be made if reimbursement is not made from any other health plan, insurance policy or benefit plan covering you, your lawful Spouse or your dependents.

Reimbursement for outlined expenses will only be made for eligible health expenses incurred during the year (and in the case of new employees, only during the portion of the year after participation began).

Excess Contributions: Use-It-or-Lose-It-Rule

If a balance remains in your account after the Plan Year's reimbursements have been processed, this amount will be forfeited. This is an IRS imposed Use-It-or-Lose-It-Rule. It requires that you forfeit any money that remains in your Health Care FSA after you have received reimbursement for all timely claimed Covered Expenses that you incurred during the Plan Year. To avoid forfeiting any remaining FSA Balance, all claims must be received by Cigna no later than the date identified in the section entitled "Your Flexible Spending Account (FSA) At-A-Glance" as the last date to submit claims to Cigna.

Excess Contributions: Carryover and the Use-It-or-Lose-It Rule

You will be able to carry over into the next Plan Year any unused funds remaining in your account after the Plan Year's reimbursements have been paid, providing the funds remaining meet the criteria established by your Plan for Carryover (i.e., your year-end FSA balance is greater than the minimum and less than the maximum amount allowed to carry

over). Any unused funds over the maximum amount or under the minimum amount allowed to be carried over and remaining in your FSA account after all claims have been processed for that Plan Year will be forfeited. To avoid forfeiting any remaining FSA balance, all claims must be received by Cigna no later than the date identified in the section entitled “Your Flexible Spending Account (FSA) At-A-Glance” as the last date to send in claims for reimbursement.

When You Make Contributions

Your Employer deducts your Plan contribution from your pay each pay period. These are Pre-tax Contributions. Your Employer credits the deducted amounts to your Health Care FSA over the course of the Plan Year. Here is how the deduction amounts are calculated:

If you enroll during the annual enrollment period, the amount that you elect to contribute for a Plan Year is divided by the number of pay periods in the Plan Year. Your first contribution will be on the date identified in the section entitled “Your FSA At-A-Glance” and will continue on each pay period for the remainder of the Plan Year.

If you enroll after the beginning of a Plan Year, the amount that you elect to contribute for a Plan Year is divided by the number of pay periods remaining in the Plan Year.

Even though you contribute to your FSA over the course of the Plan Year, the full amount that you elect to contribute for the Plan Year is available for reimbursement of Covered Expenses at the beginning of the Plan Year (or the effective date of your participation, if later).

When Your Contributions Stop

Your right to contribute to your FSA will stop when:

- You cancel your coverage, if permitted because of a life status change;
- You transfer to an ineligible employee status;
- Your employment with Williamson County Government terminates (including retirement) and you decline continuation of coverage under federal law (i.e., COBRA);
- You fail to make the necessary monthly contributions under COBRA to your FSA;
- You die; or
- Your Employer terminates the Plan.

You or your Covered Dependents may continue to submit claims for reimbursement of Covered Expenses you incur before the date your contributions stop. Those claims must be received by Cigna no later than the timeframe identified on the page titled Your Flexible Spending Account At-A-Glance.

You may be reimbursed for FSA claims up to your entire remaining FSA Balance, even if your claims exceed the amount of your actual contributions to your FSA.

Effect of Health Care FSA Contributions on Other Plans

Your Health Care FSA contributions will not affect other pay-related benefits, such as 401(k), life insurance and disability income because your “eligible earnings” for those benefit plans is calculated BEFORE your salary is reduced.

Effect of Health Care FSA Contributions on Social Security

Your Health Care FSA contributions will reduce the amount you pay in Social Security taxes so your future Social Security benefits may be slightly reduced.

HC-FSA6

V3

Covered Expenses

You can use your FSA to pay for many of the types of expenses that qualify for a federal income tax deduction.

You cannot request reimbursement for an expense through your FSA and then deduct the same expense on your federal income tax return (or your Spouse’s federal income tax return).

Whose Expenses Can Be Covered

You can use your FSA to pay Covered Expenses for yourself and your Covered Dependents.

Your Covered Dependents include:

- Your lawful Spouse;
- Your child, who includes your natural or legally-adopted child; a child placed with you for adoption; and your stepchild (that is, the natural or legally-adopted child of your current legal Spouse) but only if the child is under age 26; and
- Any other qualifying child or relative you may claim as a dependent for federal income tax purposes.

