WILLIAMSON COUNTY GOVERNMENT
AMENDED AND RESTATED PREMIUM CONVERSION AND FLEXIBLE BENEFIT PLAN

(Section 125 Plan)

(Effective as of January 1, 2016)

(NOVEMBER 2015)

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PREAMBLE

Williamson County Government ("Employer") adopted the Williamson County Government Premium Conversion Plan ("Plan"), effective as of August 1, 1996, to allow eligible Employees to pay certain insurance premiums on a pre-tax basis. Effective as of January 1, 2001, the Employer expanded the Plan to add flexible spending accounts through which employees may receive reimbursements of certain dependent care expenses and added a health care flexible spending account feature to the Plan effective as of January 1, 2005. Subsequently, the Employer decided to make more benefits available and changed the Plan to allow eligible Employees to make pre-tax contributions to health savings accounts associated with the Employer-sponsored "high-deductible health plan", effective as of January 1, 2014. The Employer established the Plan with the intent it satisfy applicable "cafeteria plan" requirements.

Proposed Treasury Regulation Section 1.125-1(c)(1) permits a "cafeteria plan" document to be comprised of multiple documents. The eligibility, participation, contribution, and other requirements applicable to certain of the benefits available through the Plan are set forth in the specific component plan documents that describe the various benefit packages offered to eligible Employees.

The Plan is hereby amended and restated in its entirety, effective as of January 1, 2016, except as otherwise provided herein and consists of the premium conversion feature (described in this document), the dependent care reimbursement feature (described in Appendix A), and the health care reimbursement feature (described in Appendix B). This document is intended to consolidate certain Plan provisions into a single document and to incorporate by reference into this document certain related plans described in Article IV below.

The provisions in this document in conjunction with the applicable provisions in the component plan documents are intended to satisfy the written plan document requirement applicable to "cafeteria plans" under Treasury Regulation Section 1.125-1(c). If there are any conflicts between the provisions in the Plan and the provisions in any other related benefit plan documents with respect to "cafeteria plan" requirements, the terms of the Plan shall control.

ARTICLE I

ESTABLISHMENT OF PLAN

1.1 **Effective Date.** The Effective Date of this amended and restated Plan is set forth in Section 2.7 below.

1.2 **Purpose.** The Plan is created exclusively to provide Employees, as defined in Section 2.8 below, the means to exchange all or part of their otherwise taxable Compensation, as defined in Section 2.5, for other non-taxable Plan benefits they may select under Article IV.

1.3 **Qualification.** The Plan is intended to qualify as a cafeteria plan under Section 125 of the Internal Revenue Code of 1986, as amended ("Code") and shall be administered and interpreted to comply with applicable provisions under Section 125; it is not intended to be an employee benefit plan under section 3(3) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

The Williamson County Government Dependent Care Flexible Spending Account Plan, as defined in Section 2.6 and described in Appendix A, is part of this Plan and is intended to qualify as a dependent care assistance program under section 129 of the Code. Appendix A is intended to satisfy the writing requirement of Code section 129(d)(1).

The Williamson County Health Care Flexible Spending Account Plan, as defined in Section 2.11 and described in Appendix B, is part of this Plan and is intended to qualify as a health plan under section 105(e) of the Code and to comply with the requirements applicable to "self-insured medical expense reimbursement plans" under Code section 105(h) and the implementing Treasury regulations. Appendix B is intended to satisfy the writing requirements of Treasury Regulations section 1.105-11(b)(1)(i).

1.4 **Duration.** The Plan is established with the intention of being maintained for an indefinite period of time; however, the Employer, as defined in Section 2.4, in its sole discretion and in accordance with the provisions of Article VIII may amend the Plan from time to time or terminate the Plan or any Program or benefit offered under it at any time.

ARTICLE II

DEFINITIONS

The following words and phrases, when capitalized, shall have the following meanings:

2.1 **Board** means the Board of Commissioners of Williamson County Government.

2.2 **COBRA** means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, and implementing Treasury Regulations.

2.3 **Code** means Internal Revenue Code of 1986, as amended, and its regulations.

2.4 **Committee** means the Purchasing and Insurance Committee appointed by the Board to function as Plan Administrator pursuant to Article VII below.

2.5 **Compensation** means the total cash remuneration the Employer pays an Employee for personal services the Employee renders during the portion of a Plan Year the Employee is eligible to participate in this Plan. This remuneration is calculated before any income tax or employment tax withholdings and before any salary reduction contributions are taken under any employee benefit plan the Employer maintains under Code sections 125 or 401(k). The term *Compensation* does not include reimbursed expenses, bonuses, cash awards, or other remuneration payable other than in cash.

2.6 **Dependent Care Flexible Spending Account Plan ("Dependent Care FSA")** is the arrangement set forth in Appendix A through which eligible Employees may be reimbursed for certain dependent care expenses.

2.7 **Effective Date** means the date the Plan becomes operative; the initial Effective Dates were August 1, 1996 with respect to the Premium Conversion Plan; January 1, 2001 with respect to the Dependent Care FSA; and January 1, 2005, for the Health Care FSA. This amended and restated Plan is effective as of January 1, 2016, except as otherwise provided herein.

2.8 **Employee** means a member of the Board, Committee, or Williamson County Board of Education ("Board of Education") who, under applicable law, is considered eligible to participate in the Plan; or a person currently performing personal services under his or her Employer's control in any job category (see Article 3.1):

(A) on a regular full-time work schedule as defined by the Employer;

(B) who otherwise satisfies the applicable participation requirements under the Plan.

Employee does not mean:

(1) a self-employed individual, as defined in Code section 401(c)(1)(B),

(2) a member of the Board, Committee, or Board of Education who is not an employee, as defined in Treasury Regulation Section 1.125-1,

(3) a person the Plan Administrator determines is the Employer's independent contractor, and

(4) a person the Plan Administrator determines the Employer has engaged as a consultant or advisor on a retainer or fee basis.

2.9 **Employer** means the Williamson County Government and any affiliated entity or organization (including the Williamson County Board of Education) and any successor(s) of any of them which, with the approval of the Employer, and subject to such conditions as the Employer may impose, may adopt the Plan as permitted by federal law. However, for purposes of Article VII below, the term "Employer" shall mean the Williamson County Government.

2.10 **FMLA** means the Family and Medical Leave Act of 1993, as amended.

2.11 **Health Care Flexible Spending Account Plan ("Health Care FSA")** is the arrangement set forth in Appendix B through which eligible Employees may be reimbursed for certain medical expenses.

