Travis County Commissioners Court Agenda Request

Meeting Date: September 24, 2013
Prepared By/Phone Number: Shannon Steele, HRMD 854-6046
John Rabb HRMD, 854-2742
Elected/Appointed Official/Dept. Head: Leslie Browder, County Executive
Commissioners Court Sponsor: Judge Samuel T. Biscoe

AGENDA LANGUAGE:

Consider and take appropriate action on the following to be effective October 1, 2013:

A. Plan Document: Flexible Spending Accounts for Healthcare and Dependent Care
B. Summary Plan Description (SPD): Flexible Spending Accounts for Healthcare and Dependent Care

BACKGROUND/SUMMARY OF REQUEST AND ATTACHMENTS:

Please see attached documentation.

STAFF RECOMMENDATIONS:

HRMD Staff and the County Attorney's office have carefully reviewed both documents and recommend approval of the Plan Document and Summary Plan Description.

ISSUES AND OPPORTUNITIES:

Please see attached documentation.

FISCAL IMPACT AND SOURCE OF FUNDING:

No funding is required for the approval of the Plan Document or the Summary Plan Document. Funding for the administration of the Flexible Spending Accounts was previously approved by Commissioner's Court on August 20, 2013.

REQUIRED AUTHORIZATIONS:

Human Resources Management	Shannon Steele, 854-6046
Human Resources Management	John Rabb, 854-2742
Human Resources Management	Debbie Maynor, 854-9170
Planning and Budget Office	Leslie Browder, 854-9106

Human Resources Management

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Backup Memorandum

DATE: September 24, 2013

TO: Members of the Commissioners Court

VIA: Leslie Browder, County Executive, Planning and Budget Office

FROM: Debbie Maynor, Director, Human Resources Management Department
John Rabb, Benefits Manager
Shannon Steele, Benefits Administrator

Subject: **Plan Document and Summary Plan Description (SPD) for Travis County Flexible Spending Account Benefit**

Proposed Motion

Consider and take appropriate action on the following to be effective October 1, 2013:

A. Plan Document: Flexible Spending Accounts for Healthcare and Dependent Care
B. Summary Plan Description (SPD): Flexible Spending Accounts for Healthcare and Dependent Care

Summary

The contract for the administration of the Flexible Spending Accounts was approved by the Commissioners Court on August 20, 2013 for the plan year beginning on October 1, 2013. The administration of the plans will transition from FBMC to Total Administrative Services Corporation. The Plan Document and SPD have been updated with the new administrative information and procedures.

The Plan Document describes the Plan's terms and conditions related to the operation and administration of the Plan. The SPD summarizes the benefits and coverages of the Plan. The IRS requires that employers adopt the Plan and is a requirement for tax advantaged plans.

The Plan Document and SPD provide valuable information to members of the plan regarding the benefits of the plan and any requirements or exclusions that they need to be aware of in order to fully understand their benefits. A few examples of what might be included in an SPD are shown below:

- A description of the benefits included in the plan that is written in understandable language,
- A listing of allowed changes during the plan year,

- Claim reimbursement procedures if participating in a Medical, Dependent or Qualified Transportation Benefit, and
- Legal aspects of the plan including the appeals process, COBRA, and contact information.

Staff Recommendation:

HRMD Staff and the County Attorney's office have carefully reviewed both documents and recommend approval of the Plan Document and Summary Plan Description.

Issues and Opportunities:

Plans are required to make Summary Plan Descriptions available. Our plan is to post this information on Travis Central for ease of access by employees as well as participants through their online account with the plan administrator. A printed copy may be made by accessing online, or if needed, by contacting HRMD and a printed copy will be provided.

Budgetary and Fiscal Impact

None

Plan Document

FlexSystem®

Article I: Table of Contents

Article II: Purpose

2.01 **Creation and Title.** The Employer adopts this Cafeteria Plan as indicated by the Employer signature in Article XI - 11.01, and creates this Cafeteria Plan under the terms and conditions set forth in this Plan Document as well as through the Enrollment Communications that are expressly incorporated by reference into this Plan Document and described in Article XI - 11.06.

2.02 **Effective Date.** The original Effective Date of this Cafeteria Plan and the Effective Date of this Plan Document are identified on the Plan Schedule, see Article XI.

2.03 **Purpose.** The Plan allows Participants to elect between cash Compensation or certain nontaxable Qualified Benefits Plans maintained by the Employer as identified on the Plan Schedule, see Article XI. The Employer intends that this Plan qualify as a Cafeteria Plan under Section 125 of the Internal Revenue Code. Notwithstanding any term in this Plan Document, if any term is found to be in conflict with federal or state law, the term will automatically be amended to comply with the federal or state law.

Article III: Definitions

3.01 **Change in Status Event.** A Change in Status Event allows a Participant to revoke or change his/her pre-tax election during the Plan Year, and outside of the scheduled open Enrollment period. The Employer allows all of the Change in Status Events published by the IRS for this type of Plan under 26 CFR 1.123-4, as amended. A Participant who becomes eligible under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA") for coverage under an accident or health benefit offered by the Employer will be allowed to make a consistent election, or election change under this Plan.

3.02 **Code.** The Internal Revenue Code of 1986, as amended from time to time.

3.03 **Compensation.** All the earned income, salary, wages and other earnings paid by the Employer to a Participant during a Plan Year, including any amounts contributed by the Employer pursuant to a salary reduction agreement which are not includable in gross income under Sections 125, 402(g)(3), 402(h), 403(b) or 457(b) of the Internal Revenue Code.

3.04 **Dependent.** For the purpose of the tax advantages available under this Plan, a Dependent is an individual who is a dependent of a Participant within the meaning of Section 152(a) of the Internal Revenue Code, and any child of the Participant to whom IRS Rev. Proc. 2008-48 applies (regarding certain children of divorced or separated parents who receive more than half of their support for the calendar year from one or both parents and are in the custody of one or both parents for more than half of the calendar year). For the purposes of the tax advantages available under Qualified Benefit Plans that provide accident and health benefits as defined under Sections 105 and 106 of the Code, a Dependent is determined without regard to Subsections (b)(1), (b)(2), and (d)(1)(B) thereof and includes any child (as defined in Code § 152(f)(1)) of the Participant who at the end of the taxable year has not attained age 27.

3.05 **Effective Date.** The date specified in the Plan Schedule, see Article XI, on which the Plan was first effective, and the date that this Plan Document is in effect.

3.06 **Eligible Employee.** An Employee who is eligible to participate in the one or more Qualified Benefits Plans sponsored by the Employer, limited to Employees as defined below who meet the additional requirements in the Plan Schedule, see Article XI, and not including the following:

(a) Employees who are Non-Resident Aliens (within the meaning of Section 7701(b)(1)(B) of the Internal Revenue Code) who are deriving no earned income (within the mean ing of Section 911(d)(2) of the Code) from the Employer which constitutes income from sources within the United States (within the meaning of Section 861(a)(3) of the Code); and,

(b) Employees who are self-employed individuals (as described in Section 401(c) of the Internal Revenue Code) including sole proprietors, partners in a partnership, or more than 2% owners of subchapter "S" Corporations. This exclusion applies to the Spouse, children, parents, and grandparents under the Code Section 318 attribution rules.

An Eligible Employee will also meet any additional conditions and terms as defined in the Enrollment Communication.

If an Employee is not eligible to participate in this Plan and allowed to participate under any Qualified Benefits Plan, then the Employee cost will be paid with taxable income, and the Compensation will not be reduced by the Employer.

3.07 **Employee.** An Employee is a person who is currently or hereafter employed by the Employer, or by any other Employer aggregated under Sections 414(b), (c), (m), (n), or (o) of the Internal Revenue Code and the regulations thereunder, including a leased Employee subject to Section 414(n) of the Code.

3.08 **Employer.** The Employer adopting this Plan under Article XI, and any affiliate or subsidiary that, with the consent of the Employer becomes an Employer, by adopting the Plan, or any successor business organization that assumes the obligations of the Employer.

3.09 **Enrollment Communication.** The Employer will provide a written Enrollment Communication at open Enrollment and during the Plan Year for midyear enrollees. The Enrollment Communication will provide the specific process for Enrollment in the Qualified Benefits Plans. The Enrollment Communication is expressly incorporated by reference into this Plan Document.

3.10 **Participant.** Any person who has been or is an Eligible Employee and who qualifies to participate and enrolls in a Qualified Benefits Plan.

3.11 **Plan Year.** Commencing on the first day of the Plan Year and each anniversary thereof, except that the first Plan Year may include a period of fewer than twelve (12) consecutive months. The Plan Year is identified on the Plan Schedule, see Article XI.

3.12 **Qualified Benefits Plan.** Employer-sponsored plans that are allowed tax advantages under this Plan pursuant to Section 125(f) of the Internal Revenue Code.