Because the Health Care FSA is subject to federal tax rules, federal law determines who can be your Covered Dependents – and have their expenses covered – under the Plan.

What Expenses Are Covered

Covered Expenses under the Health Care FSA consist of any expense for medical care as defined in IRS Code Section 213. The following list includes some of the most common eligible expenses. For additional information, refer to IRS Publication 502, visit the IRS website at <http://www.irs.gov> or visit www.cigna.com/expenses.

- All Deductibles, Coinsurance and Copayments charged to an individual (not premiums or payroll contributions) under any medical or dental plan

- All Coinsurance and Copayments charged to an individual for prescriptions
- All expenses charged by a licensed physician or dentist for treatment of a medical case provided in the doctor's or dentist's office, in a hospital, in the individual's home or at the place of an accident and not already paid by insurance
- Routine physical exams
- Immunizations
- Vision related supplies (i.e. eyeglasses, contact lenses and supplies)

The following is a list of some of the most common items that require a letter of medical necessity (or prescription) proving it is a treatment for illness or medical condition:

- Massage
- Fitness program, gym membership or fitness equipment
- Alternative health treatments

Over-the-Counter Drugs, Medicines and Medical Supplies

Over-the-Counter Drugs and Medicines

Over-the-counter drugs and medicines (other than insulin) are reimbursable through a Health Care FSA ONLY IF the drug or medicine is prescribed by a physician and an itemized receipt is submitted.

For example, the cost of pain relievers like aspirin or acetaminophen, cough syrup, allergy medicines, and antacid relievers that you purchase is reimbursable only if you obtain a prescription for the over-the-counter medicine from your doctor.

Over-the-Counter Medical Supplies

Over-the-counter medical supplies and equipment, such as crutches or bandages, are Covered Expenses and are reimbursable without a prescription.

Other Over-the-Counter Items

The cost of other types of over-the-counter items used for general wellness, such as cosmetics, toiletries and nutritional supplements (for example vitamins) are NOT Covered Expenses and are not reimbursable.

See section entitled "Claims for Reimbursement" for information on the documentation that you must submit to claim reimbursement for over-the-counter items that are Covered Expenses.

HC-FSA7

V1

Coordination With Your Medical Plan Option

Your employer may also offer a Cigna Medical Plan Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA). You may enroll in both the Cigna Medical Plan HSA or HRA option and the Health Care FSA, but there are some restrictions imposed by federal law on how these plans work together.

If you are enrolled in an HRA and the Health Care FSA, when your medical claim is processed and you have out-of-pocket expenses, they may be reimbursed from your HRA fund or Health Care FSA. Please contact your plan administrator for additional details.

You may also use a Health Care FSA for eligible expenses that are not covered by an HRA Medical Plan option, such as the cost of eyeglasses and certain over-the-counter medication, although you may need a prescription. See section entitled "Over-the-Counter Drugs, Medicines and Medical Supplies".

HC-FSA8

V1

Claims For Reimbursement

How to File a Claim for Reimbursement

You can visit www.myCigna.com to use the Online Reimbursement Request form or download a FSA claim form. The following general steps should be followed in order to file a reimbursement claim:

Complete the employee portion of the reimbursement claim form in full. Answer all questions, even if the answer is "none" or "N/A" (not applicable).

Attach all necessary documentation of expenses including your Explanation of Benefits, to the reimbursement claim form. When you have health care expenses for which an Explanation of Benefits is not provided, such as the cost of eyeglasses, submit an itemized receipt for the expense along with your claim for reimbursement.

When you submit claims for health care expenses, you must provide a written statement (Explanation of Benefits) from an independent third party stating that the expense has been incurred and the amount of the expense, a written statement (Explanation of Benefits) that the expense has been reimbursed or is not reimbursable under any other plan coverage, and a written statement (Explanation of Benefits) that the amount will not be claimed as a tax deduction.

If you file paper claims, you should submit them for each individual. Please do not attach or staple claims together. If additional information is needed to process your claim or the

claim of your dependent, you will be notified. If you receive a letter regarding your claim, prompt completion and return of the letter with any requested attachments will expedite processing of the claim. The claim will be denied for lack of necessary information if the information requested in the letter is not supplied within forty-five (45) days. If you submit the requested information after the 45-day period, this will be treated as a new submission of the claim.