2.12 Health Savings Account ("HSA") means an account (as defined in Section 223(d) of the Code) an eligible Employee establishes with the HSA trustee or custodian the Employer designates to administer the account on behalf of the Employee.

2.13 Period of Coverage means the Plan Year with respect to Premium payment benefits and reimbursement benefits. However, if an individual begins to participate in the Plan during the Plan Year, the Period of Coverage requirement shall commence only after the Employee satisfies the applicable requirements in Article III below. The Period of Coverage requirement shall not apply to HSA contributions.

2.14 Plan means the Williamson County Government Amended and Restated Premium Conversion and Flexible Benefit Plan as set forth in this document and in Appendices A and B and as amended from time to time.

2.15 Plan Administrator means the Committee or person(s) appointed pursuant to section 7.1 and who is/are authorized and responsible for managing and directing the operation and administration of the Plan.

2.16 Plan Year initially meant the short Plan Year that began August 1, 1996 and ended December 31, 1996, with respect to the premium conversion portion of the Plan. Thereafter, the Plan Year for the premium conversion feature means the 12-month period beginning January 1 and ending December 31 of each year. Plan Year means the 12-month period that begins on January 1 and ends on December 31 of each year with respect to the HSA, Health Care FSA, and Dependent Care FSA features under the Plan.

2.17 Uniformed Services means the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or emergency.

ARTICLE III

ELIGIBILITY, PARTICIPATION, AND COVERAGE

3.1 Eligibility.

(A) Any Employee defined in Sections 2.8(A) and (B):

(1) shall become eligible to participate in the portion of the Plan described in Section 4.3(A) (premium payments) thirty-one days after the date of the individual's date of hire; and

(2) shall become eligible to participate in the portions of the Plan described in Section 4.3(B)(1) (Dependent Care FSA) and 4.3(B)(2) (Health Care FSA) thirty-one days after the date of the individual's date of hire .

Subject to Section 5.1(C), a newly eligible Employee may elect to participate on (1) the date the Employee first becomes eligible (under this Article III or Section 5.1(F)); or (2) the first day of any Plan Year thereafter.

(B) Any time an Employee spends on an FMLA leave or during an absence from work for duty in the Uniformed Services will count toward fulfilling any length-of-service requirement, as required by law.

3.2 Participation. Employees become Plan participants as of the date they satisfy the eligibility requirements of Section 3.1 and the enrollment and election requirements of Section 5.1.

3.3 Coverage.

(A) Date Coverage Begins. Eligible Employees become covered Employees as of the date specified in Section 5.1(C).

(B) Coverage During Leave of Absence.

(1) Paid Leave. During a paid leave of absence, an Employee shall continue to participate in the benefits he or she elected, except that participation in the Dependent Care FSA portion of the Plan described in Appendix A will be suspended on the day on which the Employee's paid leave began. If the Employee returns to active employment in the same Plan Year as the paid leave began, any Dependent Care FSA benefit shall be automatically reinstated as of the date of such return to active employment, and any salary reduction agreement shall be reinstated and adjusted to reflect the period of suspension.

(2) Unpaid Leave. Except as provided in Section 3.3(F) below, Plan coverage for an Employee on an approved unpaid leave of absence shall be terminated on the last date of coverage for which the Employee makes a contribution for the premium payment benefit (described in Section 4.3(A)) and/or the Health Care FSA benefit described in Appendix B. Notwithstanding any other provision to the contrary, the Employee's participation in the Dependent Care FSA shall be terminated on the day on which the Employee's leave began.

The terms of the particular benefit plan (identified in Section 4.3(A)) under which the participant receives premium payment benefits shall control whether and to what extent coverage and benefits under that plan will continue. If the Employee remains eligible to participate in the particular benefit plan during the leave of absence and desires to continue participating, before going on leave the Employee may pre-pay the amount of premiums or contributions due during the leave or the Employee may pay the amounts due with after-tax contributions on the same schedule as payments would have been made if the Employee were not on leave.

(C) Date Coverage Ceases. Plan coverage ceases on the earliest of:

(1) the last day during which the Employee last satisfies the eligibility and participation requirements of Sections 3.1 and 3.2, respectively,

(2) the date coverage ceases in accordance with Section 3.3(B),

(3) the effective date of a Plan amendment that terminates coverage for the Employee's job category, or

(4) the date of Plan termination.

(D) Effect of Terminated Coverage. Termination of coverage automatically cancels an Employee's salary reduction agreement and benefit elections on the date coverage terminates. The terms of the particular benefit plans described in Article IV that govern the Employee's premium payment benefits shall control whether and to what extent coverage and benefits under the particular plan will continue.

(E) Reinstatement of Coverage.

(1) If Coverage Terminated Because of Leave of Absence. Except as hereinafter provided, a former Employee who returns to an Employer's service during the same Plan Year he or she took an unpaid leave of absence and lost coverage under the Plan may make new benefit elections for the remainder of the Plan Year to the extent provided under the change in status provisions in Section 5.1(F).

(2) If Coverage Terminated Because of Employment Termination. A former Employee who returns to an Employer's service during the same Plan Year in which he or she terminated employment must again satisfy the eligibility and participation requirements of Sections 3.1 and 3.2, respectively, and shall not be eligible to participate until the next Plan Year, except as required under the Section F below.

(F) Coverage Under Family and Medical Leave Act, Uniformed Services Employment and Reemployment Rights Act, and the Consolidated Omnibus Budget Reconciliation Act.

(1) Family and Medical Leave Act of 1993. If not otherwise provided for herein, the Plan shall provide coverage for an eligible Employee solely to the extent necessary to comply with the Family and Medical Leave Act of 1993 ("FMLA"), and the Plan shall be interpreted and administered as necessary to comply with FMLA and the rulings and regulations issued thereunder.

(2) Uniformed Services Employment and Reemployment Rights Act. An eligible Employee who is on an unpaid leave during a period of duty in the Uniformed Services may, at the Employee's option, continue benefits (except the Dependent Care FSA benefits) under the Plan to the extent required by law so long as the Employee continues to make any required contributions as set forth in Section 3.3(B)(2).

(3) Coverage Contingent Upon Contribution. Any coverage provided as a result of this Section 3.3(F) shall continue so long as the Employee continues to pay the applicable contributions required for the particular benefit and as permitted or required by law.

(4) COBRA. An Employee's COBRA continuation coverage rights with respect to Health Care FSA benefits shall be governed by Code Section 4980B and Treasury Regulation Section 54.4980B.