3.13 **Spouse.** An individual who is legally married to a Participant but is not separated from a Participant or under a decree of legal separation.

Article IV: Administration

4.01 **Employer's Duties.** In addition to any rights, duties or powers specified in this Plan Document, the Employer will have the following rights, duties, and powers:

(a) to interpret the Plan, to determine the amount, manner and time for payment of any benefits under the Plan, and to construe or remedy any ambiguities, inconsistencies or omissions under the Plan;

(b) to adopt and apply any rules or procedures to ensure the orderly and efficient administration of the Plan, and from time to time, amend or supplement such rules and regulations;

(c) to determine the rights of any Participant, Spouse, or Dependent to benefits under the Qualified Benefit Plans;

(d) to develop appellate and review procedures for any Participant, Spouse, or Dependent denied benefits under the Plan;

(e) to maintain records it may require in connection with the proper administration of the Plan;

(f) to employ any agents, attorneys, accountants or other parties (who may also be employed by the Employer) and to allocate or delegate to them such powers or duties as is necessary to assist in the proper and efficient administration of the Plan, provided that such allocation or delegation and the acceptance thereof is in writing;

(g) to correct any defect, supply any omission, or reconcile any inconsistency in the Plan in such a manner and to such extent as it shall be deemed expedient to administer the Plan;

(h) to amend or terminate this Plan.

4.02 **Information to be Provided to the Employer.** The Employer, or any of its agents, will collect employment records of Participants under the Plan. These records will include, but will not be limited to, any information regarding period of employment, leaves of absence, salary history, termination of employment, or any other information the Employer may need for the proper administration of the Plan. A Participant will furnish the Employer the data the Employer reasonably requests to ensure the proper and efficient administration of the Plan, with documentation for items such as proof of relationship as needed.

4.03 **Interpreting Plan Terms.** Any interpretation of any provision of this Plan made in good faith by the Employer as to the terms of this Plan is final and will be binding upon the parties.

4.04 **Misstatements.** Any misstatement or other mistake of fact will be corrected as soon as reasonably possible upon notification to the Employer and any adjustment or correction attributable to such misstatement or mistake of fact will be made by the Employer as he considers equitable and practicable.

4.05 **Review Procedures.** An Employee or his/her authorized representative can appeal a decision made to deny Enrollment in a Qualified Benefits Plan or a decision to disallow an election change by sending a written request for an appeal to the Employer within 60 days of the decision to deny Enrollment or an election change. The ap peal will be performed in a manner that does not afford deference to the initial determination and will be conducted by the Employer or designee. A Participant can request, free of charge, reasonable access to, and copies of, all documents and records relevant to the decision. Benefit appeals for denied claims are addressed in the Qualified Benefits Plan descriptions provided by the Employer.

4.06 **Rules Apply Uniformly.** The Employer will perform assigned duties in a reasonable manner and on a nondiscriminatory basis, and will apply uniform rules to all Participants similarly situated under the Plan.

4.07 **Facility of Payment.** Whenever a Participant who is entitled to receive a benefit under this Plan is under legal disability or is incapacitated to be unable to manage his/her financial affairs, the Employer may make payments to the Participant's legal representative, relative, or for the benefit of such Participant in such manner as the Employer considers advisable. Any such payment of a benefit in accordance with the provisions of this document shall be a complete discharge of any liability for the making of such payment under the provisions of this Plan.

4.08 **Information to be Furnished.** Participants shall provide the Employer with such information and evidence, and shall sign such documents, as may be requested reasonably from time to time for the purpose of administering the Plan.

4.09 **Medical Child Support Orders.** The Employer will adhere to the terms of any judgment, decree, or court order (including a court's approval of a domestic relations settlement agreement) which complies with federal or applicable state law. The Employer will comply with the administrative requirements described under 29 USC Sec. 1169 relating to Qualified Medical Child Support Orders (QMCSO), including any federal regulations or state laws relating to the same. On the date coverage is provided as directed by a QMCSO the Employee-parent will become eligible to participate in this Plan in order to pay his/her share of the cost of the coverage on a pre-tax basis.

Article V: Eligibility and Participation

5.01 **Eligibility Requirements.** Each Employee who enrolls in a Qualified Benefits Plan must be eligible to participate in this Plan to receive the tax advantages made available under this Plan. The eligibility for this Plan is set forth in the Plan Schedule, see Article XI.

5.02 **Current Employees at the time of Plan inception.** At the time of Plan adoption, all non-excluded Employees who meet the eligibility requirements may participate.

5.03 **New Employees.** New Employees engaged for employment after the Plan adoption, who meet the eligibility requirements, may participate in the Plan the next following entry date as indicated in the Plan Schedule, see Article XI.

5.04 **Re-employment of Former Employees.** A Participant whose employment terminates and is subsequently re-employed within 30 days of his/her separation of service and within the same Plan Year will immediately rejoin the Plan with the same Benefit elections. Should the Participant return within 30 days of his/her separation of service during the following Plan Year, the Participant will be allowed to change elections through the Plan Enrollment process. A Participant whose employment terminates and who is subsequently re-employed with more than 30 days separation of service will need to re-satisfy Plan eligibility requirements to rejoin the Plan. Any unused reimbursement Benefits Account balance prior to the initial separation of service date will be forfeited.

5.05 **Becoming a Participant.** To become a Participant, an Eligible Employee shall enroll in a Qualified Benefits Plan by any application, agreements, or process as may be required by the Employer at the time of Enrollment. The Enrollment Communication provided by the Employer at the time of Enrollment will define the process for becoming a Participant. By completing the Enrollment process, the Employee shall be deemed for all purposes to have agreed to participate and to conform to the Plan requirements. An Employee, electing to participate in the Plan, is choosing to participate for the entire Plan Year. The annualized sum of salary reduction benefit elections shall constitute a current obligation of the Employee to

the Employer. Such obligation may be revoked or changed only when the Employee has experienced and documents a Change in Status Event, when the request is consistent with the event, and notice is provided to the Plan within 30 days.

5.06 **Notification to Employees.** The Employer will communicate (in writing) to all Participants the terms and conditions of this Plan through administrative communications at the time of Enrollment and as needed during the Plan Year. These communications are expressly incorporated by reference into this Plan Document.

5.07 **Termination of Participation.** A Participant will automatically cease to be a Participant on the earliest of the following dates:
(a) the date on which this Plan or any Qualified Benefits Plan is terminated by the Employer;
(b) the end of the Plan Year, unless the Participant enrolls in a Qualified Benefits Plan for the next Plan Year;
(c) the date on which the Participant fails to pay any required premium (including payment by salary reduction);
(d) when the Participant's employment with Plan Sponsor is terminated this Plan will terminate on the earlier of the day of the termination or the day using the rule stated in the SPD, whether termination is initiated by the Participant or the Plan Sponsor, however the Participants election can continue to be used for one or more of the Qualified Benefit Plans for the specified period of time communicated in the SPD. Participation under each Qualified Benefit Plan is described in the materials provided by the Employer; see Article XI Section 11.6 for a list of plans and literature available from the Employer.

5.08 **Family Medical Leave Act.** The Family & Medical Leave Act of 1993 (29 U.S.C. 2611) as amended, is referred to as FMLA. FMLA Leave will not be available to Employees for Plan Years in which the Employer has 50 or fewer Employees as counted in that Act. For Plan Years in which the Employer has more than 50 Employees, the Employer is required to make FMLA Leave available to Eligible Employees under circumstances that are prescribed by applicable federal law, including a period in which an Employee is off due to the FMLA shall be treated in accordance with the rules for a layoff or a leave of absence and provided to the extent required by the FMLA (e.g., the Employer will continue to pay its share of the contribution to the extent the Participant opts to continue coverage). If the Employer is subject to the FMLA, a Participant may revoke or continue an election through the Plan upon commencement of the FMLA Leave, whether such leave is paid or unpaid. This provision applies in addition to any other right to revoke and reelect benefits under the Plan. Upon return from FMLA Leave, a Participant may be reinstated to all pre-leave elections.

5.09 **Uniformed Services Employment & Reemployment Rights Act (USERRA).** The Employer shall permit Participants to continue benefits elections as required under the Uniformed Services Employment & Reemployment Rights Act and shall provide such reinstatement rights as required by such law.

5.10 **Layoff, Leave of Absences, and Sabbaticals.** Continuation under the Plan may occur in one of the following ways:
(a) In the case of a planned layoff, an Employee may be able to pre-fund a Qualified Benefits Plan through the end of the planned leave or the end of the Plan Year.
(b) During the period which the Employee is off and receiving a salary, the pre-tax deductions may continue. If the Employee is not receiving a salary, he/she may continue to fund his/her election with after-tax dollars while on leave. (Payment schedule to be agreed upon between the Employer and Employee prior to the commencement of the leave.)

