Agenda Item #: 3Z-1

PALM BEACH COUNTY
BOARD OF COUNTY COMMISSIONERS

AGENDA ITEM SUMMARY

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Meeting Date: February 5, 2013 [X] **Consent** [ ] **Regular**
[ ] **Ordinance** [ ] **Public Hearing**

Department: **Risk Management**
Submitted By: **Risk Management**

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I. EXECUTIVE BRIEF

Motion and Title: Staff recommends motion to approve:

A) Palm Beach County Board of County Commissioners Cafeteria Plan Basic Plan Document, as amended
B) Cafeteria Plan Adoption Agreement, as amended

Summary: Effective January 1, 2013, the Patient Protection and Affordable Care Act (ACA) has mandated a statutory limit to the maximum amount an employee can elect to contribute to a health care flexible spending account. The maximum annual election is now $2,500 per year. The ACA requires employers to amend Cafeteria Plan Documents by December 31, 2014 to reflect this new limit. Staff requests Board approval of the County's amended Cafeteria Plan Basic Plan Document and associated Cafeteria Plan Adoption Agreement to reflect the mandatory reduction from $3,900 to $2,500 per year, effective January 1, 2013. Countywide (TKF)

Background and Policy Issues: The Cafeteria Plan provides for the pre-tax payment of insurance premiums for qualifying benefit policies offered to eligible employees and employee contributions to flexible spending accounts that are excludable from gross income under Code Section 125, reimbursement of certain medical expenses that are excludable from gross income under Code Section 105(b), and reimbursement of certain dependent care expenses that are excludable from gross income under Code Section 129. The Board has offered a Cafeteria Plan to its employees since June 1, 1988. The Plan provides eligible employees with the ability to have monthly payroll deductions withheld on a pre-tax basis and used to fund eligible medical or child care expenses. This employee benefit also provides the Board with a tax savings reflective of that portion of payroll that would otherwise be assessed for Medicare and Social Security expense.

Attachments:

1) Adoption Agreement, Cafeteria Plan
2) Palm Beach County Board of County Commissioners Amended and Restated Cafeteria Plan Basic Plan Document

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Recommended by: Nancy L Bolton 1/16/13
Department Director **Date**

Approved By: 1/31/13
Assistant County Administrator **Date**

II. FISCAL IMPACT ANALYSIS

A. Five Year Summary of Fiscal Impact

Fiscal Years	2013	2014	2015	2016	2017
Capital Expenditures					
Operating Costs					
External Revenues					
Program Income (County)					
In-Kind Match (County)					
Net Fiscal Impact	0				
# ADDITIONAL FTE POSITIONS (Cumulative)	0	0	0	0	0

Is Item Included In Current Budget? Yes ____ No ____

Budget Account Exp No: Fund ____ Department ____ Unit ____ Object ____
Rev No: Fund ____ Department ____ Unit ____ Object ____

B. Recommended Sources of Funds/Summary of Fiscal Impact:

Because enrollment and participation levels change each year, the fiscal impact is indeterminable. Based on FY12 enrollment and participation levels, the cost savings of approximately $58,000 would decrease by approximately $10,000.

Departmental Fiscal Review: Jessica Kalb

III. REVIEW COMMENTS

A. OFMB Fiscal and/or Contract Dev. and Control Comments:

1/23/13
OFMB
1/17 JB 1118

1/30/13
Contract Administration
1-30-13

B. Legal Sufficiency:

1/31/13
Assistant County Attorney

C. Other Department Review:

Department Director

This summary is not to be used as a basis for payment.

ADOPTION AGREEMENT
CAFETERIA PLAN

The undersigned adopting employer hereby adopts this Plan. The Plan is intended to qualify as a cafeteria plan under Code section 125. The Plan shall consist of this Adoption Agreement, its related Basic Plan Document and any related Appendix and Addendum to the Adoption Agreement. Unless otherwise indicated, all Section references are to Sections in the Basic Plan Document. This is a replacement of the prior Adoption Agreement and hereby replaces any and all prior Adoption Agreements.