ARTICLE IV

BENEFITS

4.1 Benefit Options. As a condition of Plan participation, an eligible Employee must elect either:

(A) to receive the full unreduced compensation benefit described in Section 4.2, or

(B) to forego all or part of the unreduced compensation benefit described in Section 4.2 and make pre-tax contributions in exchange for premium payment benefits, HSA benefits, and/or reimbursement account benefits described in Section 4.3.

4.2 Unreduced Compensation Benefit. In lieu of the benefits described in Section 4.3 that an eligible Employee otherwise could elect, he or she may elect to receive unreduced compensation. The unreduced compensation benefit is subject to the Employer's regular payroll practices; applicable local, state, and federal income tax withholding; employment taxes; and other applicable deductions. The unreduced compensation benefit is not additional Compensation. The unreduced compensation benefit shall cease whenever the Employee goes on an unpaid leave of absence, terminates employment, or the Employer determines, in its sole discretion, that Compensation is not payable to such Employee.

4.3 Premium Payment, HSA, and Reimbursement Benefits. By electing premium payment benefits, HSA benefits, and/or reimbursement benefits, an Employee converts a portion of his or her Compensation for the Plan Year into contributions to the particular plan or program that governs the selected benefit. The terms of the particular plan or program, as amended from time to time, shall govern an Employee's rights and obligations under it. Employees may elect one or more of these benefits.

(A) Premium Payment Benefits. A participant may elect to participate in one or more of the plans identified on the attached Schedule 1 (as may be amended from time to time) and may elect any available coverage level under such plan as the premium payment benefit.

(**B) Reimbursement Benefits.**

1) Dependent Care FSA Benefit. If under the terms of the Dependent Care FSA arrangement (described in Appendix A) an Employee is eligible to participate in that program, he or she may elect any reimbursement level available under the program as the Dependent Care FSA benefit.

(2) Health Care FSA Benefit. If under the terms of the Health Care FSA arrangement (described in Appendix B) an Employee is eligible to participate in that program, he or she may elect any reimbursement level available under the program as the Health Care FSA benefit.

(C) Health Savings Account ("HSA") Contributions.

If an Employee participates in the Employer's "high deductible" group health plan and is an "eligible individual" as defined in Section 223(c) of the Code, the individual may elect benefits under the Health Savings Account portion of the Plan by electing to make Health Savings Account contributions on a pre-tax salary reduction basis

subject to the maximum amount permitted in Code Section 223 and as permitted under Code Section 125(d)(2)(D). In addition the Employer may make contributions to the Health Savings Account for the benefit of an eligible Employee and shall comply with Treasury Regulation Section 54.4980G-5 and any applicable superseding guidance.

The Employer must follow the Employees' properly completed elections to reduce their Compensation in exchange for benefits under the Plan. Subject to the provisions in Section 5.12 below and the Health Care FSA arrangement (described in Appendix A), Employees shall forfeit unused salary reductions, as required under applicable law. Forfeitures may not be cashed out or applied toward any other Plan benefit.

4.4 Limits For Certain "Highly Compensated Participants" and "Key" Employees. Benefits payable under the Plan to each highly compensated participant and key employee, as defined in Code Sections 125(e) and 416(i)(1), respectively, are limited to the extent necessary to avoid violating the nondiscrimination requirements under Code Sections 125(b)(1) and 125(b)(2).

4.5 Notification of Premium Payment Benefit and Reimbursement Benefit Amounts. Prior to the initial and annual enrollment/election period (described in Article V below), the Plan Administrator shall provide written notification to eligible Employees and participants of the amount of the premium payment benefits, HSA contributions, and reimbursement benefits available under the Plan. The amount of the premium payment benefits shall be the contributions required of the Employee to participate in the group health or other benefit plan(s) for which a premium payment benefit is available under the Plan. Any such written notification is hereby incorporated by reference and made part of the Plan. Subject to the dollar limits available under the Plan, Employees may elect the amount of reimbursement benefits as discussed in Appendix A and Appendix B.

4.6 Application of Other Plans. Notwithstanding any other provision of the Plan, an Employee electing one or more premium payment benefits under the Plan shall be subject to the provisions, conditions, limitations, and exclusions of the health and/or other benefit plan(s) listed in Section 4.3 for which he/she elects the premium payment benefit. All applicable documents of such plans are hereby incorporated by reference to the extent their provisions apply to or affect the operation of this Plan and do not conflict with applicable "cafeteria plan" requirements.

ARTICLE V

PROCEDURES

5.1 Enrollment/Election Procedures

(A) Elections.

(1) Automatic Elections for Premium Payment Benefits. An eligible Employee shall be deemed to elect to make salary reductions to pay the entire amount of his or her share of the premium(s) required for the benefits the Employee elected under Section 4.3 above unless he or she affirmatively elects otherwise before the Period of Coverage begins.

(2) **Reimbursement Benefits.** An eligible Employee may enroll, make elections, and direct the Employer to make salary reductions for reimbursement benefits by filing the appropriate, completed forms or agreements with the Plan Administrator before the Period of Coverage begins.

(B) **Annual Enrollment**. Approximately one to three months before each Plan Year begins, the Plan Administrator shall provide an open enrollment period during which Employees may make new elections or change existing ones for the next Plan Year.

(C) **Deadlines.**

(1) **Initial Enrollment/Election For New Employees.** For an Employee who becomes eligible after the first day of a Plan Year but before the next annual enrollment period (described in Section 5.1(B)), the Plan Administrator shall provide enrollment forms, salary reduction agreement forms (as applicable), and other necessary information to a new Employee as soon as possible but no later than 30 days before the Employee becomes eligible to participate in the Plan. The Employee must complete and return the prescribed forms to the Plan Administrator before the date on which the Employee becomes eligible for benefits under the Plan to elect coverage under the Plan for the period beginning on the date the Employee becomes eligible and continuing through the remaining portion of the Plan Year. Enrollments, elections and salary reduction agreements timely made shall be effective as of the first payroll period following the date the Employee becomes eligible to participate.

(2) **Annual Enrollment/Election For Current Employees.** For Employees who become eligible as of the first day of a Plan Year, the deadline for enrolling and making elections is the date the Plan Administrator specifies as set forth in Section 5.1(B) above.

(D) **Missed Deadline Yields "Default Election".**

(1) **Enrollment Regarding Premium Payment Benefits.** With respect to premium payment benefits, an Employee who fails to timely submit a valid form electing not to make pre-tax premium payments shall be subject to the automatic election in Section 5.1(A)(1) above.