Article VI: Elections

6.01 **Available Benefits.** The Qualified Benefits Plans offered under this Plan are listed on the Plan Schedule; see Article XI. The option for an Employee to make after-tax contributions for certain Qualified Benefits Plans will be communicated by the Employer at the time of Enrollment.

6.02 **Election Maximum Amounts.** Each Participant shall elect any combination of the benefits made available. No Participant may choose available benefits costing more than the maximum amount, if any, as indicated in the Qualified Benefits Plan. The maximum election amounts will be included in the Enrollment Communication and the literature available for each Qualified Benefits Plan.

6.03 **Failure to Elect.** A Participant failing to complete the Enrollment process on or before the specified due date for the Plan Year, or a midyear enrollee during the Plan Year, shall be deemed to have elected to receive his full Compensation in cash. The Employer will communicate any applicable Enrollment deadlines in writing at the time of Enrollment.

6.04 **Effective Periods for Elections.** The election must be made by each Participant prior to the commencement of each Plan Year, and shall be irrevocable except as provided for in a Change in Status Event that would allow an election change. Participants may not carry over any unused contributions or available benefits from one Plan Year to a subsequent Plan Year unless the Plan Schedule indicates that the Plan has incorporated the Grace Period. Further, Participants may not use any contributions from one Plan Year to purchase any available benefits that will be provided in a subsequent Plan Year unless the Plan has incorporated the Grace Period and the purchase of the available benefit occurs during that Grace Period.

6.05 **Change in Status Events.** No Participant in the Plan will be allowed to alter or discontinue the Participant's benefits elections during a Plan Year except when due to and consistent with a Change in Status Event. Enrollment requests must be made within 30 days of the Change in Status Event and be consistent with the event. Notwithstanding, an Employee can make a prospective change to a Health Savings Account (HSA) election under this Plan during the Plan Year without having a Change in Status Event.

A Change in Status Event allows a Participant to change his/her contribution election during the Plan Year, and outside of the scheduled open Enrollment period. The Employer has elected to allow all of the Change in Status Events published by the IRS for this type of plan. An unpermitted election change will cause the elected benefit to be included in a Participant's gross income and can disqualify the Plan from tax preferred status.

Upon the occurrence of a Change in Status Event, the Participant will notify the Employer within 30 days and complete the forms provided by the Employer. The Employer can require additional documentation for evidence of the event. The new election will be effective prospectively and will apply only to those benefits accruing to the Participant, the Participant's Spouse, or the Participant's Dependents after the effective date of the election change. With respect to an election change under the special Enrollment period provisions of HIPAA, "timely submitted" will mean submitted no later than the last day of such special Enrollment period.

6.06 **Non-Discrimination.** The Plan is not intended to discriminate in favor of highly compensated individuals or key Employees as to eligibility to participate or contribu-

tions and benefits as required by the Code. The Employer may exclude or limit certain highly compensated individuals from participation in the Plan, in the Employer's judgment, such actions serve to assure that the Plan does not violate applicable nondiscrimination rules. The Employer can make necessary adjustments to Employee contributions during the Plan Year to assure that the Plan passes the required discrimination tests.

Article VII: Contributions

7.01 **Employer Contributions.** The Employer will contribute out of its general assets the amounts necessary to meet its obligations under the Plan. Unless the Employer provides differently in the Enrollment Communication or separate Plan Documents for the various Qualified Benefits Plans, there are no segregated funds established to collect or maintain the contributions. Contributions to the Plan for any Plan Year will be limited to the amounts necessary to pay for the Qualified Benefits Plans elected by the Participants.

The Employer may provide additional contributions in the way of cash or spending credits that can be used for any Qualified Benefits Plan, or used in a limited manner as defined by the Employer. The Employer may make defined contributions to specific Qualified Benefit Plans. The Enrollment Communications will include the amount of any Employer contribution, the rules defining how the Employer contributions can be used by the Participants, and any limitations on the use of Employer contributions. Employer contributions will continue to be provided while on approved FMLA Leave to the same extent provided to an Employee actively at work.

7.02 **Employee Salary Reductions.** The Participant shall agree to reduce his/her Compensation from the Employer by such amounts as are necessary to provide for those Qualified Benefits Plans which the Participant has elected. "Employee" salary reduction amounts are "Employer" contributions for purposes of Internal Revenue Code Section 125 and its applicable regulations. No Participant shall have, by virtue of the Plan, any interest in any specific asset or assets of the Employer. A Participant has only an unsecured contractual right to receive the benefits defined and limited by the Qualified Benefits Plans.

7.03 **Administrative Fees.** The Employer may charge the Employee reasonable cafeteria plan administrative fees. If any administrative fees are required, the Enrollment Communication will include the amount of the administrative fee and whether it is with held from the Employee's salary reduction.

Article VIII: Records and Reports

8.01 **Responsibility.** The Employer shall exercise authority and responsibility to comply with the Plan relating to Participant records, balances, and benefits payable under this Plan. The Employer also shall be responsible for all Plan reporting and disclosure requirements.

8.02 **Records.** The Employer will process claims and maintain Employer account records, which shall record "deposits" and check "balances" prior to each reimbursement. An information report will be provided periodically to Plan Participants showing previous balances, deposits, payments, reimbursements, and current balances.

8.03 **Examination of Records.** The Employer will make each Participant's records under the Plan available for his/her examination at reasonable times and during normal business hours.

Article IX: Plan Termination

9.01 **Plan Termination.** The Plan or any portion of the Plan shall be subject to termination at any time by the Employer, provided however, that such termination shall not affect any right or claim arising under the Plan prior to termination. Any unclaimed funds shall become payable as the Employer may direct. Such direction may include, but not be limited to a continuation of the Plan in order to pay balances in accordance with elected benefits.

9.02 **Rights to Terminate.** In accordance with the procedures set forth in this section, the Employer may terminate the Plan at any time. In the event of a dissolution, merger consolidation, or reorganization of the Employer, the Plan shall terminate unless the Plan is adopted and continued by a successor to the Employer in accordance with the resolution of its Board of Directors.

Article X: Plan Construction

10.01 **Taxation.** The Employer intends that this Plan be in compliance with Section 125 of the Internal Revenue Code, and therefore, the Employer may deduct the amount paid for the benefits provided from federal income and employment taxes. This Plan has not been submitted to the Internal Revenue Service, and there is no assurance that the intended tax benefit under this Plan will be realized. Neither the Employer nor its designated representatives makes any commitment or guarantee that any amounts elected or paid for the benefit of a Participant will be excludable from the Participant's gross income for federal or state income tax purposes, or that any other federal or state tax treatment will apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether each payment is excludable from the Participant's gross income for federal and state income tax purposes, and to notify the Employer if the Participant has reason to believe that any such payment is not so excludable. Any Participant, by accepting a benefit under this Plan, agrees to be liable for any tax penalties and interest which may be imposed by the Internal

Revenue Service with respect to these benefits.

10.02 **Adoption by Related Organizations.** Upon the approval of the Employer, this Plan may be adopted by any organization in affiliation with the Employer. For the purpose of this Plan affiliated organizations are described in Section 414(b), (c) or (m) of the Internal Revenue Code. The adopting organizations shall execute and deliver to the Employer a supplemental agreement providing for the adoption of this Plan and such other documents as the Employer deems necessary or desirable. The provisions of this Plan shall be applicable to such organization to the extent provided in the supplemental agreement.

10.03 **Uniform Exercise of Powers.** In the exercise of any of its powers, duties and discretion under this Plan, and within the scope of its authority, and in all of its acts, decisions, and determinations hereunder, the Employer shall at all times act in good faith and in a non-discriminatory manner and shall follow a consistent policy on comparable issues. All Employer actions and determinations shall be duly recorded. All such records, together with such other documents as may be necessary for the administration of this Plan, shall be preserved. Decisions regarding any Employer-disputed questions relative to the rights of a Participant hereunder and upon all matters within the scope of its authority shall be final and binding on all parties in interest.

10.04 **Construction.** No provision of this Plan shall be construed to conflict with any Treasury Department, Department of Labor, or Internal Revenue Service Regulation, Ruling, Release, or Proposed Regulation or other order which affect, or could affect, the terms of the Plan. This Plan will be in compliance with any changes related to the Internal Revenue Code. This 125 Plan is not subject to the Employee Retirement Income Security Act of 1974 (ERISA); however the Qualified Benefits Plans offered by the Employer can be subject to ERISA. Refer to the Qualified Benefits Plan for details.

10.05 **Entire Document.** This document, including any appendices or supplements thereto, shall constitute the entire and complete document, and as such shall govern the rights, liabilities and obligations of the Plan, except as the Plan may be modified.

10.06 **Severability.** In the event any provisions of this document shall be held illegal or invalid for any reason by law or a court of competent jurisdiction, said illegality or invalidity shall not affect the remaining provisions included herein either initially, or beyond the date said provisions are first held to be illegal or invalid, provided the basic purposes hereof can be affected through the remaining valid and legal provisions.