Send complete information to:

Cigna HealthCare
Post Office Box 182223
Chattanooga, TN 37422-7223
Or send by facsimile to: 423-553-8953

The Online Reimbursement Request form can be used to submit expenses for multiple patients.

If you have questions regarding your claim, please call the number on the back of your ID card or 1-800-Cigna24.

Reimbursements from your flexible health care reimbursement account in an amount up to your annual election amount will be made at the time the reimbursement claim is processed.

All claims will be processed and paid as identified in the section entitled “Your Flexible Spending Account (FSA) At-A-Glance”. Please note Cigna can only receive claims during regular business hours. Claims filed outside of business hours are recorded as received the next business day.

All requests for benefits may be filed at any time during the year and within the 3-month period immediately following the end of the year.

Flexible Spending Account Debit Cards

The Flexible Spending Account Debit Card can be used to pay eligible expenses at your health care professional’s office, dentist’s office, pharmacies and hospitals. Most, but not all debit card transactions at these locations will be automatically substantiated; however, in some cases, you may be asked to submit proof, such as an itemized receipt, of your debit card purchases.

Claims Determination Procedures

The Claims Administrator will provide you with notice of the claim determination within a reasonable period of time, but no later than 30 days after receipt of the claim. This time period will be delayed, if the plan requests additional information, until the requested information is received by the plan. The plan may also request a 15 day extension if matters beyond its control require the extension and notice is provided to you within the 30 day period.

If your claim is denied in whole or in part, the notice will include:

- The specific reason or reasons for the denial.
- References to Plan provisions on which the denial is based.

- A description of any additional information or material needed to approve your claim and an explanation of why such material or information is necessary.
- A description of the Plan’s procedures for appealing the decision and a statement of your rights to bring a civil action under ERISA.
- A statement that you may request a copy, free of charge, of any internal rule, guideline, protocol or other similar criterion that was relied upon in denying your claim.

When Claims Are Paid

Once a Health Care FSA claim is approved, a payment check will be issued.

Health Care FSA payments are always made to you and cannot be made directly to the provider of services.

Approved healthcare claims will be paid in full up to the amount of your Health Care FSA balance even if your claims exceed the amount of your actual contributions to FSA.

Deadline for Filing Claims

You must submit FSA claims for Covered Expenses incurred during a Plan Year by the date identified in the section entitled “Your Flexible Spending Account (FSA) At-A-Glance” as the last date to submit claims to Cigna of the following year. Any claim received after that date will NOT be processed.

Under the IRS’s Use-It-or-Lose-It Rule, you will forfeit any funds left in your FSA beyond the maximum amount allowed under Carryover after payment of all timely submitted claims for expenses you incur during the Plan Year.

FSA Statements

You will receive a written explanation for every Health Care FSA payment made from your account. The explanation will show the amount paid and your current account balance. You will receive paper copies unless you indicate a preference at www.myCigna.com to receive these explanations by online delivery only.

In addition, quarterly account statements are available at www.myCigna.com, which can help you track your account balance so you know how much you have available to pay claims. You can indicate your preference to receive paper copies of these quarterly statements by visiting www.myCigna.com.

How To Appeal A Denial Of Reimbursement

If we deny your request to be paid back for a service, you can appeal it. You or your authorized representative may start the appeals procedure.

Appeals Procedure

To initiate an appeal, you must submit a request for an appeal in writing to Cigna within 180 days of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable to or choose not to write, you may ask Cigna to register your appeal by telephone at the toll-free number on your Benefit Identification card, explanation of benefits, or claim form. Your appeal will be reviewed and the decision made by someone not involved in the initial decision. We will respond in writing with a decision within 60 calendar days after we receive an appeal for a reimbursement determination. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

Legal Action

If your plan is governed by ERISA, you have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the outcome of the Appeals Procedure. In most instances, you may not initiate a legal action against Cigna until you have completed the appeal process.

Additional Information on Covered and Excluded Benefits

If you would like to receive information regarding a specific drug, medical test, device or procedure which is either a covered or excluded benefit under this plan, you may either call the toll-free number on your Explanation of Benefits or claim form or log onto www.myCigna.com.

HC-FSA11

Administrative Information

Qualified Medical Child Support Order (QMCSO)

Your Employer's Health Care FSA Plan will comply with the terms of a QMCSO. A QMCSO is a judgment, decree, or order that is issued by a court or through an administrative process established under state law that assigns to a child the right of a participant to receive benefits under an employer-provided health plan, and that the Plan Administrator has determined is qualified under the terms of ERISA and applicable state law.