COMPANY INFORMATION

1. Name of adopting employer (Plan Sponsor): **Palm Beach County Board of County Commissioners**
2. Address: **100 Australian Avenue, Suite 200**
3. City: **West Palm Beach** **4.**State: **Florida** **5.** Zip: **33406**
6. Phone number: **561-233-5400** **7.** Fax number: **561-233-5420**
8. Plan Sponsor EIN: **59-6000785**
9. Plan Sponsor fiscal year end: **September 30**
10a. Plan Sponsor entity type:
i. [ ] C Corporation
ii. [ ] S Corporation
iii. [ ] Non profit
iv. [ ] Partnership
v. [ ] Limited Liability Company
vi. [ ] Limited Liability Partnership
vii.[ ] Sole Proprietorship
viii. [ ] Union
ix. [X] Government agency
10b. If **10a.viii** (Union) is selected, enter name of the representative of the parties who established or maintain the Plan: _____
11. State of organization of Plan Sponsor: **Florida**
12a. The Plan Sponsor is a member of an affiliated service group:
[X] Yes [ ] No
12b. If **12a** is "Yes", list all members of the group (other than the Plan Sponsor): **Palm Tran, Inc & Supervisor of Elections**
13a. The Plan Sponsor is a member of a controlled group:
[ ] Yes [X] No
13b. If **13a** is "Yes", list all members of the group (other than the Plan Sponsor):_____

PLAN INFORMATION

A. GENERAL INFORMATION

1. **Plan Number**: **501**
2. **Plan name**: a. **Palm Beach County Board of County Commissioners**
b. **Section 125 Flexible Spending Plan**
3. **Effective Date:**
3a. Original effective date of Plan: **June 1, 1988**
3b. Is this a restatement of a previously-adopted plan?
[X] Yes [ ] No
3c. If **A.3b** is "Yes", effective date of Plan restatement: **January 1, 2009**
NOTE: If **A.3b** is "No", the Effective Date shall be the date specified in **A.3a**, otherwise the date specified in **A.3c**; provided, however, that when a provision of the Plan states another effective date, such stated specific effective date shall apply as to that provision.
4a. **Plan Year** means each 12-consecutive month period ending on **December 31** (e.g. December 31). If the Plan Year changes, any special provisions regarding a short Plan Year should be placed in the Addendum to the Adoption Agreement.
4b. The Plan has a short plan year:
[ ] Yes [X] No
4c. If **A.4b** is "Yes", the short plan year begins _____ and ends on _____.

Plan Features

10a. **Premium Conversion Account.** Contributions to fund a Premium Conversion Account are permitted (Section 4.01) (If "No", questions regarding Premium Conversion Accounts are disregarded.):
[X] Yes [ ] No

10b. **If A.10a** is "Yes", select the types of Insurance Contracts for which a Participant may seek reimbursement under Section 4.01:
i. [X] Employer Group Medical
ii. [X] Employer Dental
iii. [X] Employer Disability
iv. [X] Employer Group Term Life
v. [ ] Individually - Owned Medical
vi. [ ] Individually - Owned Dental
vii. [ ] Individually - Owned Disability
viii. [ ] Other

10c. If **A.10a** is "Yes" and **A.10b.viii** (other contracts) is selected, describe other types of Insurance Contracts: _____.

11a. **Health Care Reimbursement Account.** Contributions to fund a Health Care Reimbursement Account are permitted (Section 4.02) (If "No", questions regarding Health Care Reimbursement Accounts are disregarded.):
[X] Yes [ ] No

11b. **HSA Account.** Contributions to fund an HSA Account are permitted (Section 4.08):
[ ] Yes [X] No

12. **Dependent Care Assistance Account.** Contributions to fund a Dependent Care Assistance Account are permitted (Section 4.03) (If "No", questions regarding Dependent Care Assistance Accounts are disregarded.):
[X] Yes [ ] No
NOTE: The maximum amount of expense that may be contributed/reimbursed in any Plan Year for the Dependent Care Assistance Account is the maximum amount permitted by federal tax law ($5,000 or $2,500 if the Participant is married and filing a separate federal tax return).

13. **Adoption Assistance Account.** Contributions to fund an Adoption Assistance Account are permitted. (Section 4.04) (If "No", questions regarding Adoption Assistance Accounts are disregarded.):
[ ] Yes [X] No
NOTE: The maximum amount of expense that may be contributed/reimbursed for the Adoption Assistance Account is the maximum amount permitted by federal tax law for the prior year ($10,960 for Plan Years beginning in 2006). The annual limit shall be reduced for adoption assistance expenses incurred any prior Plan Year.