10.07 **Benefits Provided through Third Parties.** In the case of any benefit provided through a third party, such as an insurance company, pursuant to a contract or policy with such third party, if any conflict or inconsistency exists between the description of benefits contained in this Plan and such contract or policy, then the terms of such contract or policy shall control.

10.08 **Rights Against the Employer.** Neither the establishment of the Plan, nor any modification thereof, nor any distribution hereunder, shall be construed as giving to any Participant or any person whomsoever any legal or equitable rights against the Employer, its shareholders, directors, or officers, as such, or as giving any person the right to be retained in the employ of the Employer.

10.09 **Successor-Businesses.** Unless this Plan be sooner terminated, a successor to the business of the Employer, by whatever form or manner resulting, may continue this Plan by appropriate supplemental agreement.

Article XI Plan Adoption and Schedule

11.01 **Employer Adoption.** By signing this Plan Document, the Employer identified below represents that it has formally adopted this Cafeteria Plan.

Employer: TRAVIS COUNTY TEXAS

By: _____

Printed: SAMUEL T. BISCOE

Title: COUNTY JUDGE

11.02 **Plan Year.** The Plan Year is from

October 1, 2013 to September 30, 2014.

11.03 **Effective Date.** This Cafeteria Plan was originally effective on January 1, 1987. This Cafeteria Plan has been restated by this Plan Document effective October 1, 2013.

11.04 **Eligible Employee.** An Employee who meets the definition of an Eligible Employee, 3.06, and the requirements in this part 11.04, can enroll in this Plan by completing the process outlined in the Enrollment Communications.

An Eligible Employee must be regularly scheduled to work 20 hours per week in order to enroll in this Plan. Part-time Employees working fewer hours are not Eligible Employees. Temporary Employees are not eligible.

Description of Excluded Employees

Union. Employees who are included in the unit of Employees covered by a collective bargaining agreement between the Employer and Employee representatives, provided benefits were the subject of good faith bargaining and two percent or less of the Employees of the Employer who are covered pursuant to that agreement are professionals (as defined in Treasury regulation Section 1.410(b)-9). For this purpose, the term "Employee Representatives" does not include any organization more than half of whose members are Employees who are owners, officers, or executives of the Employer.

_____ Excluded
_____ Eligible
__X__ Not applicable

Seasonal Employees regularly working less than

_____ months within a year.

__X__ Excluded
_____ Eligible
_____ Not applicable

Employees under _____ years of age.

_____ Excluded
_____ Eligible
__X__ Not applicable

11.05 **Commencement of Participation.** An Eligible Employee can enroll in this Plan at the annual open Enrollment period or upon completion of the employment requirement identified below:

_____ No wait, on the date of hire
_____ 30 days after the date of hire
_____ 60 days after the date of hire
_____ 90 days after the date of hire
_____ First of the month after the date of hire
__X__ First of the month after 30 days of continuous employment
_____ First of the month after 60 days of continuous employment
_____ First of the month after 90 days of continuous employment (not allowed for plans that are new or renewing January 1, 2014)
_____ Other _____

11.06 Qualified Benefits Plans. The Plan Documents and Summary Plan Descriptions identified in the chart below are expressly incorporated by reference into this Plan Document and provide specific description of each of the benefits available through the plan, including the periods during which the benefits are provided (the periods of coverage if different from the Plan Year for this Plan), and the Plan's rules governing participation.

The following Plans are offered under this Cafeteria Plan:

Check if offered under this Plan:	Qualified Benefits Plans	Available Plan Documents or Summary Plan Description (SPD)
____	Medical or Medical-Related Premium for a group health plan. (This can include an imbedded or standalone dental/vision plan.)	A Medical or Medical-Related Premium SPD will be provided by the Employer within 90 days of Enrollment and upon request.
____	Health Savings Account (HSA)*	Details will be provided in the Enrollment Communication.
____	Non-Employer-Sponsored Premium Account Plan for individual health plans (NESP).	See Appendix A.
__X__	Medical or Medical-Related Expense Reimbursement Benefit (Health FSA).	See Appendix B. A Medical or Medical-Related Expense Reimbursement Benefit SPD will be provided by the Employer within 90 days of Enrollment and upon request.
__X__	Dependent Care Benefit.	See Appendix C.
____	Supplemental Insurance (Voluntary Indemnity Plans).	Details will be provided in the Enrollment Communication.
____	Disability Insurance Premium (Employee Only) - Pre-taxing Employee contributions will make benefits paid taxable compensation.	Details will be provided in the Enrollment Communication.
____	Voluntary/Group Term Life Insurance **	Details will be provided in the Enrollment Communication.

NOTES

* A Participant is required to make an election before the start of the Plan Year, or before the first day of his/her coverage, showing the amount contributed to an HSA tax free under this Plan. A Participant will be able to change his/her HSA election for any month in the Plan Year regardless of whether the Employee can show a Change in Status Event.

** The cost of excess coverage as determined in Table I, published by the IRS, a will be imputed income. Excess coverage is any amount over a $50,000 benefit.

COBRAToday COBRA Administration

DirectPay Health Reimbursement Arrangements (HRA)

FlexSystem Flexible Spending Accounts (FSA)

ERISAEdge ERISA Compliance

FMLAMatters FMLA Administration

PayPath Payroll Services

TASC Health Savings Accounts (HSA)

Total Administrative Services, Inc.

2302 International Lane, Madison, WI 53704-3140

800.422.4661

Plan Document: Appendix B

Medical or Medical-Related Expense Reimbursement Benefits Plan (Health Flexible Spending Account, or FSA)

All terms and conditions stated in the Plan Document and Appendix B are applicable to this Medical or Medical-Related Expense Reimbursement Benefits Plan (Health FSA) unless specifically changed by this Appendix B.

All capitalized terms in this Appendix B are defined exactly as in the Plan Document, Article III, Definitions.

This Plan is intended to provide reimbursement for certain medical expenses incurred by Participants and not otherwise covered by insurance or by the Employer. The Employer intends that the Plan qualify as an accident and health plan under Section 105 and 106 of the Internal Revenue Code, and that the nontaxable benefits provided under the Plan be eligible for exclusion from Participant incomes under Section 105(b) of the Code.

The Employer will provide a Summary Plan Description within 90 days of enrollment or on request. The Summary Plan Description will identify the Plan Administrator for this Plan.

Maximum Contribution. The maximum salary reduction that a Participant can make per Plan Year will be communicated in the Enrollment Communications that are provided to each Eligible Employee at open enrollment or at the time a new or existing Employee becomes eligible for enrollment in the Plan. Beginning Plan Years on and after January 1, 2013, a Participant's salary reduction cannot exceed the greater of these two: either the maximum salary reduction communicated in the Enrollment Communications or the maximum limit per Code Section 125(i), indexed for inflation.

Qualified Expenses. A medical expense incurred during a Plan Year, or applicable Grace Period if any, by a Participant, the Participant's Spouse, or the Participant's Dependents while the Participant is covered under this Plan. Medical expenses are reimbursable only to the extent allowed as a medical expense under Section 213(d) of the Internal Revenue Code. For purposes of the Plan, an expense is incurred on the date when the underlying services giving rise to the medical expenses are performed and not on the date that the services are billed by the service-provider or paid by the Participant.

Benefits. Benefits are provided from the Employer's general assets. There are no segregated funds established for this Plan. The amount of the Participant's annual election is available on each day of the Plan Year in which the Employee is a Participant.

A Participant is entitled to benefits under the Plan for a Plan Year in an amount that does not exceed the Participant's annual election, and Employer contributions, if any. The amount of a Participant's annual election will be uniformly available during the Plan Year.

Claims. A claim under this Health FSA can be reimbursed only if the Participant provides a written statement from an independent third party stating that the medical expense has been incurred, the amount of the expense, and that the medical expense has not been reimbursed nor is it reimbursable under any other health plan coverage. If claims are submitted electronically, the Participant will sign a certification upon Enrollment or acceptance of an electronic card that claims submitted under the card have not been reimbursed by any other insurance or self-insured plan, and that the Participant is not seeking reimbursement under any other insured or self-insured plan.

Each claim will be substantiated by the submission of a third-party statement that shows that the claim is for a Qualified Benefits Expense, or by automated means that comply with guidelines established under IRS Rev. Rul. 2003-43.

Services purchased under a prefunded debit card can be automatically substantiated as allowed under IRS Notice 2006-69, including claims that are automatically substantiated using the Inventory Information Approval System (IIAS), amounts that are a multiple of a health plan copayment (up to five multiple co-payments).

Death of Participant. In the event of the death of the Participant prior to the payment of any claims, payment will be made in the following priority:

(a) Executor of the Estate of the deceased Participant,
(b) Spouse, or,
(c) Family member held responsible for payment of deceased's medical bills.