If you have questions about or wish to obtain a copy of the procedures governing a QMCSO determination (at no charge), contact the Plan Administrator.

Optional Continuation Coverage

To the extent mandated by federal law, you will be allowed to continue coverage under the Health Care FSA even after your termination of employment. Such coverage, however, will require you to continue making the deposits you have elected on an after tax basis.

If You Have Questions

If you have questions about continuation coverage, you should contact your Plan Administrator.

In administering the Plan, the Plan and Claims Administrators may come into contact with what is considered "protected health information" (PHI) under the Health Insurance Portability and Accountability Act (HIPAA). Cigna and the Plan Administrator have taken specific steps to protect and limit access to this information. For example, Cigna has:

- Designated a Privacy Officer;
- Developed privacy policies and procedures, including a sanctions policy that applies to employees and business partners who violate privacy policies;
- Implemented safeguards to protect against improper disclosure of PHI;
- Provided a complaint resolution process; and
- Entered into agreements requiring its business associates to safeguard PHI.

As part of the compliance efforts, a HIPAA Notice of Privacy Practices is provided to employees. If you would like to review the privacy policies, receive another copy of the privacy notice or just need more information, please contact the Plan Administrator.

HC-FSA12

V1

Plan Administration Information

The name of the Plan is: Williamson County Government

The name, address, zip code and business telephone number of the sponsor of the Plan (your Employer) is:

Williamson County Government
1320 West Main Street
Franklin, Tennessee 37064
615-595-1270

Employer Identification Number (EIN): 626000913

Plan Number: See Plan Administrator

Plan Type: Health Care Flexible Spending Account.



The name, address, zip code and business telephone number of the Plan Administrator is the Employer named above.

Type of Administration: Third-party administration

Claims Administration: Cigna

The Plan's year ends on: 06/30.

The Health Care FSA is funded by your Pre-tax Contributions to the Plan through reductions of your salary. Contributions to the Plan are deposited into a trust fund and used to pay Covered Expenses. Any forfeited funds are used to pay the administrative costs of the Plan. The Flexible Spending Account is not an insurance contract.

Discretion of Plan Administrator and Claims Administrator

The Plan Administrator has the sole discretion to determine any eligibility/election issues, any issues that are not clearly either eligibility/election issues or coverage/benefit issues and any issues that arise in connection with a request for a voluntary review of a coverage/benefit decision. The Plan Administrator has the authority to interpret any of the Plan's provisions relevant to such issues, including ambiguous and disputed terms, and to make any related factual determinations. The Plan Administrator's determinations and interpretations on these issues are final and binding on all parties.

The Plan Administrator delegates to the Claims Administrator the discretionary authority to interpret and apply Plan terms and to make factual determinations in connection with its review of coverage/benefit issues under the Plan. The Claims Administrator has the authority to interpret any of the Plan's provisions relevant to coverage/benefit issues, including ambiguous and disputed terms, and to make any related factual determinations. The Claim Administrator's determinations and interpretations on these issues are final and binding on all parties, except in cases involving a request to the Plan Administrator for voluntary review of a coverage/benefit decision.

Plan Modification, Suspension and Termination

Williamson County Government reserves the right to modify, suspend, or terminate the Plan at any time. Your coverage or benefits during your employment or after retirement may be modified or terminated as a result of such change. Any modification or termination of the Plan will not affect your rights or those of your Covered Dependents as to Covered Expenses you incur while the Plan is still in effect.

Plan Amendments

The Plan may be amended at any time by a written document signed by any duly authorized officer of Williamson County Government.

Statement of Rights

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants:

Receive Information About Your Plan and Benefits

- examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure room of the Employee Benefits Security Administration.
- obtain, upon written request to the Plan Administrator, copies of documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each person under the Plan with a copy of this summary financial report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied or ignored you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Enforce Your Rights

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of documents governing the plan or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court.

In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

HC-FSA13

V2

Definitions

Following are some important terms. They appear with capitalized letters throughout this document.

Actively-at-Work

You are considered Actively-at-Work:

- If you are performing the regular duties of your work, on a regularly scheduled basis, on any of your Employer's scheduled work days, either at your Employer's place of business, in your home, or at some location to which you are required to travel for your Employer's business;
- On a day which is not one of your Employer's scheduled work days if you were at work on the preceding scheduled work day;
- If you are receiving Short Term Disability Plan benefits from your Employer; or
- If you are on an approved paid or unpaid leave of absence except for a Long Term Disability leave of absence.