B. ELIGIBILITY

Exclusions/Modifications

The term "Eligible Employee" shall not include (Check items **B.1** - **B.5a** as appropriate):

1. [ ] **Union.** Any Employee who is included in a unit of Employees covered by a collective bargaining agreement, if benefits were the subject of good faith bargaining, and if the collective bargaining agreement does not provide for participation in this Plan.

2. [X] Any **leased employee.**

3. [X] **Non-Resident Alien.** Any Employee who is a non-resident alien who received no earned income (within the meaning of Code section 911(d)(2)) which constitutes income from services performed within the United States (within the meaning of Code section 861(a)(3)).

4. [X] **Part-time.** Any Employee who is expected to work less than 30 hours per week.

5a. [ ] **Other.** Other Employees described in **B.5b** (any exclusion must satisfy Code section 125(g) and the requirements under Section 5.01).

5b. If **B.5a** is selected, describe other Employees excluded from definition of Eligible Employee: _____.

6a. Allow immediate participation for all Eligible Employees employed on the date specified in **B.6b**:
[ ] Yes [X] No

6b. If **B.6a** is "Yes", all Eligible Employees employed on _____ shall become eligible to participate in the Plan as of such date.

7. If **A.10a** is "Yes", (Contributions to fund a Premium Conversion Account are permitted), an Employee shall be an Eligible Employee with respect to the Premium Conversion Account if the Employee is eligible to participate in the benefit plans described in **A.10b**:
[X] Yes [ ] No

8a. Indicate whether the Plan will make any other revisions to the term "Eligible Employee":
[ ] Yes [X] No

8b. If **B.8a** is "Yes", describe any further modifications to the term "Eligible Employee": _____.

Service Requirements

10. Minimum age requirement for an Eligible Employee to become eligible to be a Participant in the Plan: None

11. Minimum service requirement for an Eligible Employee to become eligible to be a Participant in the Plan:
- **i.** [ ] None.
- **ii.** [ ] Completion of _____ hours of service
- **iii.** [X] Completion of 60 days of service
- **iv.** [ ] Completion of _____ months of service
- **v.** [ ] Completion of _____ years of service

12a. Frequency of entry dates:
- **i.** [ ] An Eligible Employee shall become a Participant in the Plan as soon as administratively feasible upon meeting the requirements of **B.10** and **B.11**.
- **ii.** [X] first day of each calendar month
- **iii.** [ ] first day of each plan quarter
- **iv.** [ ] first day of the first month and seventh month of the Plan Year
- **v.** [ ] first day of the Plan Year

12b. If **B.12.a.i** (immediate entry) is not selected, an Eligible Employee shall become a Participant in the Plan on the entry date selected in **B.12a** that is:
- **i.** [X] coincident with or next following
- **ii.** [ ] next following

the date the requirements of **B.10** and **B.11** are met.

13. If **A.10a** is "Yes", (Contributions to fund a Premium Conversion Account are permitted), an Eligible Employee shall become eligible to become a Participant in the Plan with respect to the Premium Conversion Account at the same date as he or she becomes eligible to participate in the Insurance Contracts(s) described in **A.10b**:
[X] Yes [ ] No

14a. Indicate whether the Plan will make any other revisions to the eligibility rules specified in **B.10 - B.13**:
[ ] Yes [X] No

14b. If **B.14a** is "Yes", describe any further modifications to the eligibility rules specified in **B.10 - B.13**: _____.

Transfers/Rehires

15. Permit Participants who are no longer Eligible Employees (for reasons other than Termination) to continue to participate in the Plan until the end of the Plan Year (Section 3.02):
[ ] Yes [X] No
NOTE: If "No" is selected, a Participant who has a change in job classification or a transfer that results in the Participant no longer qualifying as an Eligible Employee shall cease to be a Participant as of the effective date of such change of job classification or transfer.

16. Automatically reinstate benefit elections for Terminated Participants who are rehired within 30 days of Termination and permit new benefit elections for Terminated Participants who are rehired more than 30 days after Termination (Section 3.03(a)):
[ ] Yes [X] No
NOTE: If "No" is selected, a Terminated Participant shall not be able to Participate in the Plan until the later of the first day of the subsequent Plan Year or the first entry date following reemployment.