Amounts Paid in Error. Upon any benefits payment made in error, the Plan Sponsor will inform the Participant that they are required to repay the amount that has been paid in error to or on the behalf of a Participant. This includes and is not limited to amounts exceeding the Participant's annual election, amounts for services that are determined not to be Qualified Expenses, or amounts that are not substantiated (as when a Participant does not provide adequate documentation to substantiate a claim upon request). The Employer may take reasonable steps to recoup such an amount, including reducing the amount of future benefits reimbursements by the amount paid in error.

Change in Enrollment. No Participant in the Plan will be allowed to alter or discontinue the Participant's elections during a Plan Year except when due to and consistent with a Change in Status Event. Change In Status enrollment requests must be made within 30 days of the Change In Status Event and be consistent with the actual Change in Status.

The new Benefits Enrollment Form, if determined by the Employer to be submitted in a timely fashion and consistent with the Status Change, will be effective prospectively and will apply only to those Benefits accruing to the Participant, the Participant's Spouse or the Participant's Dependents after the effective date of the new Benefits Enrollment Form. With respect to an election change under the special enrollment period provisions of HIPAA, "timely submitted" will mean submitted no later than the last day of such special enrollment period. The Employer will determine if the new Benefits Enrollment Form has been timely submitted consistent with the nature of the Change in Status.

Limited Coverage under this Plan (Spouse covered under an HSA). Section 1201 of the Medicare Prescription Drug, Improvement & Modernization Act of 2003, added Section 223 to the Internal Revenue Code to permit eligible individuals to establish Health Savings Accounts (HSAs) for taxable years beginning on or after December 31, 2003. In order to allow an Employee's Spouse to contribute to an HSA Account, an Employee is required to submit a written request to the Benefits Coordinator requesting "single" or "Parent and Child(ren)" enrollment in this Health FSA. Qualified Expenses are limited to covered services or supplies provided to the Employee and Dependents that are not covered under the Spouse's HSA. No claims for family members covered under the HSA can be submitted under this Plan.

Nondiscrimination. The Plan is not intended to discriminate in favor of highly compensated individuals regarding eligibility to participate, contributions, and benefits in accordance with applicable provisions of the Code. The Plan Administrator may take such actions as excluding certain highly compensated employees from participation in the Plan or adjusting elections midyear, if in the Employer's judgment, such actions serve to assure that the Plan does not violate applicable nondiscrimination rules.

Forfeiture (Use-it-or-lose-it Rule). A Participant forfeits any amount of his/her annual election that exceeds of the amount of claims reimbursed during any Plan Year. A Participant who terminates coverage during the Plan Year has a run out period in which to submit eligible claims. A Participant who is covered through the end of the Plan Year will have a run out period in which to submit eligible claims. The duration of these run out periods will be provided in the Summary Plan Description provided by the Employer.

Upon such forfeiture, the Participant's accrual will be reduced to zero. Forfeiture of benefits under the Plan can be reallocated to existing Participants in any reasonable manner that has no relation to prior claims history. Forfeitures of benefits may also be applied towards the cost of administering the Plan.

COBRA Continuation Coverage. The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") as amended from time to time, does not apply to any group health plan of the Employer for any calendar year if all employers maintaining the Plan normally employed fewer than 20 employees on a typical business day during the preceding calendar year. Any Participant eligible for COBRA continuation coverage under this Plan, shall be allowed to continue to participate in the Plan until the end of the Plan Year in which the qualifying event occurred, as long as such Participant complies with the provisions set out in COBRA. A Participant is eligible for COBRA coverage only when the cost to continue to the end of the Plan Year exceeds the remaining benefit.

The Employer shall adopt rules relating to continuation coverage, as provided under Section 4980B of the Internal Revenue Code or applicable state law, as may be required from time to time, and shall advise affected individuals of the terms and conditions of such continuation coverage.

Plan Administrator's Duties. The Plan Administrator, identified in the Summary Plan Description, will have full and complete discretion to determine eligibility for participation and benefits under this Plan, including, without limitation, the determination of those individuals who are deemed Employees of the Employer (or any controlled group member). The Plan Administrator's decision will be final, binding, and conclusive on all parties having or claiming a benefit under this Plan. This Plan is to be construed to exclude all individuals who are not considered Employees for purposes of the Employer's payroll system, and the Plan Administrator is authorized to do so, despite the fact that its decision may result in the loss of the Plan's tax qualification.

In addition, the Plan Administrator has the discretionary authority to interpret the Plan in order to make eligibility and benefits determinations as it may determine at its sole discretion. The Plan Administrator also has the discretionary authority to make factual determinations regarding whether any individual is eligible and entitled to receive any benefits under the Plan.

The Plan Administrator is responsible for the administration of the Plan. In addition to any rights, duties or powers specified throughout the Plan, the Plan Administrator will have the following rights, duties and powers:

(a) to interpret the Plan; to determine the amount, manner, and time for payment of any benefits under the Plan; and to construe or remedy any ambiguities, inconsistencies, or omissions under the Plan;

(b) to adopt and apply any rules or procedures to insure the orderly and efficient administration of the Plan;

(c) to determine the rights of any Participant, Spouse, Dependent or beneficiary to benefits under the Plan;

(d) to develop appellate and review procedures for any Participant, Spouse, Dependent, or beneficiary denied benefits under the Plan;

(e) to provide the Employer with such tax or other information it may require in connection with the Plan;

(f) to employ any agents, attorneys, accountants or other parties (who may also be Employees of the Employer) and to allocate or delegate to them such powers or duties as is necessary to assist in the proper and efficient administration of the Plan, provided that such allocation or delegation and the acceptance thereof is in writing;

(g) to report to the Employer, or any party designated by the Employer, after the end of each Plan Year pertinent information regarding the administration of the Plan, to report any significant problems as to the administration of the Plan, and to make recommendations for modifications regarding procedures and benefits, or any other change which might ensure the efficient administration of the Plan.

The Federal Privacy and Security Rule. The employer will comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH) and the Final Rule issued on January 17, 2013 (effective March 23, 2013).

Plan Document: Appendix C

Dependent Care Benefits Plan

All terms and conditions stated in the Plan Document and Appendix C are applicable to this Dependent Care Benefits Plan unless specifically changed by this Appendix C.

All capitalized terms in this Appendix C are defined exactly as in the Plan Document, Article III, Definitions.

This Plan is intended to provide reimbursement for certain Dependent Care Expenses incurred by Participants. The Employer intends that the Plan qualify as a dependent care assistance plan under Section 129(d) of the Internal Revenue Code, and that the nontaxable benefits provided under the Plan be eligible for exclusion from Participant incomes under Section 129 of the Code.

Maximum Contribution. A Participant can defer the lesser of $5000, their earned income, or the Spouse's earned income, per plan Year. If a Spouse is disabled or a full-time student with no income, then the Spouse is deemed to have a monthly income of $250, if one dependent, $500 if two or more dependents. A married Participant who files a separate tax return is limited to $2,500 per year. Contributions to the Plan are made and limited in accordance with the Participant's annual election.

Maximum Benefit. A Participant can never withdraw more funds than actually contributed on the date a claim is submitted. If a Participant fails to use his/her entire election at the end of the Plan Year or upon other termination of the Plan, the unused election cannot be cashed out and becomes the property of the Employer.

Dependent Care Expenses. Expenses incurred by a Participant for the care of a Qualified Person or for related household services which would be considered employment-related expenses under Section 21(b)(2) of the Internal Revenue Code.

Qualifying Person - All child and Dependent Care Expenses must be for the care of one or more Qualifying Persons. A Qualifying Person is defined as the following:

(a) A child whom is claimed as the Participant's Dependent and who was under the age of 13 when the care was provided;

(b) A Participant's Spouse who was physically or mentally unable to care for himself/herself and lived with the Participant for more than half of the year;

(c) A person who was physically or mentally unable to care for himself or herself and lived with the Participant for more than half of the year, and either of the following:

(1) Was the Participant's Dependent; or

(2) Would have been the Participant's Dependent without the occurrence of one of the following:

i) He or she received gross income equal to or in excess of the exemption amount for Dependents under Internal Revenue Code § 151(d);

ii) He or she filed a joint tax return;

iii) The Participant, or the Participant's Spouse if filing jointly, could be claimed as a Dependent on someone else's federal tax return.

Child of divorced or separated parents: Even if a Participant cannot claim a child as a Dependent, he or she is treated as a Qualifying Person if one of the following applies.

(a) The child was under the age of 13 or was physically or mentally unable to care for himself/herself; or

(b1) The Participant was the child's custodial parent (the parent with whom the child lived for the greater part of the calendar year), and

(b2) The non-custodial parent is entitled to claim the child as a Dependent under the special rules for a child of divorced or separated parents.

If this applies, the non-custodial parent cannot treat the child as a Qualifying Person.