Carryover

An IRS rule which permits Clients to carry over unused Pre-Tax Contributions from one year to the next, up to a maximum (not to exceed the IRS maximum amount of \$500), or a minimum amount, as defined by your Employer. Clients can choose to allow the presence of Carryover funds to result in automatic enrollment in FSA for the next Plan Year. (Carryover cannot be allowed for plans which also provide an Extended Claim Period.) See "Your Flexible Spending Account (FSA) At-A-Glance" section for details.

Civil Union

A formal relationship legally recognized in some states, but not under federal law, that gives same-gender couples rights and responsibilities similar to those of a marriage. State law imposes requirements and conditions that you must meet to have a valid Civil Union.

Coinsurance

The part of the cost of any medical services that you must pay after you have met any plan deductibles. For example, if your medical plan pays 80 percent of the cost of medical expenses after you have met your deductible, your coinsurance payment would be 20 percent.

Copayment

The amount, usually a flat dollar amount, of the cost you must pay to a network healthcare professional at the time you receive health care services or supplies.

Contribution Frequency

The timing of your Employer's collection of your contributions to your FSA account.

Covered Dependents

Those persons described as Covered Dependents in the section entitled "Whose Expenses Can Be Covered".

Covered Expenses

Expenses that are eligible for reimbursement under the FSA, as described in the section entitled "What Expenses Are Covered".

Deductible

The dollar amount you must pay out-of-pocket before your medical plan option begins to reimburse you for expenses covered by that plan.

Domestic Partner

A person in a relationship with a Williamson County Government employee, such that he or she meets the criteria for a domestic partnership and there is a valid "Affidavit of Domestic Partnership" on file with Williamson County Government.

Employer

Any corporation or other business entity that is owned by Williamson County Government and that participates in the Williamson County Government benefits program.

ERISA

The Employee Retirement Income Security Act of 1974, as amended.

FMLA Leave

A leave of absence under the Family and Medical Leave Act.

FSA Balance

The maximum coverage amount elected for your FSA for the plan year, minus the total amount of claims paid.

Life Status Change

A term defined in accordance with IRS rules that describes when you may be permitted to change your FSA elections, other than during an annual enrollment period. You may make election changes if you have a life status change event and the benefit election change you want to make is consistent with the life status change event. The life status change events are:

- You marry, divorce or have an annulment or a legal separation.
- You have a child, adopt a child or assume legal guardianship of a child.
- Your Spouse, partner or child dies.
- You or your Covered Dependent's employment starts or terminates.
- You or your Covered Dependent changes your work location or residence to a place outside your medical plan's service area, have a reduction or increase in hours of employment (including a switch between full-time and part-time status), begins or ends an unpaid leave of absence, strike or lockout.
- Your Covered Dependent satisfies or ceases to satisfy the requirements for Covered Dependent status due to attainment of age, financial dependency, or any similar circumstances.

If your change is on account of and corresponds with the Life Status Change, you may elect or cancel coverage or change your contributions to an FSA.

If you are not Actively-at-Work (for example, you are on a disability leave), you may change your Health Care FSA elections only if the following occurs:

- Birth or adoption of a child.
- Marriage.
- Divorce.
- Death of your Spouse or child.

Partner

The person with whom you have a Domestic Partner arrangement, Civil Union or same-gender marriage that is legally recognized in the state where you reside.

Plan Year

The 12-month period identified in the section entitled "Your FSA At-A-Glance".

Pre-tax Contributions

Deposits to the FSA that are deducted from your wages before federal, Social Security, and in most cases, state and local income taxes have been withheld.

Spouse

Your lawful Spouse, as recognized under both state and federal law.

Termination of Employment Date

The date your employment with Williamson County Government officially ends (usually, your last day of work at Williamson County Government).

Use-It-or-Lose-It Rule

An IRS rule requiring that Pre-tax Contributions to plans be used for Covered Expenses incurred during the Plan Year under an FSA or else be lost. Unused Pre-tax Contributions cannot be carried over from one year to the next, nor can they be returned to you.