C. BENEFITS

Premium Conversion

1a. If **A.10a** is "Yes" (Contributions to fund a Premium Conversion Account are permitted), provide for automatic enrollment for the Premium Conversion Account:
[X] Yes [ ] No
NOTE: If **C.1a** is "Yes", a Participant shall be deemed to elect to contribute the entire amount of any premiums payable by the Participant for the benefit plans described in **A.10b**.

1b. If **A.10a** is "Yes" (Contributions to fund a Premium Conversion Account are permitted), provide for automatic adjustment of Participant elections for changes in the cost of insurance pursuant to the terms of Treas. Reg. 1.125-4:
[X] Yes [ ] No

Health Care Reimbursement

2. If **A.11** is "Yes" (Contributions to fund a Health Care Reimbursement Account are permitted), enter the maximum amount that can be contributed to a Health Care Reimbursement Account in any Plan Year: 2,500.

3. If **A.11** is "Yes" (Contributions to fund a Health Care Reimbursement Account are permitted), specify whether a Participant shall continue making contributions after Termination of employment for the remainder of the Plan Year:

i. [ ] Yes - Continue contributions on an after-tax basis and reimbursements will be allowed for the remainder of the Plan Year.

ii. [X] No - Contributions shall cease upon Termination and reimbursements will be allowed only for expenses incurred prior to Termination.

NOTE: Any required COBRA elections described in Section 4.06 shall supersede this **C.3**.

4a. If **A.11** is "Yes" (Contributions to fund a Health Care Reimbursement Account are permitted), indicate whether a Participant may revise a Health Care Reimbursement Account election upon a change of status:

i. [ ] Yes - without limitation

ii. [ ] Yes – but no decrease to the extent that new annual contribution amount would be less than the amount previously reimbursed at the time of the election change

iii. [X] Yes - a Participant may only increase an election upon a change of status

iv. [ ] Yes - with limitations described in **C.4b**.

v. [ ] No

NOTE: The rules regarding the revision of Health Care Reimbursement Account elections in this **C.4** are also subject to the conditions and limitations provided in **C.12**.

4b. If **A.11** is "Yes" and if **C.4a.iv** is selected (Yes - with limitations described in **C.4b**), describe the limitations: _____.

5a. If **A.11** is "Yes" (Contributions to fund a Health Care Reimbursement Account are permitted), exclude coverage for over the counter drugs:

[ ] Yes [X] No

5b. If **A.11** is "Yes" (Contributions to fund a Health Care Reimbursement Account are permitted), exclude coverage for other expenses described in **C.5c**:

[ ] Yes [X] No

5c. If **A.11** is "Yes" and **C.5b** is "Yes", describe other expenses that are not eligible for reimbursement: _____.

NOTE: If **A.11** is "Yes" (Contributions to fund a Health Care Reimbursement Account are permitted), reimbursements may be made for any expense that qualifies for exclusion from income under Code section 105(b) (other than certain long term care expenses and insurance premiums), except as provided in **C.5a-c**.

6a. If **A.11** is "Yes" (Contributions to fund a Health Care Reimbursement Account are permitted), describe method to coordinate coverage in the Plan with Health Savings Accounts (Section 6.01(j)):

i. [X] **None.** Coverage in the Plan is not limited or the Plan is not used in conjunction with a Health Savings Account.

ii. [ ] **Permitted Coverage.** Coverage in the Plan is only provided for permitted insurance and other specified coverage (e.g., coverage for accidents, disability, dental care, vision care or preventive care within the meaning of Code section 223(c)(1) and Rev. Rul. 2004-45 (but not through insurance or for long-term care services).

iii. [ ] **Post Deductible Coverage.** The Plan will not pay or reimburse any medical expense incurred before the minimum annual deductible under Code section 223(c)(2)(A)(i) is satisfied.

iv. [ ] **Both Permitted and Post Deductible Coverage.** Until the minimum annual deductible under Code section 223(c)(2)(A)(i) is satisfied, coverage in the Plan is only provided for permitted insurance and other specified coverage (e.g., coverage for accidents, disability, dental care, vision care or preventive care within the meaning of Code section 223(c)(1) and Rev. Rul. 2004-45 (but not through insurance or for long-term care services). The Plan will pay or reimburse all medical expenses otherwise allowed by the Plan incurred after the minimum annual deductible under Code section 223(c)(2)(A)(i) is satisfied.