Benefits and Claims - Benefits are provided only for the reimbursement of a Qualified Person's Dependent Care Expenses that are incurred during the Plan Year and during the period in which the Employee was a Participant. Benefits are limited to the amount that has actually been withheld from the Participant's Compensation on the date the claim is processed.

Reimbursement will be made under the Plan only on the basis of Dependent Care Expenses incurred for the care of a Qualified Person, as presented to the Employer on a written form specified by the Employer. It is the Employer's duty to construe what are and what are not Dependent Care Expenses subject to reimbursement from a Participant's dependent care reimbursement benefits account. If the Employer determines that an expense is a Dependent Care Expense subject to reimbursement, the Employer will reimburse the Participant for the Dependent Care Expense within a reasonable time. To make the determination that a Dependent Care Expense subject to reimbursement has been incurred, the Employer may require proper evidence of any or all of the following:

(a) the name of the Qualified Person for whom the expenses have been incurred;

(b) the nature of the services incurred;

(c) the date the services were incurred;

(d) the amount of the requested reimbursement; and,

(e) that the expenses have not been otherwise paid through a program offered by the Employer or any other employer, or reimbursed from any other source.

The Employer will be the sole arbiter of what constitutes a Dependent Care Expense subject to reimbursement under the Plan.

In the event of the death of the Participant prior to the payment of any claims, payment will be made in the following priority:

(a) Executor of the Estate of the deceased Participant,

(b) Spouse of decedent.

Amounts Paid in Error - Upon any benefit payment made in error, the Employer will inform the Participant that they are required to repay the amount that has been paid to or on the behalf of a Participant in error. This includes and is not limited to amounts over the Participant's annual election, amounts for services that are determined not to be Dependent Care Expense, or when a Participant does not provide adequate documentation to substantiate a claim upon request. The Employer may take reasonable steps to recoup such an amount including reducing the amount of future benefit reimbursements by the amount paid in error.

Forfeiture (Use-it-or-lose-it Rule) - A Participant forfeits any amount of his/her annual election that exceeds of the amount of claims reimbursed during any Plan Year. A Participant who terminates coverage during the Plan Year has a run out period in which to submit eligible claims. A Participant who is covered through the end of the Plan Year will have a run out period in which to submit eligible claims. The duration of these run out periods will be provided in the Summary Plan Description provided by the Employer.

Upon such forfeiture, the Participant's accrual will be reduced to zero. Forfeited funds can be retained by the Employer, or at the discretion of the Employer, forfeitures of benefits under the Plan can be reallocated to Participants in any reasonable manner that has no relation to prior claims history. Forfeitures of benefits also may be applied towards the cost of administering the Plan. Forfeitures of benefits will become the sole property of the Employer.

Change in Enrollment. No Participant in the Plan will be allowed to alter or discontinue the Participant's elections during a Plan Year except when due to and consistent with a Change in Status. Change in Status Event enrollment requests must be made within 30 days of the Change in Status Event and be consistent with the actual Change in Status, as defined by the IRS.

The new Benefits Enrollment Form, if determined by the Employer to be submitted in a timely fashion and consistent with the Status Change, will be effective prospectively and apply only to those Benefits accruing to the Participant, the Participant's Spouse, or the Participant's Dependents after the effective date of the new Benefits Enrollment Form.

Nondiscrimination. The Plan is not intended to discriminate in favor of highly compensated individuals regarding eligibility to participate, contributions, and benefits in accordance with applicable provisions of the Code. The Employer may take such actions as excluding certain highly compensated employees from participation in the Plan or adjusting elections midyear, if in the Employer's judgment, such actions serve to assure that the Plan does not violate applicable nondiscrimination rules.

TASC • 2302 International Lane • Madison, WI 53704-3140 • 1-800-422-4661 • Fax: 608-663-2754 • www.tasconline.com

Summary Plan Description

Note to Employer: The United States Department of Labor requires this summary or a copy of it be given to each employee.

County of Travis Flexible Compensation Plan

Plan Sponsor (Employer), Plan Administrator and Agent for Legal Service

County of Travis, a political subdivision of Texas
c/o Leslie Browder, County Executive
700 Lavaca Street Suite 1560
Austin, TX 78701

Plan Administrator accepts service of legal process.

Phone Number: 512-854-9165
Plan Name: T-Flex Plan
Plan Number: N47612
Federal Tax Id: 74-6000192

Plan Year: 10/01 – 09/30 of next calendar year

Grace Period: 75 days
Grace Period End Date: 12/14 after end of Plan Year (only applies to Medical Out of Pocket Expenses)
Runout: 15 days for Medical Out of Pocket Expenses; 90 days for Dependent Care
Runout End Date: 12/30 following end of Plan year and Grace Period, if applicable

Client TASC Id: 4305-3758-7880
Group Name: County of Travis

Employer's Plan Name:

PURPOSE

Your Employer has adopted this Flexible Compensation Plan to allow you to select from among benefit options made available under the Flexible Compensation Plan and pay for the selected benefits for yourself, your spouse, and your dependents via pre-taxed salary reduction contributions. You may choose from these "tax free" benefits in lieu of receiving taxable compensation. The Plan is intended to qualify as a "Cafeteria Plan" within the meaning of Section 125(d) of the Internal Revenue Code, and the benefits you elect will be excluded from your income under Section 125(a).

BENEFITS OFFERED TO EMPLOYEES:	**Maximum Participant Salary Reduction**
Medical (Out-of-Pocket) Expenses	$2,500.00
Dependent Care Expenses	$5,000.00
Transportation Expenses	$5880.00

This Flexible Compensation Plan allows you to reduce your taxable income in direct proportion to (a) your contribution to the cost of your elected benefits and (b) your contribution to any account based tax advantaged plan or fringe benefit plan offered by your Employer that is governed by the Internal Revenue Service (IRS) Code.

ELIGIBILITY REQUIREMENTS: The benefits offered above are available to the following employees as stipulated below:

Probationary Employees	1st of the month following 30 days of employment

This Plan defines a Plan-eligible employee to be an individual classified by the Employer as a common-law employee who is on the Employer's W-2 payroll.

Existing Employees. If you are employed by the Employer on the Plan's effective date, you shall be eligible to participate on the later of the Plan's Effective Date or on the date you satisfy the Eligibility Requirements stated above.

New Employees. If your employment begins after the Plan's Effective Date, you will be eligible to participate on the entry date noted above for Probationary Employees, following the date you satisfy the Eligibility Requirement stated above.

Summary Plan Description

Note to Employer: The United States Department of Labor requires this summary or a copy of it be given to each employee.

Plan Sponsor (Employer), Plan Administrator and Agent for Legal Service

County of Travis, a political subdivision of Texas
c/o Leslie Browder, County Executive
700 Lavaca Street Suite 1560
Austin, TX 78701

Plan Administrator accepts service of legal process.

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Grace Period End Date: 12/14 after end of Plan Year (only applies to Medical Out of Pocket Expenses)
Runout: 15 days for Medical Out of Pocket Expenses; 90 days for Dependent Care
Runout End Date: 12/30 following end of Plan year and Grace Period, if applicable

Client TASC Id: 4305-3758-7880
Group Name: County of Travis

PURPOSE

Your Employer has adopted this Flexible Compensation Plan to allow you to select from among benefit options made available under the Flexible Compensation Plan and pay for the selected benefits for yourself, your spouse, and your dependents via pre-taxed salary reduction contributions. You may choose from these "tax free" benefits in lieu of receiving taxable compensation. The Plan is intended to qualify as a "Cafeteria Plan" within the meaning of Section 125(d) of the Internal Revenue Code, and the benefits you elect will be excluded from your income under Section 125(a).

BENEFITS OFFERED TO EMPLOYEES:	**Maximum Participant Salary Reduction**
Medical (Out-of-Pocket) Expenses	$2,500.00
Dependent Care Expenses	$5,000.00
Transportation Expenses	$5880.00

This Flexible Compensation Plan allows you to reduce your taxable income in direct proportion to (a) your contribution to the cost of your elected benefits and (b) your contribution to any account based tax advantaged plan or fringe benefit plan offered by your Employer that is governed by the Internal Revenue Service (IRS) Code.

ELIGIBILITY REQUIREMENTS: The benefits offered above are available to the following employees as stipulated below:

Probationary Employees	1st of the month following 30 days of employment

This Plan defines a Plan-eligible employee to be an individual classified by the Employer as a common-law employee who is on the Employer's W-2 payroll.

Existing Employees. If you are employed by the Employer on the Plan's effective date, you shall be eligible to participate on the later of the Plan's Effective Date or on the date you satisfy the Eligibility Requirements stated above.

New Employees. If your employment begins after the Plan's Effective Date, you will be eligible to participate on the entry date noted above for Probationary Employees, following the date you satisfy the Eligibility Requirement stated above.

Re-employment of Former Employees. A former employee who is re-employed within 30 days after termination may become a participant immediately upon re-hire.

Age Requirement. No maximum age requirement may be imposed for participation in the Plan.