(2) **Enrollment Regarding Reimbursement Benefits.** Any Employee who fails to timely submit a valid enrollment/election form and salary reduction agreement for reimbursement benefits shall be deemed to have declined participation in the Plan and will not be eligible to participate in the Plan until the next Plan Year, except as provided in Section 5.1(F) below.

(3) **Enrollment Regarding HSA Contributions.** An Employee's right to elect HSA contributions shall be made in accordance with Section 5.1(G) below.

(E) **Validity of Enrollment/Election Forms and Salary Reduction Agreements.**

(1) **Plan Administrator Approval.** Enrollment and election forms and salary reduction agreements will take effect only if valid, as determined by the Plan Administrator.

(2) Remedial Modification or Rejection. The Plan Administrator may modify or reject any enrollment and election form and/or salary reduction agreement or take other action it deems appropriate under rules uniformly applicable to similarly situated persons to satisfy nondiscrimination requirements of Code section 125(b). Any remedial modification, rejection or other action the Plan Administrator makes must be on a reasonable basis that does not discriminate in favor of highly compensated individuals or participants, as defined in Code sections 125(e)(1) and (2), respectively, or key employees, as defined in Code section 416(i)(1).

(F) Changing Elections For Premium Payment Benefits and Reimbursement Benefits.

(1) General Rule. Except as provided in Section 5.1(G) below, all elections (including default elections described in Section 5.1(D)) and salary reduction agreements shall remain in force during the entire Plan Year to which they apply unless changed or revoked as provided in this Section 5.1(F). During the annual enrollment period, however, Employees may make new benefit elections or change existing ones for the forthcoming Plan Year.

(2) Revocation of Election Upon Termination of Employment or Change in Status. Except as provided in Article III and this Section 5.1(F), elections (including default elections) and salary reduction agreements for a Plan Year shall be irrevocable.

(a) Termination of Employment. Employees' elections (including default elections) and salary reduction agreements shall be revoked upon termination of employment.

(b) Change in Status. An eligible Employee may revoke any election (including a default election) and make a new one if needed or appropriate because of--and within 30 days after--a *change in status* that affects eligibility for coverage under the Plan. *Change in status* means:

(i) the Employee's marriage, divorce, annulment, or legal separation;

(ii) the birth, adoption, or placement for adoption, of an Employee's child;

(iii) the death of the Employee's spouse or child;

(iv) a change in the Employee's employment status or the employment status of the Employee's spouse or dependent (e.g., termination or commencement of employment, reduction or increase in work hours, strike or lockout or new worksite);

(v) the Employee or the Employee's spouse commences or returns from an unpaid leave of absence;

(vi) a change in the Employee's job class that affects his eligibility for coverage under a plan listed in Section 4.3;

(vii) a significant change in health care coverage of the Employee or the Employee's spouse through the plan of the spouse's employer, and

(vii) a dependent satisfies or ceases to satisfy eligibility requirements for coverage under the Plan because of age.

A timely election and salary reduction change must be consistent with the *change in status* and must take effect as of the first payroll period following receipt by the Plan Administrator of the new election form, but not earlier than the date of the change in status.

(3) Changes in Cost. (These rules do not apply to Health Care FSA benefits under Appendix B.)

(a) Automatic Increase or Decrease for Insignificant Cost Changes. If the cost of a benefit increases or decreases during a Plan Year by an insignificant amount, then the Plan shall automatically make a prospective increase or decrease, as applicable, in each affected Employee's pretax contributions or aftertax contributions (as applicable) to reflect such change. The Plan Administrator, on a reasonable and consistent basis, will automatically effectuate this prospective increase or decrease. The Plan Administrator (in its sole discretion) will decide, in accordance with prevailing IRS guidance, whether increases or decreases in costs are "insignificant" based upon all the surrounding facts and circumstances (including, but not limited to, the dollar amount or percentage of the cost change).

(b) Significant Cost Increases/Decreases. If the Plan Administrator determines the cost of a benefit significantly increases during a Plan Year, an Employee may make a corresponding prospective increase in his or her contributions, or revoke his or her election, and in lieu thereof, receive coverage under another Plan option which provides similar coverage, or the Employee may drop coverage if no similar coverage is available. If the Plan Administrator determines the cost of an Employee's benefit significantly decreases during a Plan Year, the individual may revoke his or her election, and in lieu thereof, receive coverage under the decreased Plan option which provides similar coverage. In the event of a decrease, eligible Employees who were not previously enrolled could elect the decreased Plan option. The Plan Administrator (in its sole discretion) will decide, in accordance with prevailing IRS guidance, whether a change in cost is significant and what constitutes "similar coverage" based upon all the surrounding facts and circumstances.

(c) Limitation on Change in Cost Provisions for Dependent Care FSA Benefits. The above "Change in Cost" provisions apply to Dependent Care Reimbursement Accounts under Appendix A *only* if the cost change is imposed by a dependent care provider who is not

a "relative" of the Employee by blood or marriage. For this purpose a relative is an individual who is related to the Employee by a relationship described in Code Section 152(a) or other IRS guidance, taking into account the rules under Code Section 152(f).

(4) Change in Coverage. (These rules do not apply to Health Care FSA benefits under Appendix B.)

(a) Significant Curtailment. If the Plan Administrator determines that an Employee's coverage under this Plan is significantly curtailed during a Plan Year but does not result in a loss of coverage, the Employee may revoke his or her election under the Plan subject to the following limitation. In that case, each affected Employee may prospectively elect coverage under another benefit option which provides similar coverage but the individual cannot drop coverage. If the Plan Administrator determines that an Employee's coverage under this Plan is significantly curtailed and results in a loss of coverage, the Employee may elect coverage under another benefit option which provides similar coverage, or the individual may drop coverage if no other similar option is available. Coverage under an accident or health plan is deemed "significantly curtailed" only if there is an overall reduction in coverage provided to Employees under the Plan so as to constitute reduced coverage to Employees in general. The Plan Administrator (in its sole discretion) will decide, in accordance with prevailing IRS guidance, whether a curtailment is "significant," and whether a substitute benefit constitutes "similar coverage" based upon all the surrounding facts and circumstances.

(b) Addition or Significant Improvement of Benefit Package Option. If, during a Plan Year, the Plan adds a benefit or significantly improves an existing benefit option, an affected Employee may revoke his or her election and make a new election on a prospective basis for coverage under the new or improved benefit plan. Participants who previously waived coverage may elect to participate in the new or improved benefit. The Plan Administrator (in its sole discretion) will decide, in accordance with prevailing IRS guidance, whether there has been a "significant improvement" in a benefit option.