6b. If **A.11** is "Yes", **C.6a** is not "None" and **D.3a** is "Yes" (grace period allowed), indicate period when the limitations described in **C.6a** apply:

i. [ ] Entire Plan Year.

ii. [ ] Only during the grace period described in **D.3**.

NOTE: If no grace period is allowed in **D.3a**, the limitations in **C.6a** shall apply for the entire Plan Year.

6c. If **A.11** is "Yes" and **C.6a** is not "None", the limitations shall apply to:

i. [ ] All Participants.

ii. [ ] Only Participants who are also eligible to participate in the high deductible health plan.

iii. [ ] Only Participants who are also enrolled in the high deductible health plan.

NOTE: If **C.6a** is "None" or **C.6c** is not "All Participants", eligibility for a Health Savings Account may be limited.

7. If **A.11** is "Yes" (Contributions to fund a Health Care Reimbursement Account are permitted), describe method to coordinate coverage in the Plan with a Company-sponsored health reimbursement arrangement ("HRA") for expenses that are reimbursable under both this Plan and the HRA (Section 6.01(e)):

i. [X] **None.** Plan is not used in conjunction with a Company-sponsored HRA.

ii. [ ] **HRA first.** A Participant shall not be entitled to payment/reimbursement under the Health Care Reimbursement Account until the Participant has received his or her maximum reimbursement under the HRA.
iii. [ ] **Cafeteria plan first.** A Participant shall not be entitled to payment/reimbursement under the HRA until the Participant has received his or her maximum reimbursement under the Health Care Reimbursement Account.

Company Contributions

8a. Indicate whether the Company may contribute to the Plan (Section 4.09):
i. [ ] Yes - in Company's sole discretion.
ii. [ ] Yes - pursuant the method described in **C.8b**.
iii. [X] No.

8b. If **C.8a** is "Yes - pursuant the method described in **C.8b**", describe how the contributions are determined and allocated: _____.

9a. If **C.8a** is not "No", indicate whether the Plan permits Participants to elect cash in lieu of benefits:
i. [ ] No.
ii. [ ] Yes - with limitation.
iii. [ ] Yes - without limitation.

9b. If **C.8a** is not "No" and **C.9a** is "Yes - with limitation", describe any limitations: _____.

Elections

NOTE: The Plan Administrator may establish a minimum dollar amount or percentage of Compensation for all elections provided that such minimum is non-discriminatory.

10. When may continuing Participants **make** elections regarding contributions (Section 4.06(b)):
i. [ ] The _____ day period ending prior to the beginning of the Plan Year
ii. [X] Pursuant to Plan Administrator procedures.

NOTE: If **C.10.i** is selected, the Plan Administrator may require that elections be made no later than a certain number of days prior to the beginning of the Plan Year. See Section 4.06(a) for procedures regarding new Participants.

11. The election for a continuing Participant who fails to make an election within the period described in **C.10** shall be determined in accordance with the following (Section 4.06(c)-(d)):
i. [] **Election not to participate.** The Participant shall be treated as having elected not to participate in the Plan.
ii. [ ] **Continue same election.** Elections for the applicable Plan Year shall be the same as the elections made in the prior Plan Year.
iii. [X] **Continue same election for the Premium Conversion Account.** Elections for the applicable Plan Year shall be the same as the elections made in the prior Plan Year but only with respect to the Premium Conversion Account. The Participant shall be treated as having elected not to participate in the Plan with respect to any other Accounts.

12. When may Participants **modify** elections regarding contributions (Section 4.07(a)):
i. [X] At any time permitted under Treas. Reg. section 1.125-4.
ii. [ ] Pursuant to Plan Administrator procedures.

13a. A Participant may elect to continue coverage on a pre-tax or after tax basis for non medical benefits when on leave of absence under the FMLA (Section 4.06(f)):
i. [X] Yes - A Participant may continue coverage for all benefits to which he is entitled when on FMLA leave.
ii. [ ] No - A Participant may continue coverage for Premium Conversion Accounts and Health Care Reimbursement Accounts only.

13b. A Participant may elect to continue coverage on a pre-tax or after tax basis pursuant to **C.13a** when on a leave of absence other than a leave of absence under the FMLA:
i. [X] Yes.
ii. [ ] Yes - but subject to the conditions and limitations described in **C.13c**.
iii. [X] No.