2016 AMENDMENT

TO THE WILLIAMSON COUNTY GOVERNMENT

**HEALTH CARE FLEXIBLE SPENDING ACCOUNT SUMMARY PLAN DESCRIPTION
AND PLAN DOCUMENT**

WHEREAS, Williamson County Government ("Employer") maintains the Williamson County Government Health Care Flexible Spending Account Plan ("Health Care FSA") as part of the Williamson County Government Premium Conversion and Flexible Benefit Plan ("Flexible Benefit Plan") to provide benefits for eligible employees; and

WHEREAS, the Employer initially established the Health Care FSA effective as of January 1, 2005, and subsequently made various changes to the arrangement; and

WHEREAS, several years ago, the Employer retained Cigna as the third-party administrative services provider ("TPA") for the Health Care FSA; and

WHEREAS, on or about September 24, 2015, the TPA provided the Employer with a document entitled "Summary Plan Description" ("SPD") for the Health Care FSA, showing an incorrect effective date of July 1, 2015 and containing certain other inaccuracies; and

WHEREAS, page 5 of the SPD indicates it is "also the Health Care FSA plan document"; and

WHEREAS, the Flexible Benefit Plan is intended to qualify as a "cafeteria plan" under Internal Revenue Code ("Code") Section 125; and

WHEREAS, the Health Care FSA is intended to be as a "medical reimbursement arrangement" under Code Section 105 and through which eligible employees may make "pre-tax" contributions to obtain reimbursement of certain eligible "uninsured medical care expenses" incurred under the Employer's group health plan; and

WHEREAS, on September 13, 2005, the Employer adopted a "grace period" during which participants were permitted to use amounts remaining in their health care flexible spending accounts at the end of a Plan year to pay for "eligible health care expenses" incurred during the 2-1/2 month period immediately following the end of the particular Plan year; and

WHEREAS, the Employer decided to eliminate the 2-1/2 month "grace period" available under the Health Care FSA effective for Plan years after December 31, 2014, and adopt the "\$500 carryover" feature, initially effective as of January 1, 2015, as a limited exception to the Code's "use-it-or-lose-it" rules generally applicable to "flexible spending account arrangements"; and

WHEREAS, effective as of January 1, 2014, the Employer redesigned its group health plan to include a "high deductible" component with a "health savings account" feature, intended to comply with Code Section 223; and

WHEREAS, effective as of January 1, 2014, the Flexible Benefit Plan was changed to allow eligible employees to make contributions to their respective health savings accounts on a pre-tax basis through the Flexible Benefit Plan; and

WHEREAS, page 10 of the SPD provides "the Plan may be amended at any time by a written document signed by any duly authorized officer of Williamson County Government"; and

WHEREAS, the Employer desires to amend certain provisions in the SPD;

NOW, THEREFORE, the Employer hereby amends the SPD as follows and adopts the SPD, as corrected, effective as of January 1, 2016, and the SPD and this Amendment shall be incorporated by reference into the Flexible Benefit Plan as Appendix B and shall be construed and interpreted in accordance with applicable cafeteria plan requirements:

I.

On the cover page of the SPD, delete all references to "sample" and change the effective date from July 1, 2015, to January 1, 2016.

II.

On page 4 of the SPD, in the chart, entitled "Your Flexible Spending Account (FS) At-A-Glance", delete in their entirety the first three lines, and substitute in lieu thereof the following to clarify the period of coverage under the Health Care FSA is the same period as the Plan Year, which begins on January 1 and ends on December 31 of each year:

Date FSA begins:	January 1
Date FSA ends:	December 31
Plan Year:	January 1 to December 31

III.

On page 5 of the SPD, delete the text at the last bullet in the right column and substitute in lieu thereof the following:

- Subject to the Carryover feature described below, only Covered Expenses you incur during the Plan Year will be eligible for reimbursement from your Health FSA.

IV.

On page 5 of the SPD, delete in its entirety the last paragraph in the right column (that carries over to page 6 in the left column) and substitute in lieu thereof the following:

If you have unused funds remaining in your Health FSA account at the end of the Plan Year, you will automatically be enrolled in the Health FSA for the immediately following Plan Year and your new balance will equal the lesser of (1) \$500 or (2) your unused Health FSA balance ("Carryover"). If you receive any Carryover amount for the following Plan Year, you may not make contributions to the HSA for any month during the following Plan Year.

V.