(c) Change in Coverage of Spouse or Dependent Under Their Employer's Plan. An Employee may make a prospective election change that is on account of and corresponds with a change made under another employer plan (including the Plan or the plan of the spouse's, former spouse's, or dependent's employer), so long as (a) the cafeteria plan or qualified benefits plan of the spouse's, former spouse's, or dependent's employer permits its participants to make an election change that would be permitted under IRS regulations; or (b) the Plan permits Employees to make elections for a period of coverage that is different from the period of coverage under the cafeteria plan or qualified benefits plan of the spouse's, former spouse's, or dependent's employer. The Plan Administrator shall determine, based on prevailing IRS guidance, whether a requested

change is on account of and corresponds with a change made under the plan of the spouse's, former spouse's, or dependent's employer.

(5) **HIPAA Special Enrollment Rights.** If an eligible Employee or an eligible Employee's spouse or dependent is entitled to special enrollment rights under a group health plan, as required by Code Section 9801(f), and medical coverage was declined under the group health plan because of the existence of outside medical coverage and eligibility for such coverage is subsequently lost due to legal separation, divorce, death, termination of employment, reduction in hours, or exhaustion of the maximum COBRA period, or if a new dependent is acquired as a result of marriage, birth, adoption, or placement for adoption, then an eligible Employee may revoke a prior election for health coverage and make a new election (including salary reduction election) on a prospective basis, provided that the election corresponds with such special enrollment rights and it is made no later than 30 days after the loss of the other medical coverage. For purposes of this provision, (1) an election to add previously eligible dependents as a result of the acquisition of a new spouse or dependent child shall be considered to be consistent with the special enrollment rights; and (2) a HIPAA special enrollment election attributable to the birth or adoption of a new dependent child may, subject to the provisions of the underlying group health plan, be effective retroactively (up to 30 days).

(6) **Certain Judgments, Decrees and Orders.** If a judgment, decree, or order resulting from a divorce, legal separation, annulment or change in legal custody (including a qualified medical child support order) requires health coverage for an eligible Employee's dependent child (including a foster child who is a dependent of the eligible Employee), an eligible Employee may: (1) change his or her election to provide coverage for the dependent child (provided that the order requires the eligible Employee to provide coverage); or (2) change his or her election to revoke coverage for the dependent child if the order requires that another individual (including the eligible Employee's spouse or former spouse) provide coverage under that individual's plan if the other coverage is actually obtained.

(7) **Medicare and Medicaid.** If an Employee or an Employee's spouse or dependent who is enrolled for health coverage under this Plan becomes entitled to Medicare or Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act providing for pediatric vaccines), the Employee may prospectively reduce or cancel the health coverage of the person becoming entitled to Medicare or Medicaid. Further, if an eligible Employee or an eligible Employee's spouse or dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, then the eligible Employee may prospectively elect to commence or increase the health coverage under the Plan.

An eligible Employee entitled to make a new election under this Section 5.1(F) must do so within 30 days after the event. An Employee who is eligible to elect benefits but declined to do so during the initial election period, or during a subsequent open enrollment period, may file a pretax contribution election change within 30 days after the occurrence of an event described in this Section 5.1(F), but only if the election

under the new salary reduction agreement is made on account of and corresponds with the event. Subject to the provisions of the underlying group health plan, elections made to add medical coverage for a newborn or newly adopted dependent child pursuant to a HIPAA special enrollment right may be retroactive for up to 30 days. All other new elections shall be effective prospectively for the pay period immediately following the date the eligible Employee files his new salary reduction agreement with the Plan Administrator.

(G) Changing Elections for HSA Contributions. An eligible Employee who elects to make HSA contributions may start and stop the election or increase or decrease the election as of the first day of any month as long as the change is effective prospectively and provided the Employee submits the election to the Plan Administrator no later than the 15th day of the month before the beginning of the particular month in which the change is to become effective. The Plan Administrator may place additional restrictions on the election of HSA contributions; provided however, the same restrictions shall apply to all Employees and shall comply with applicable law.

5.2 General Claim Procedures. Except as hereinafter provided, the provisions of this Section shall apply to every claim for a benefit under the Plan regardless of the basis asserted for the claim and regardless of when the act or omission upon which the claim is based occurred. Claims relating to a plan governing a specific medical, dental, prescription drug and/or vision benefit are reviewable only under that particular plan's terms.

Claim procedures for the Dependent Care FSA arrangement shall be as modified in Appendix A.

Claim procedures for the Health Care FSA arrangement shall be as modified in Appendix B.

5.3 Claims Administration. The Plan Administrator shall have the duty to receive and review claims for benefits under the Plan, to determine what amount, if any, is due and payable under the terms and conditions of the Plan, and to make appropriate disbursements of benefit payments to persons entitled thereto.

5.4 Claimants. An Employee (or his duly authorized representative) may file a claim for benefits to which such claimant believes he or she is entitled. The Plan Administrator may establish reasonable procedures for determining whether an individual has been authorized to act on behalf of an Employee.

5.5 Claim Forms. The Plan Administrator shall furnish to a claimant, upon request, the form(s) required for filing a claim for benefits under the Plan.

5.6 Deadline for Filing a Claim. Except for Dependent Care FSA and Health Care FSA benefits, no claim for Plan benefits incurred during a particular Plan Year shall be payable unless a properly completed claim form, including all necessary documentation of supplies and services rendered, is received by the Plan Administrator during that Plan Year or no later than March 31 following the last day of the Plan Year in which the claim was incurred.

5.7 Proof of Claim. As a condition of receiving a Plan benefit and as often as the Plan Administrator determines is reasonably necessary, an Employee must submit such evidence as the Plan Administrator shall require for purposes of determining whether a claim is reimbursable under the terms of the Plan.

5.8 Decision on the Claim. Unless special circumstances require an extension of time for processing the claim, the Plan Administrator shall send to the claimant by mail, postage prepaid, notice of the decision on the claim within a reasonable period of time but not later than 30 days after the Plan Administrator receives the claim. If an extension is necessary, the claimant shall be given a written notice of the required extension prior to the expiration of the initial 30-day period. The period may be extended one time for up to 15 days, provided the Plan Administrator determines an extension is necessary due to matters beyond the control of the Plan. If the claimant fails to submit sufficient information for the claim to be decided, the notice of extension shall specifically describe the required information needed, and the claimant shall have 45 days from the receipt of the notice to provide the requested information. The notice shall indicate the circumstances requiring the extension and the date by which the Plan Administrator expects to render a decision.