GENERAL INFORMATION

This Flexible Compensation Plan allows you to pay your cost for the benefit plans you elected that are sponsored by your Employer through a Salary Reduction Agreement. This may lower your federal and state taxes. Under this Flexible Compensation Plan one type of benefit plan offered by your Employer may be funded by your salary reduction: reimbursement benefits. Reimbursement benefits are benefits paid under an agreement to reduce your salary by the amount you elected to defer and pay you tax free benefits for certain qualified medical and dependent care expenses, as authorized under the Internal Revenue Code.

Administration. Your Employer or appointed Plan Administrator is responsible for the administration of your Employer Sponsored General Welfare Plans. Should you need to see any records or have any questions regarding these Plans, contact the Plan Administrator. The Plan Administrator has sole discretionary authority (a) to interpret the Plan in order to make eligibility and benefit determinations, and (b) to make factual determinations as to whether any individual is eligible and entitled to receive any benefits under the Plan. A health insurance issuer is not responsible for the Plan's administration (including payment of claims).

The Plan Administrator appoints TASC as a Service Provider to maintain certain Plan records and to be responsible for the Plan's day-to-day administration. TASC is not a Plan Administrator and has no discretionary authority regarding the Plan.

Plan Termination or Amendment. The Employer, or appointed Plan Administrator, has the right, in its sole discretion, to terminate the Plan or to modify or amend any provision of the Plan at any time. Upon the termination or partial termination of the Plan, Participants have no Plan benefits except with respect to covered events giving rise to benefits occurring prior to the date of Plan termination or partial termination, except as otherwise expressly provided in writing by the Employer.

Excess Payments. Upon any benefit payment made to a Participant in error under the Plan, said Participant will be informed and required to repay the errant amount. This includes and is not limited to amounts over the Participant's annual election, amounts for services that are determined to be ineligible, or when adequate documentation to substantiate a paid claim upon request is not provided. The Employer may take reasonable steps to recoup such an amount including withholding the amount from future salary or wages, and subtracting from future benefit reimbursement(s) the amount paid in error.

No Continued Employment. No provisions either of the Plan or of this Summary grant any employee any rights of continued employment with the Employer or in any way prohibit changes in the terms of employment of any employee covered by the Plan.

Non-Assignment Of Benefits. No Participant or beneficiary may transfer, assign or pledge any Plan benefits except as may be required pursuant to (a) a "Qualified Medical Child Support Order" (which provides for Plan coverage for an alternate recipient), (b) other applicable law, or (c) electronic payment made directly to a healthcare provider,.

CONTRIBUTIONS AND ENROLLMENT

Participant Contributions. By participating in the Plan, you agree to have your annual compensation reduced by the total cost of the Plan benefits you elected.

Enrollment Elections. The annual enrollment materials will include the enrollment procedures to make annual elections for your pretax contributions. These enrollment materials are incorporated in this Summary Plan Description by reference.

The various benefit plans offered by your Employer may operate under different plan years. For instance, an Employer may enter into an annual contract with an insurance company (to provide benefits to employees) under a contract year that differs from the Plan Year established for this Flexible Compensation Plan. If this is the case, different Plan benefit entry dates will apply.

If you are not eligible to participate in this Plan but are allowed to participate in another benefit plan offered by your Employer, under the eligibility terms of that Plan, your costs will be paid with taxable income, and your compensation will not be reduced by the Employer.

BENEFITS AND QUALIFYING CHANGE IN STATUS EVENTS

The laws governing Flexible Compensation Plans generally do not allow you to change your benefit and contribution elections during a Plan Year. Your elections are irrevocable and any balance in your account at the close of the Plan Year, or the Grace Period following the end of the plan year as applicable is forfeited and becomes the property of your Employer; this irrevocable election rule does not apply if you experience a qualifying change in status event, in which case the election change requested must be on account of and consistent with the qualifying event.

Any request to change your election must be submitted in writing within 30 days of any applicable qualifying event. The new benefit elections may start only after your change in status has taken place and the new paperwork has been filed.

A qualifying change in status event may be one of the following:

A change in legal marital status (marriage, death of spouse, divorce, legal separation and annulment).
The adoption, birth, or death of a child or dependent.
Dependent satisfies or ceases to satisfy dependent eligibility requirements.
The change in employment status of you, your spouse or dependent.
Change in your residence.*
Beginning or ending adoption proceedings.
Automatic changes upon cost increases or decreases.*
Significant cost increases.*
Significant curtailment of coverage.*
Addition or elimination of similar benefits package option.*
Change in coverage of a spouse or dependent under an employer plan.*
FMLA.
Loss of group health coverage sponsored by governmental or education institution.*
A judgment, decree or order requiring coverage for a spouse or child.
Medicare or Medicaid entitlement.
Termination of Medicaid or SCHIP** coverage.
Eligibility for Employment Assistance under Medicaid or SCHIP**.

* These qualifying events do not apply to the Medical Expenses Reimbursement Plan.
** State Children's Health Insurance Program.

Under the qualifying events of Termination of Medicaid or SCHIP coverage and eligibility for employment assistance under Medicaid or SCHIP, the employee must request the group health benefit change no later than 60 days after the date of termination or after the date eligibility is determined under Medicaid or SCHIP.

THE REIMBURSEMENT PLANS

BENEFITS OFFERED TO EMPLOYEES Section of this Summary Plan Description lists Medical (Out-of-Pocket) Expenses, and Dependent Care Expenses your Plan includes that Reimbursement Plan.

The Participant Reference Guide, incorporated by express reference into this Summary Plan Description, includes all of the information you need to access your reimbursement accounts and submit claims for reimbursement. By visiting the Account Manager link addressed in this Guide you may access information about your reenrollment, your available funds, annual election, total contributions, and total reimbursements. These plans provide tax free benefits for medical and dependent daycare claim reimbursements in accordance with IRS guidelines and protocols.

Medical (Out-of-Pocket) Expenses Reimbursement Plan. All medical claim expenses must be (a) for medical care as defined in Code Section 213(d) which is rendered or received during the Plan Year, with certain limitations described under Services Not Covered; (b) incurred by an employee who has made a valid pre-tax election to participate in the Plan, such employee's spouse, or tax dependent for healthcare purposes as defined in Section 105(b), (c) not otherwise taken as a medical deduction by a taxpayer and (d) not covered under any other benefit program.

A medicine or drug that is available for purchase without a prescription is considered an over-the-counter medicine. Under federal law, an over-the-counter medicine obtained on or after January 1, 2011 may be reimbursed tax free only if a Participant obtains and submits a prescription with their claim for reimbursement. A Participant must submit a 'prescription' that meets all state law requirements of the state in which the prescription was written. The person who wrote the prescription must be allowed to prescribe drugs under applicable state law. A medicine is any over-the-counter item the IRS determines is purchased for the primary purpose of applying the drug or biological contained in the item. Insulin will continue to be reimbursed without a prescription.

The following examples—even those recommended by a doctor—do not qualify as expenses eligible for reimbursement under the Medical Expenses Reimbursement Plan: insurance premiums; expenses for cosmetic procedures or cosmetic items; items that are for a Participant's general wellbeing; items the Participant would have purchased even if the Participant had no medical condition (for example, a toothbrush); vacation and travel expenses even if for rehabilitation or prescribed by a doctor; long-term care expenses that are not for actual medical care; expenses incurred in stockpiling over-the-counter items in quantities that could not reasonably be used during the current Plan Year.

Dependent Care Expenses Reimbursement Plan. This Plan provides employees with tax free dependent care assistance only when the assistance is necessary for the Participant to leave the home to engage in activity directly related to his/her employment. Qualified expenses under the Dependent Care Expenses Reimbursement Plan include any expenses that you could take as a credit against tax on your income tax form for the care of a Qualified Person. Benefits are provided only to the extent of your payroll deduction on the date the claim is processed. The tax laws further limit how much you may contribute to this Plan. Under the law and the terms of the Plan,

you may defer no more than the lesser of your actual (or, if you are married and if less, your spouse's) income for the year or $5000 per year to this Program. A married Participant who files separate tax returns is limited to $2500 per year.

QUALIFIED RESERVIST DISTRIBUTION

A Participant who is called to active duty in the US Armed Services and enrolled in the Medical Expenses Reimbursement Plan may elect to receive a Qualified Reservist Distribution of all or a portion of the unused balance in his/her individual Medical Expenses Reimbursement Plan subject to the requirements of Code Section 125(h) and the applicable regulations thereunder. The Employer may limit this distribution to the amount you have contributed to the Plan that has not been used to reimburse you for claims submitted.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

The Plan will provide benefits in accordance with a QMCSO and adhere to the terms of any judgment, decree, or court order which (1) relates to the provision of child support related to health benefits for a child of a Participant in a group health plan; (2) is made pursuant to a state domestic relations law; and (3) which creates or recognizes the right of an alternate recipient—or assigns to an alternate recipient the right—to receive benefits under the group health plan under which a Participant or other beneficiary is entitled to receive benefits. Participants may obtain, without charge, a copy of the Plan's procedures from the Plan Administrator.