On page 6, delete the first full paragraph in the left column immediately before the section entitled "When You Have a Life Status Change" and substitute in lieu thereof the following:

You have a right to opt out of the Carryover. Before the end of the current Plan Year in which you have an unused balance in your Health FSA account, you may notify the Plan Administrator in writing that you do not want your unused balance carried over to the following Plan Year. Any unused funds remaining in your Health FSA account after all your claims have been processed for that current Plan Year will be forfeited. If you decline or waive the Carryover for the following Plan Year, you may make contributions to the HSA during the following Plan Year if you are an "eligible individual" under Code Section 223(c)(1)(A), provided that you did not elect to participate in the Health FSA for that following Plan Year.

VI.

On page 7 of the SPD, delete in its entirety the last sentence at the end of the section, entitled "When Your Contributions Stop", in the left column and substitute in lieu thereof the following to clarify an employee's reimbursement will not be limited to the balance in the individual's account:

You may be reimbursed for FSA claims up to the entire amount you elected to contribute to your Health Care FSA account, even if your claims exceed the amount of your actual contributions to your Health Care FSA.

VII.

On pages 9, 10, 11, and 13 of the SPD, delete all references to "ERISA", the Employee Retirement Income Security Act of 1974, as amended, and all provisions describing ERISA requirements because Section 4(b) of ERISA expressly provides that ERISA provisions "shall not

apply to any employee benefit plan if such plan is a governmental plan (as defined in section 3(32)". Section 3(32) of ERISA defined "governmental plan" in pertinent part as follows:

(32) The term 'governmental plan' means a plan established or maintained for its employees by the Government of the United States, by the government of any State or political subdivision thereof, or by any agency or instrumentality of any of the foregoing.

VIII.

On page 7 of the SPD, at the end of the Section entitled "Cost and Contributions", in the right column add the following new language:

Maximum Salary Reduction Contribution: Notwithstanding any other provisions to the contrary in the SPD, the maximum annual salary reduction contribution an employee may elect for reimbursement under the Health Care FSA for any Plan Year shall not exceed \$2,500 for Plan Years beginning on or after January 1, 2016. The \$2,500 maximum contribution limit shall apply to each employee regardless of the number of individuals whose eligible medical expenses are reimbursable under the employee's Health Care FSA. The \$2,500 limit will be indexed for cost-of-living adjustments after December 31, 2013.

Elimination of 2-1/2 Month Grace Period—For Plan Years after December 31, 2014, and notwithstanding any other provisions in the SPD to the contrary, the Health Care FSA portion of the Flexible Benefit Plan no longer provides for the 2-1/2 month "grace period" described in Internal Revenue Notice 2005-42 and Proposed Treasury Regulation Section 1.125-1(e).

Carryover Period—Notwithstanding any other provisions in the SPD to the contrary, employees who have unused amounts credited to their Health Care FSA accounts as of December 31 of a Plan Year may carry over up to \$500 of the unused amount to the immediately following Plan Year to pay, or be reimbursed, for eligible medical expenses incurred at any time during the following Plan Year ("Carryover Period"), provided the individual is a participant on the last day of the Plan Year immediately preceding the Carryover Period. For this purpose, the amount remaining unused as of the end of the Plan Year is the amount unused after eligible medical expenses have been reimbursed at the end of the "Run-Out period" for the Plan Year (as defined below). The Carryover Period will be applied uniformly to all employees who participate in the Health Care FSA, determined as of the last day of the particular Plan Year. With respect to a participant, the amount that may be carried over to the immediately following Plan Year is equal to the lesser of (1) any unused amount in the Health Care FSA for the immediately preceding Plan Year; or (2) \$500.

Maximum Salary Reduction Contribution Not Affected by Carryover Amount—In addition to carrying over an unused amount of up to \$500 to the next Plan Year, a participant also may elect (for that next Plan Year) up to the maximum allowed salary reduction contribution permitted under the Health Care FSA arrangement. The amount carried over shall not count against or otherwise affect the indexed \$2,500 salary reduction contribution amount applicable to the Plan Year.

COBRA Continuation Coverage—Any unused amount remaining in a Participant's Health Care FSA as of termination of employment shall be forfeited, unless the Participant properly and timely elects COBRA continuation coverage with respect to the Health Care FSA, subject to the requirements under Code Section 4980B and Treasury Regulations Section 54.4980B.