5.9 Notification of Denial. If a claim is denied, in whole or in part, the claimant shall be notified of the denial in writing. The notice of denial shall contain the following information: the specific reason(s) for the denial; a reference to the specific provision(s) in the Plan on which the denial is based; a description of additional material or information necessary to perfect the claim and an explanation of why the material or information is needed; and an explanation of the procedure to appeal the denial.

5.10 Right to Appeal. A claimant whose claim for benefits under the Plan has been denied, in whole or in part, shall have the right to appeal the denial.

(A) Documentation for Appeal. The petition for appeal shall be in writing and shall state the name and address of the claimant; the fact that the claimant is disputing the denial of a claim; the date of the notice of denial; and the reason(s), in clear and concise terms, for disputing the denial. The petition shall include pertinent documentation.

(B) Deadline for Filing Appeal. The petition for appeal shall be delivered to the Plan Administrator within 180 days after receipt of the notice of denial. Failure to file a petition for appeal within the 180-day period shall constitute a waiver of the claimant's right to appeal the denial. During the 180-day period, the claimant shall have the opportunity upon written request to the Plan Administrator to review documents, records or other information relevant to the claimant's claim for benefits and may submit issues or comments in writing. The claimant shall be provided reasonable access to, and copies of, the relevant information free of charge. Upon good cause shown, the Plan Administrator may permit the petition to be amended or supplemented.

(C) Decision on Appeal. Unless special circumstances require an extension of time for processing, a decision on appeal shall be made by the Plan Administrator within 60 days after receipt of the written petition for appeal. If an extension is necessary, the claimant shall be given a written notice of the required extension prior to the expiration of the initial 60-day period. The notice shall indicate the circumstances requiring the extension and the date by which the Plan Administrator expects to render a decision. In no event may the extension exceed 60 days from the end of the initial period.

(D) Notification of Determination on Appeal. The claimant shall be advised of the determination on appeal in writing, stating the specific reason(s) for the decision and

specific reference(s) to the provision(s) of the Plan on which the decision is based. The notice shall include a statement that the claimant is entitled upon request and free of charge, reasonable access to, and copies of, documents, records, and other information relevant to the claimant's claim for benefits. The decision of the Plan Administrator on appeal shall be final and binding on all parties including the claimant and any person claiming under the claimant.

5.11 Legal Remedy. Before pursuing a legal remedy, a claimant shall first exhaust all claims and appeals procedures required under the Plan.

5.12 Payment Procedures.

(A) Payment of Claim. Benefits shall be payable to the claimant upon establishment of the right thereto. Notwithstanding the foregoing, if a claimant is adjudicated bankrupt or purports to anticipate, alienate, sell, transfer, assign, pledge, encumber, or charge any benefit payable under the Plan, voluntarily or involuntarily, the Plan Administrator, in its sole discretion, may hold or cause to be held, or apply such payment of benefit, or any part thereof, to or for the benefit of such claimant as the Plan Administrator deems appropriate.

(B) Facility of Payment. If a claimant dies before all amounts payable under the Plan have been paid, or if the Plan Administrator determine that the claimant is a minor or is incompetent or incapable of executing a valid receipt and no guardian or legal representative has been appointed, or if the claimant fails to provide the Plan with a forwarding address, the amount otherwise payable to the claimant may be paid to any other person or institution the Plan Administrator reasonably determines to be entitled to receive the payment without any prejudice to the Plan Administrator. Any payment made in accordance with this provision shall discharge the obligation of the Plan hereunder to the extent of such payment.

(C) Forfeiture.

(1) Unclaimed Benefits. The Plan Administrator shall take reasonable steps to ascertain the whereabouts of a claimant so as to effect delivery of benefits payable under the Plan. If a claimant has not collected benefits payable to him or her within 15 months from the date the claim was filed, the Plan Administrator may, three months after sending by certified mail a written notice of benefits to the last known address of such claimant as shown on the records of the Administrator, deem the claimant's rights to such benefit waived. Upon such waiver, the Plan shall have no liability for payment of the benefit otherwise payable.

(2) Health Savings Accounts. Any balance remaining in a participant’s HSA Account at the end of any Plan Year shall be carried forward and used to fund benefits in any subsequent Plan Year. Notwithstanding any provision to the contrary, no participant’s HSA Account balance shall be subject to forfeiture.

ARTICLE VI

CONTRIBUTIONS AND PLAN ASSETS

6.1 Contributions.

(A) Employer Contributions. The Employer shall pay an Employee's premiums and other contributions for the Employer-sponsored plans (identified in Section 4.3 and as required under those plans) provided the Employee submits written authorization in the form and manner required by the Plan Administrator for pre-tax and/or after-tax salary reductions and/or the Employee is subject to an automatic election under Article V above.

Notwithstanding any contrary Plan provision, the Employer is not obligated to deposit contributions into the Plan after it is terminated except to the extent required to pay benefits outstanding on the date the termination is adopted or, if later, effective.

(B) Salary Reductions. As a condition of Plan participation with respect to the applicable benefits under Section 4.3, Employees shall be subject to automatic elections under Article V or must agree to direct the Employer to reduce their Compensation and make pre-tax contributions to the plan governing their selected benefit(s).

The salary reduction of an Employee shall equal the sum of the Employee's share of contributions for benefits the Employee selects. Any election of benefits shall be null and void unless the Employee is subject to an automatic election for the particular benefit or the Employee authorizes salary reduction as provided for herein for the selected benefit. The Employer must apply contributions authorized by salary reduction as directed, and the Employer may not apply contributions authorized for a selected benefit to any other benefit nor may such contributions be applied during a subsequent Plan Year to any participating plan that provides benefits or coverage, except as permitted by law and the terms of this Plan.

6.2 Plan Assets. The Employer shall make payments provided for in Section 6.1(A) solely from its general assets.

ARTICLE VII

ADMINISTRATION

7.1 Plan Administrator. The Board has appointed the Committee to serve as Plan Administrator.

7.2 Plan Administrator's Duties. The Plan Administrator shall:

(A) manage and carry out the Plan's operation and administration according to the Plan's terms and applicable law;

(B) maintain:

(1) whatever records and data are necessary or desirable for the Plan's proper operation and administration, and

(2) the Plan's governing documentation for inspection by anyone who participates or is eligible to participate in the Plan;

(C) notify Employees eligible to participate in the Plan of:

(1) the Plan's availability and terms,

(2) the benefits available for election,

(3) the maximum annual salary reduction amounts for each available benefit, and

(4) the procedures for enrolling and making and changing elections;

(D) supply eligible Employees with any forms and agreements they must complete;

(E) prepare and file all annual reports or returns, plan description, financial statements, and other documents required by law or under the Plan's terms; and

(F) record its and the Employer's acts and determinations regarding the Plan and preserve these records in its custody.