LEAVE OF ABSENCE

Family and Medical Leave Act (FMLA). If you go on a qualifying leave under the federal Family and Medical Leave Act (FMLA), to the extent required by the FMLA, your Employer will continue to maintain your benefit package options providing health coverage (including the Medical Expenses Reimbursement Plan) on the same terms and conditions as if you were still active. Your Employer may require you to continue coverage while you are on paid leave (as long as Participants on non-FMLA paid leave are required to continue coverage). If so, you will pay your share of the contributions by the method normally used during any paid leave.

If your coverage ceases while on FMLA leave, you will be permitted to re-enter the Plan upon return from such leave, and to participate in the Plan on the same basis as you had been prior to the leave or as otherwise required by the FMLA. You may elect reinstatement in the Plan at the same coverage level in effect before the FMLA leave (with increased contributions for the remaining period of coverage) or at a reduced pro-rata coverage level for the period of FMLA leave during which you did not make contributions. Your coverage may be automatically reinstated as well, but only if coverage for employees on non-FMLA leave is automatically reinstated upon return from leave.

Unpaid FMLA Leave. If you are going on unpaid FMLA leave and you opt to continue your Medical and Dental Insurance Benefits, then you may pay your share of the contributions in one of three ways:

(1) Catch-up. Your Employer may advance your share of contributions while you are on leave. Upon your return from leave, your Employer may recover the advanced amounts on either a pre-tax or after-tax basis. Check with your Employer to determine if this option is available under your Plan.

Non-FMLA Leave. If you go on an unpaid leave of absence that does not affect eligibility, then you will continue to participate and the contribution due from you will be paid by pre-payment before going on leave, with after-tax contributions while on leave, or with catch-up contributions after the leave ends, as determined by the Plan Administrator. If you go on an unpaid leave that affects eligibility, then the Change in Status rules will apply.

Military Leave. If you take a leave of absence due to military service, you may continue coverage under this Plan as required by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

TERMINATION OF PARTICIPATION

Participants are enrolled in the Plan for the entire Plan Year or the portion of the Plan Year remaining after enrollment. You will automatically cease to be a Participant on the earliest of the following dates:

a. Your death, resignation or termination of employment with the Employer;
b. The date the Plan terminates;
c. The date on which you fail to pay any required premium (including payment by salary reduction) under the Plan;
d. The date you no longer meet the requirements for eligibility in the Plan; or,
e. The date you revoke your election under a qualifying change in status event.

When participation has terminated, you are eligible to incur claims against any positive account balance through the eligibility end date.

Positive Balance: Upon termination your annual election amount will be limited to the greater of the amount paid for coverage (total contributions) less previously paid reimbursements or the total of paid reimbursements from the Plan.

As a terminated Participant, you are not eligible for the grace period unless your eligibility end date is the same as the last day of the Plan Year.

When your participation has terminated, you may submit eligible claims for reimbursement through your run out end date as noted in the Claims Procedure section of this document.

CLAIMS PROCEDURE

If you have elected reimbursement coverage, active Participants may submit eligible claims for reimbursement through the plan's runout period. The Plan's runout period end date is 91 days following the last day of the Plan Year in order to be reimbursed from the Prior Plan Year.

All other claim procedures for the Plan are provided in a separate administrative document upon the original enrollment in the Plan. An additional copy may be provided without charge upon request.

CLAIM DENIALS

Claims Under the Medical (Out-of-Pocket) Expensesand Dependent Care Expenses Reimbursement Benefits. The claims procedure described below will apply if (a) a claim for reimbursement under the Medical (Out-of-Pocket) Expenses or Dependent Care Expenses components of the salary reduction plan is wholly or partially denied, or (b) you are denied a benefit under the salary reduction plan due to an issue germane to your coverage under the Plan.

If your claim is denied in whole or in part, you will be notified in writing by the Plan Administrator within 30 days after the date the Plan Administrator received your claim. (This time period may be extended for an additional 15 days for matters beyond the control of the Plan Administrator, including in cases where a claim is incomplete.) The Plan Administrator will provide written notice of any extension, including the reasons for the extension and the date by which a decision by the Plan Administrator is expected. When a claim is incomplete, the extension notice will also specifically describe the required information, will allow you 45 days from receipt of the notice in which to provide the specified information, and will effectively suspend the time for a decision on your claim until the specified information is provided.)

Notification of a denied claim will detail:

- specific reason(s) for the denial;
- specific Plan provision(s) on which the denial is based;
- a description of any additional material or information necessary for you to validate the claim and an explanation of why such material or information is necessary;
- appropriate information on the steps to be taken if you wish to appeal the Plan Administrator's decision, including your right to submit written comments and have them considered and your right to review (upon request and at no charge) relevant documents and other information.

Appeals. If your claim is denied in whole or part, then you (or your authorized representative) may request review upon written application to the Plan Administrator. Your appeal must be made in writing within 180 days after your receipt of the notice that the claim was denied. If you do not appeal on time, you will lose both the right to appeal the denial and the right to file suit in court. Your written appeal should state the reasons that you feel your claim should not have been denied. It should include any additional facts and/or documents that you feel support your claim. You will have the opportunity to ask additional questions and make written comments, and you may review (upon request and at no charge) documents and other information relevant to your appeal. The address to use when filing an appeal will be included in the benefit or enrollment denial letter.

Decision on Review. Your appeal will be reviewed and determination made within a reasonable time, defined as not later than 60 days after receipt of your appeal. If the decision on review affirms the initial denial of your claim, you will be furnished with a Notice of Adverse Benefits Determination on Review, which shall set forth the following:

- specific reason(s) for the decision on review;
- specific Plan provision(s) on which the decision is based;
- a statement of your right to review (upon request and at no charge) relevant documents and other information; and
- if an "internal rule, guideline, protocol, or other similar criterion" is relied on in making the decision on review, then a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request; and

NOTICES REQUIRED BY LAW

Special Rights on Childbirth. Under Federal law, group health plans may not restrict benefits for any hospital length of stay in connection with childbirth for (either mother or newborn child) to less than 48 hours following a vaginal delivery or less than 96 hours following a caesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than the above period. In any case, under Federal law a provider may not be required (by Plan or insurer) to obtain authorization from the plan for prescribing a length of stay up to 48 hours (or 96 hours).

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, ("COBRA") continuation shall not apply to any group health plan of the Employer for any calendar year if all employers maintaining such plan normally employed fewer than twenty (20) Employees on a typical business day during the preceding calendar year. Government entities are subject to the same continuation coverage under the Public Health Services Act. This Summary Plan Description describes your rights for the Medical Reimbursement

Plan. Your rights under any of the other Qualified Benefits Plans offered by your Employer are described in the Summary Plan Description(s) for that Plan and may be obtained from your Plan Administrator.

If you elect to participate under the Medical Expenses Reimbursement Plan and are considered a Participant on the day before experiencing a qualifying event, COBRA continuation ends on the last day of the Plan Year in which the qualifying event occurred. Further, COBRA continuation coverage will not be offered if on the day of your qualifying event, the amount of your annual election less any reimbursed claims is less than the amount of premium required to continue the Medical Expenses Reimbursement Plan until the end of the Plan Year.

A Participant who experiences a qualifying event is considered a qualified beneficiary. When a qualified beneficiary experiences a qualifying event, they will be sent a notification explaining their rights to elect COBRA continuation coverage. Your Employer has 44 days from the date of the loss of coverage in which to send the COBRA Election Notice. A qualified beneficiary who wishes to continue coverage must notify the Plan Administrator of their desire to continue coverage within sixty days of either the date of notification or date of loss of coverage, whichever is later. If the Plan Administrator does not receive notification within this time period, you will lose your right to elect continuation coverage. Finally, qualified beneficiaries who elect continuation coverage are responsible for premiums back to the date that termination from the Plan would have occurred.

Listed below are qualifying events.

(1) Termination of employment (for reason other than "gross misconduct"); and
(2) Reduction of employee's work hours.

COBRA continuation is available until the end of the Plan Year in which the qualifying event occurs. The premium charged for the continuation coverage will be 102% of your monthly contribution. The Employer may require the COBRA payments be apportioned for the remainder of the Plan Year.

Trade Act of 2002

If you become eligible for Trade Adjustment Assistance (TAA) as defined by the Trade Act of 2002, then you will be provided with an additional 60-day enrollment period, with continuation coverage beginning on the date of such TAA approval.

Questions

If you have questions about your COBRA continuation coverage, you should contact your Employer or you may contact the nearest Regional or District Office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA); addresses and phone number of Regional and District EBSA Offices are available through EBSA's website at **www.dol.gov/ebsa**.