13c. If **C.13b** is "Yes - but subject to conditions and limitations", describe the conditions and/or limitations: _____.

D. PLAN OPERATIONS

Claims

1. Claims for reimbursement for an active Participant must be filed with the Plan Administrator (Section 6.01):
i. [X] within 120 days following the last day of each Plan Year.
ii. [ ] by _____.

2a. The Plan provides for an earlier deadline for claims submission for Terminated Participants:
[X] Yes [ ] No

2b. If **D.2a** is Yes, claims for reimbursement for a Terminated Participant must be filed with the Plan Administrator (Section 6.01):

i. [X] within 30 days following Termination of employment.
ii. [ ] by _____.

3a. The Plan provides for a 2-1/2 month grace period described in IRS Notice 2005-42 immediately following the end of each Plan Year (Section 4.05(c)):
i. [X] Yes.
ii. [ ] Yes - but limited to the Accounts described in **D.3c.**
iii. [ ] No.
NOTE: Claims for reimbursement must be filed with the Plan Administrator within the number of days specified in **D.1** following the last day the grace period.

3b. If **D.3a** is not "No", enter the first day of the first Plan Year for which the grace period will apply: January 1, 2006.

3c. If **D.3a** is "Yes - but limited to certain Accounts", enter the Accounts that are eligible for the grace period: _____.

4. Indicate whether the Company will provide debit, credit, and/or other stored-value cards for Health Care Reimbursement Accounts and/or Dependent Care Assistance Accounts (Section 6.01(i)):
[X] Yes [ ] No

Plan Administrator

5a. Designation of Plan Administrator (Section 7.01):
i. [X] Plan Sponsor
ii. [ ] Committee appointed by Plan Sponsor
iii. [ ] Other

5b. If **D.5a.iii** is selected, Name of Plan Administrator: _____

6a. Type of indemnification for the Plan Administrator (Section 7.02):
i. [X] None - the Company will not indemnify the Plan Administrator.
ii. [ ] Standard as provided in Section 7.02.
iii. [ ] Custom.

6b. If **D.6a.iii** (Custom) is selected, indemnification for the Plan Administrator is provided pursuant to an Addendum to the Adoption Agreement.

Other Provisions

7a. Claims/notices should be submitted to:
i. [ ] Plan Sponsor
ii. [X] Other

7b. If **D.7a** is Other, indicate where claims should be sent:
i. Name: TASC
ii. Address: PO Box 7308, Madison, WI 53707-7308
iii. Phone: 1-608-663-2762 (fax)

8a. Indicate whether the Health Care Reimbursement Account is subject to COBRA (Section 4.06(g)):
[X] Yes [ ] No

8b. If **D.8a** is "Yes", the contact person listed in the COBRA Notice is the same person described in **D.7** regarding claims:
[X] Yes [ ] No

8c. If **D.8a** is "Yes" and **D.8b** is "No", indicate the contact person listed in the COBRA Notice:
i. Name: _____
ii. Address: _____
iii. Phone: _____

8d. If **D.8a** is "Yes", enter the number of days within which a Participant must notify the Plan Administrator of certain qualifying events such as divorce or legal separation or a dependent child's losing coverage: 60 (60 days minimum).

9. Indicate whether the Health Care Reimbursement Account is subject to the HIPAA privacy rules (Section 7.03):
[X] Yes [ ] No

10. Indicate whether the Plan is subject to FMLA (Section 4.06(f)):
[X] Yes [ ] No

E. EFFECTIVE DATES

Use this Section to provide any effective dates for Plan provisions other than the Effective Date specified in **A.3.**

F. EXECUTION PAGE

Failure to properly fill out the Adoption Agreement may result in the failure of the Plan to achieve its intended tax consequences.

The Plan shall consist of this Adoption Agreement, its related Basic Plan Document #125 and any related Appendix and Addendum to the Adoption Agreement.

Additional participating employers may be specified in an addendum to the Adoption Agreement.

The undersigned agree to be bound by the terms of this Adoption Agreement and Basic Plan Document and acknowledge receipt of same. The Plan Sponsor caused this Plan to be executed this _____ day of _____, 20__.