7.3 Plan Administrator's Powers. Except as expressly limited or reserved in the Plan to the Board or the Employer, and except with regard to contractual approvals and budgetary decisions that are reserved to the Board of Commissioners or other designated subcommittees thereof by operation of state law, the Plan Administrator shall have the exclusive authority and right to exercise, in a uniform and nondiscriminatory manner, full discretion with respect to the administration, operation, and interpretation of the Plan. Without limiting the generality of the foregoing rights, the Plan Administrator shall have full power and discretionary authority to:

(A) require any person to furnish such information as the Plan Administrator may request from time to time and as often as the Plan Administrator determines reasonably necessary for the purpose of proper administration of the Plan and as a condition to the individual's receiving benefits under the Plan;

(B) make and enforce such rules and prescribe the use of such forms as the Plan Administrator determines reasonably necessary for the proper administration of the Plan;

(C) interpret the Plan and decide all matters arising under the Plan, including the right to remedy possible ambiguities, inconsistencies, or omissions;

(D) determine all questions concerning the eligibility of any individual to participate in, be covered by, and receive benefits under the Plan pursuant to the provisions of the Plan;

(E) determine whether objective criteria set forth in the Plan have been satisfied respecting any term, condition, limitation, exclusion, and restriction or waiver thereof;

(F) determine the amount of benefits payable, if any, to any person or entity in accordance with the provisions of the Plan; to inform the Employer or any other third party, as appropriate, of the amount of such benefits; to make claims decisions under the terms of the Plan; and to provide a full and fair review to any individual whose claim for benefits has been denied in whole or in part; provided, however, that any claim for benefits under a plan listed in Section 4.3 shall be determined solely in accordance with the terms of such plan;

(G) delegate to other person(s) any duty that otherwise would be a fiduciary responsibility of the Plan Administrator under the terms of the Plan;

(H) engage the services of such person(s) and entity or entities as it deems reasonably necessary or appropriate in connection with the administration of the Plan, at no additional cost to the Board except with the Board's prior approval;

(I) pay all reasonable and appropriate expenses in connection with the management and administration of the Plan including, but not limited to, premiums or other considerations payable under the Plan and fees and expenses of any actuary, accountant, legal counsel, or other specialist engaged by the Plan Administrator, but at no additional cost to the Board except with the Board's prior approval; and

(J) construe the Plan, including any uncertain or disputed term or provision, and to make factual findings on all Plan matters.

7.4 Finality of Decisions. The Plan Administrator shall have full power, authority and discretion to enforce, construe, interpret and administer the Plan. All decisions and determinations of the Plan Administrator with respect to any matter hereunder shall be conclusive and binding on Employees and all other interested parties.

7.5 Compensation and Bonding of Plan Administrator. Unless otherwise agreed to by the Employer, the Plan Administrator shall serve without compensation for services as such, but all reasonable expenses incurred in the performance of the Plan Administrator's duties shall be paid as specified in Section 9.17. Unless otherwise determined by the Employer or unless required by federal or state law, the Plan Administrator shall not be required to furnish bond or other security in any jurisdiction.

7.6 Reserved Powers. The Board (or its duly authorized representative) reserves the power, among others:

(A) to adopt the Plan;

(B) to terminate, amend, or merge the Plan according to Article VIII; and

(C) to appoint and remove any Plan Administrator.

ARTICLE VIII

AMENDMENT, TERMINATION, OR MERGER OF PLAN

8.1 Right to Amend the Plan. Except as provided in Section 8.3 and subject to Section 7.3, the Purchase and Insurance Committee shall have the right to amend the Plan at any time for any reason whatsoever and to delegate among its members the authority under this Section 8.1. Any amendment to the Plan shall be in writing and shall be duly adopted by the Committee in accordance with its regular procedures.

8.2 Right to Terminate or Merge the Plan. Notwithstanding that the Plan is established with the intention it be maintained indefinitely, the Board (or its duly authorized representative) reserves the unlimited right to terminate or merge the Plan as decided by the Board (or its authorized representative), at any time.

8.3 Effect of Amendment, Termination or Merger. Any amendment, termination or merger of the Plan shall be effective at such date as the Committee or Board, as applicable, shall determine except that no amendment, termination or merger may be retroactive unless remedial to comply with a law or regulatory requirement to which the Employer or the Plan is subject.

ARTICLE IX

MISCELLANEOUS

9.1 No Employment Rights. The Plan is a voluntary undertaking of the Employer and does not constitute a contract with any person. The Plan is not an inducement or condition of an Employee's employment with the Employer. Neither the establishment of the Plan, nor any modification thereof, nor any payments hereunder, shall be construed as giving to any Employee or any other person, any legal or equitable rights against the Employer, or its directors, officers, employees or agents, or as giving any person the right to be retained in the employ of the Employer.

9.2 Exclusive Rights. No individual shall have a right to benefits under the Plan except as specified herein; and in no event shall any right to benefits under the Plan be or become vested.

9.3 No Property Rights. No one has any right, title, or interest in the property of the Employer by virtue of the Plan, nor is any person entitled to interest on any benefit amounts that may be allocated or available to him or her.

9.4 No Assignment of Benefits. Benefits payable under the Plan shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge of any kind, and any attempt to effect same shall be void.

9.5 Right to Offset Future Payments. In the event a payment or the amount of a payment is made erroneously to an individual, the Plan shall have the right to reduce future payments payable to or on behalf of such individual by the amount of the erroneous or excess payment. This right to offset shall not limit the right of the Plan to recover an erroneous or excess payment in any other manner.

9.6 Right to Recover Payments. Whenever a payment has been made by the Plan, including erroneous payments, in a total amount in excess of the amount properly payable under the Plan, irrespective of to whom paid, the Plan shall have the right to recover such payments, to the extent of the excess, from the person to or for whom the payment was made.

9.7 Misrepresentation or Fraud. An Employee who receives benefits under the Plan as a result of false, incomplete, or incorrect information or a misleading or fraudulent representation may be required to repay all amounts paid by the Plan and may be liable for all costs of collection, including attorney's fees and court costs. The Plan Administrator shall decide such matters on a case-by-case basis.