Unused Balance at Plan Year End—An employee's unused Health Care FSA balance at the end of the prior Plan Year may be used (i) for expenses incurred in that prior Plan Year, but only if claimed during the "Run-Out Period" (as defined below) that begins at the end of the prior Plan Year (in effect retroactively reducing the unused amount as of the end of the prior Plan Year); or (ii) to the extent of the permitted carryover amount of up to \$500 of unused amounts from the final prior Plan Year unused amount, for expenses that are incurred at any time in the current Plan Year. Salary reduction contributions credited to an employee's Health Care FSA with respect to service in the current Plan Year may be used only for expenses incurred in the current Plan Year (unless and to the extent the current Plan Year amount may later be carried over to the following Plan Year during the Carryover Period.).

Run-Out Period—The "Run-Out Period" ends on the last day of the third calendar month following the last day of the particular Plan Year ("Run-Out Period"). Notwithstanding any provision to the contrary, the Run-Out Period as defined in this paragraph shall apply under the Health Care FSA for purposes of Participants' claims for reimbursement for eligible medical expenses incurred during a Plan Year.

Forfeitures—All contributions allocated to the Health Care FSA during a Plan year that are not used to reimburse eligible medical expenses incurred during the Plan Year shall be forfeited, except to the extent of amounts up to \$500 that are carried over to the following Plan Year. Any unused amount from the prior Plan Year in excess of the \$500 carryover limit that remains unused at the end of the Run-Out Period for the Plan Year shall be forfeited.

If, after the Run-Out Period, any balance in excess of the \$500 carryover amount remains in the employee's Health Care FSA account for a Plan Year the balance shall not be carried over to reimburse the employee for eligible medical expenses incurred during a subsequent Plan Year, and shall not be available to the employee in any other form or manner, but shall remain the property of the Employer, and the employee shall forfeit all rights with respect to such unused balance in excess of the \$500

carryover amount. Any unused amounts remaining in an employee's Health Care FSA as of termination of employment shall be forfeited unless, if applicable, the employee properly and timely elects COBRA continuation coverage with respect to the Health FSA. Amounts forfeited shall be used in a manner that complies with applicable federal law. Additionally, all provisions in the Health Care FSA arrangement shall be construed in a manner consistent with applicable federal law.

Receiving Health Care FSA Reimbursements—If the substantiation requirements under Treasury Regulation Section 1.125-6 are satisfied, the employee will receive payment in cash as reimbursement for eligible medical expenses the employee and/or the employee's spouse and eligible dependents incurred during the Plan Year (or Carryover Period, if applicable) in which the employee participated and for which the employee's Health Care FSA election is effective.

Substantiation—All expenses must be substantiated by information from a third-party that is independent of the employee and the employee's spouse and dependents. The independent third-party must provide information describing the service or product, the date of the service or sale and the amount of the expense.

Electronic Payment Cards—If the Plan Administrator permits, an employee may choose to make payment for eligible medical expenses with an electronic payment card arrangement. The terms of the electronic payment card arrangement, if applicable, will be set forth in procedures the Plan Administrator establishes.

With respect to claims employees incur during a Carryover Period, claims shall be administered as follows:

- (a) All claims incurred in the current Plan Year shall be treated as reimbursed first from unused amounts credited for the particular current Plan Year and, only after exhausting the current Plan Year amounts, then claims in the current Plan Year shall be treated as reimbursed from unused amounts carried over from the preceding Plan Year.
- (b) Any unused amounts from the prior Plan Year that are used to reimburse a current Plan Year expense (1) will reduce the amounts available to pay prior Plan Year expenses during the "Run-Out Period", (2) will be counted against the \$500 carryover amount, and (3) shall not exceed the employee's permitted carryover amount of up to \$500.

IN ALL OTHER RESPECTS, the Williamson County Government Health Care Flexible Spending Account Summary Plan Description and Plan Document is in all things ratified and confirmed.

IN WITNESS WHEREOF, Williamson County Government has caused its duly authorized officials and employees to execute this 2016 Amendment and adopt the SPD, as corrected by this Amendment, on November 24, 2015, effective as January 1, 2016.

WILLIAMSON COUNTY GOVERNMENT

By: Rogers C. Anderson
Print Name Rogers E. Anderson
Its: MAYOR
Date: November 24, 2015

WITNESS:

Mike Weber
Mike Weber
Print Name
Date: 11/24/15

WITNESS:

Nena Graham
Nena Graham
Print Name
Date: 11/24/15