ATTEST:

SHARON BOCK, CLERK
& COMPTROLLER

BY: _____
Deputy Clerk

PALM BEACH COUNTY FLORIDA, BY ITS
BOARD OF COUNTY COMMISSIONERS

BY: _____
Steven L. Abrams, Chairman

TOTAL ADMINISTRATIVE SERVICES
CORPORATION ("TASC")

BY: _____

Title: Director of Corporate Compliance

APPROVED AS TO FORM AND LEGAL SUFFICIENCY

By: _____
County Attorney

APPROVED AS TO TERMS AND CONDITIONS

By: _____
Department Director

PALM BEACH COUNTY COUNTYOF COUNTY COMMISSIONERS
AMENDED AND RESTATED
CAFETERIA PLAN
BASIC PLAN DOCUMENT

This is a replacement of the prior Cafeteria Basic Plan Document and hereby replaces any and all prior Cafeteria Plan Basic Plan Documents

PALM BEACH COUNTY COUNTYOF COUNTY COMMISSIONERS
AMENDED AND RESTATED
CAFETERIA PLAN
BASIC PLAN DOCUMENT
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ARTICLE 1
INTRODUCTION

Section 1.01 PLAN

This document ("Basic Plan Document") and its related Adoption Agreement are intended to qualify as a cafeteria plan within the meaning of Code section 125. To the extent provided in the Adoption Agreement, the Plan provides for the pre-tax payment of insurance premiums and contributions to spending accounts that is excludable from gross income under Code section 125, reimbursement of certain medical expenses that is excludable from gross income under Code section 105(b) and reimbursement of certain dependent care expenses that is excludable from gross income under Code section 129, and reimbursement of certain adoption expenses that is excludable from gross income under Code section 137.

Section 1.02 APPLICATION OF PLAN

Except as otherwise specifically provided herein, the provisions of this Plan shall apply to those individuals who are Eligible Employees of Palm Beach County Board of County Commissioners, or its affiliates Supervisor of Elections, or Palm Tran, Inc. hereinafter referred to as "the County," on or after the Effective Date. Except as otherwise specifically provided for herein, the rights and benefits, if any, of former Eligible Employees of the County whose employment terminated prior to the Effective Date, shall be determined under the provisions of the Plan, as in effect from time to time prior to that date.

ARTICLE 2
DEFINITIONS

"Account" means the balance of a hypothetical account established for each Participant as of the applicable date. "Account" or "Accounts" shall include to the extent provided in the Adoption Agreement, a Premium Conversion Account, a Health Care Reimbursement Account, a Dependent Care Assistance Account, an Adoption Assistance Account and such other account(s) or sub-account(s) as the Plan Administrator, in its discretion, deems appropriate.

"Adoption Agreement" means the document executed in conjunction with this Basic Plan Document that contains the optional features selected by the Plan Sponsor.

"Adoption Assistance Account" means the Account established with respect to the Participant's election to have adoption expenses reimbursed by the Plan pursuant to Section 4.04.

"Code" means the Internal Revenue Code of 1986, as amended from time to time.

"County" means the Plan Sponsor and any other entity that has adopted the Plan with the approval of the Plan Sponsor.

"Compensation" means the cash wages or salary paid to a Participant.

"Dependent Care Assistance Account" means the Account established with respect to the Participant's election to have dependent care expenses reimbursed by the Plan pursuant to Section 4.03.

"Effective Date" shall have the meaning set forth in the Adoption Agreement.

"Eligible Employee" means any Employee employed by the County, subject to the modifications and exclusions described in the Adoption Agreement. If an individual is subsequently reclassified as, or determined to be, an Employee by a court, the Internal Revenue Service or any other governmental agency or authority, or if the County is required to reclassify such individual an Employee as a result of such reclassification determination (including any reclassification by the County in settlement of any claim or action relating to such individual's

employment status), such individual shall not become an Eligible Employee by reason of such reclassification or determination.

"Employee" means any individual who is employed by the Employer. The term "Employee" shall not include: (i) a self-employed individual (including a partner) as defined in Code section 401(c), or (ii) any person who owns (or is considered as owning within the meaning of Code section 318) more than 2 percent of the outstanding stock of an S corporation.