9.8 Legal Action. Before pursuing legal action, a person claiming Plan benefits or seeking redress related to the Plan must first exhaust the Plan's claim and appeal procedures. Unless otherwise mandated by law, the Employer and the Plan Administrator are the only necessary parties to any action or proceeding that involves the Plan or its administration. No Employee or other person or entity is entitled to notice of any legal action, unless a court of competent jurisdiction orders otherwise.

9.9 Governing Law. The provisions of the Plan shall be administered, and all questions pertaining to the validity or construction of the Plan and the acts and transactions of the parties shall be determined, construed, and enforced, in accordance with applicable federal law and, to the extent not preempted, the laws of the State of Tennessee.

9.10 Governing Instruments. This document, together with the documentation incorporated by reference in Sections 4.5 and 4.6 and Appendix A and Appendix B, shall comprise the legal instrument governing the Plan. In case of conflict between this document (including documentation incorporated by reference and Appendix A and Appendix B) and any other writing or evidence, the terms of this document shall govern with respect to requirements applicable to "cafeteria plans".

9.11 Savings Clause. If a provision of the Plan or the application of a provision of the Plan to any person, entity, or circumstance is held invalid under governing law by a court of competent jurisdiction, the remainder of the Plan and the application of the provision to any other person, entity, or circumstance shall not be affected.

9.12 Captions and Headings. The captions and headings of an Article, Section or provision of the Plan are for convenience and reference only and are not to be considered in interpreting the terms and conditions of the Plan.

9.13 Notices. No notice or communication in connection with the Plan made by a claimant or an Employee shall be effective unless duly executed on a form provided or approved by, and filed with, the Plan Administrator (or duly authorized representative).

9.14 Waiver. No term, condition, or provision of the Plan shall be deemed waived unless the purported waiver is in a writing signed by the party to be charged with the waiver. No written waiver shall be deemed a continuing waiver unless so specifically stated in the writing, and only for the stated period, and such waiver shall operate only as to the specific term, condition, or provision waived.

9.15 Parties' Reliance. The Employer, the Plan Administrator, and anyone to whom the Plan's operation or administration is delegated may rely conclusively on any advice, opinion,

valuation, or other information furnished by any actuary, accountant, appraiser, legal counsel, or physician the Plan engages or employs. A good faith action or omission based on this reliance is binding on all parties, and no liability can be incurred for it except as the law requires. No liability shall be incurred for any other action or omission of the Employer or its employees, except for willful misconduct or willful breach of duty to the Plan.

9.16 Disclaimer. The Employer makes no assertion or warranty about:

(A) whether Plan benefits are or will be excludable from an Employee's gross income for federal or state income tax purposes, or

(B) whether any other tax treatment is or will be applicable.

9.17 Expenses. All expenses of the Plan shall be paid from Employee contributions or by the Plan, unless otherwise paid by the Employer. The Employer may advance expenses to the Plan, subject to reimbursement, without obligating itself to pay such expenses.

9.18 Indemnification. To the fullest extent permitted by law, the Employer shall indemnify and hold harmless the named fiduciaries and any officers or employees of the Employer to whom fiduciary responsibilities have been delegated, from and against any and all liabilities, claims, losses, damages, demands, costs and expenses, including attorneys' fees, arising in connection with their duties under or arising out of an alleged breach in the performance of their fiduciary duties under the Plan, other than such liabilities, claims, losses, damages, demands, costs and expenses that result from the gross negligence or willful misconduct of such person. The Employer, at its own expense, shall conduct the defense of such person in any proceeding to which this paragraph applies, subject only to the person's unsecured obligation to repay the expenses if a court of competent jurisdiction determines the indemnification was not permitted. The Employer shall have the burden of proving that indemnification is not permitted. A person who is determined not to have any indemnification rights under this paragraph shall have a right to appeal the determination at his or her own expense. The Employer shall reimburse the person for any expenses incurred in such an appeal if the person is successful and obtains a determination confirming the person's entitlement to indemnification. The Employer may satisfy its obligations under this paragraph, in whole or in part, through the purchase of a policy or policies of insurance.

9.19 Employees' Tax Obligations.

(A) Excludability Determination. Employees must determine for themselves whether Plan benefits are excludable from their gross incomes for tax purposes, and must notify the Plan Administrator if they have reason to believe a payment is not excludable. Neither the Plan nor the Plan Administrator makes any commitment or guarantee that any amount paid to or for the benefit of an Employee under this Plan will be excludable from the Employee's gross income for federal, state or local income tax purposes, or that any other federal, state or local tax treatment will apply or be available to any Employee.

(B) Liability and Payment. If the Plan Administrator determines at any time after a Plan Year's end that Employees' salary reduction or other Employer contributions exceeded limits allowed by law for any reason including, but not limited to, erroneous information, administrative error, or a final determination that the Plan

does not qualify as a cafeteria plan under Code section 125 for the Plan Year, then Employees must:

1. pay any local, state, and federal income taxes and related penalties and interest due with respect to the excess salary reduction or other Employer contributions, and

2. reimburse the Employer for the Employee's share of any local, state, and federal tax contributions the Employer would have withheld or other applicable deductions the Employer would have taken had the excess salary reduction or other Employer contributions been treated as taxable income.

Williamson County Government has caused the Plan to be executed on its behalf by its duly authorized officials and employees effective as of the dates set forth above.

WILLLIAMSON COUNTY GOVERNMENT

By: Rogers C. Anderson

Print Name Rogers C. 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

SCHEDULE 1

WILLIAMSON COUNTY GOVERNMENT AMENDED AND RESTATED

PREMIUM CONVERSION AND FLEXIBLE BENEFIT PLAN

(Section 125 Plan)

(Effective as of January 1, 2016)

Premium Payment Benefits: Pursuant to Section 4.3(A) of the Plan, each eligible Employee may elect to participate in one or more of the benefit plans listed in the chart below (subject to the terms of the applicable plan) and, pursuant to Section 5.1(A)(1) of the Plan, the Employee shall be deemed to have elected to pay his or her share of the premiums for the benefits on a pre-tax basis, unless the individual affirmatively elects otherwise before the Period of Coverage begins:

Benefit Plan	Contract/Policy Number	Carrier/Third-Party Administrative Services Provider/Claims Administrator
Medical (High-Deductible Plan with Health Savings Account Feature)	3334791-HSAF/HSA1	Cigna Health and Life Insurance Company
Medical (Not a High-Deductible Plan)	3334791-OAP1	Cigna Health and Life Insurance Company
Dental (Williamson County Government)	8404	Delta Dental Plan of Tennessee
Dental (Williamson County Board of Education)	8405	Delta Dental Plan of Tennessee
Vision	1055970	Principal Life Insurance Corp.