"Employer" means the County or any other employer required to be aggregated with the County under Code sections 414(b), (c), (m) or (o); provided, however, that "Employer" shall not include any entity or unincorporated trade or business prior to the date on which such entity, trade or business satisfies the affiliation or control tests described above.

"ERISA" means the Employee Retirement Income Security Act of 1974, as amended from time to time.

"FMLA" means the Family and Medical Leave Act of 1993 as amended from time to time.

"Health Care Reimbursement Account" means the Account established with respect to the Participant's election to have medical expenses reimbursed by the Plan pursuant to Section 4.02.

"Insurance Contract" means an insurance policy, contract or self-funded arrangement under which a Participant is eligible to receive benefits regardless of whether such policy, contract or arrangement is related to any benefit offered hereunder. Insurance Contract shall not include any product which is advertised, marketed, or offered as long-term care insurance.

"Participant" means an Eligible Employee who participates in the Plan in accordance with Articles 3 and 4.

"Plan Administrator" means the person(s) designated pursuant to the Adoption Agreement and Section 7.01.

"Plan Sponsor" means the entity described in the Adoption Agreement.

"Plan Year" means the 12-consecutive month period described in the Adoption Agreement.

"Premium Conversion Account" means the Account established with respect to the Participant's election to have insurance premiums reimbursed by the Plan pursuant to Section 4.01.

"Termination" and "Termination of Employment" means any absence from service that ends the employment of the Employee with the County.

ARTICLE 3
PARTICIPATION

Section 3.01 PARTICIPATION

Each Eligible Employee as of the Effective Date who was eligible to participate in the Plan immediately prior to the Effective Date shall be a Participant eligible to make benefit elections pursuant to Article 4 on the Effective Date. Each other Eligible Employee who was not a Participant in the Plan prior to the Effective Date shall become a Participant eligible to make benefit elections pursuant to Article 4 on the date specified in the Adoption Agreement; provided that he is an Eligible Employee on such date. Notwithstanding the foregoing, a Participant shall be eligible to make elections only for the Accounts as are specifically authorized in the Adoption Agreement.

Section 3.02 TRANSFERS

If a change in job classification or a transfer results in an individual no longer qualifying as an Eligible Employee, such Employee shall cease to be a Participant for purposes of Article 4 (or shall not become eligible to become a Participant) as of the effective date of such change of job classification or transfer; unless otherwise provided in the Adoption Agreement. Should such Employee again qualify as an Eligible Employee, he shall become a Participant as of the first day of the subsequent Plan Year; unless earlier participation is required by applicable law or permitted pursuant to the change of status provisions of Section 4.07(a). If an Employee who was not previously an Eligible Employee becomes an Eligible Employee, he shall become a Participant on the first entry date following the later of the effective date of such subsequent change of status or the date the Employee meets the eligibility requirements of this Article 3.

Section 3.03 TERMINATION AND REHIRES

(a) Participants. If a Participant has a Termination of Employment, such Employee shall cease to be a Participant for purposes of Article 4 as of his Termination of Employment. Unless otherwise provided in the Adoption Agreement, if an individual who has satisfied the applicable eligibility requirements set forth in Article 3 as of his Termination date, and who is subsequently reemployed by the County as an Eligible Employee, shall resume or become a Participant as of the later of the first day of the subsequent Plan Year or the first entry date following reemployment. Notwithstanding the foregoing and if so provided in the Adoption Agreement, the Plan Administrator shall automatically reinstate benefit elections for Terminated Participants who are rehired within 30 days of Termination and permit new benefit elections for Terminated Participants who are rehired more than 30 days after Termination.

(b) Non-Participants. An Eligible Employee who has not satisfied the applicable eligibility requirements set forth in Article 3 on his Termination date, and who is subsequently reemployed by the County as an Eligible Employee, shall be eligible to participate on the first entry date following of the later of the effective date of such reemployment or the date the individual meets the eligibility requirements of this Article 3.

Section 3.04 PROCEDURES FOR ADMISSION

The Plan Administrator shall prescribe such forms and may require such data from Participants as are reasonably required to enroll a Participant in the Plan or to effectuate any Participant elections made pursuant to Article 4.

ARTICLE 4
ACCOUNTS

Section 4.01 PREMIUM CONVERSION ACCOUNTS

(a) In General. To the extent that the Adoption Agreement authorizes Premium Conversion Accounts, each Participant may choose to receive his or her full Compensation for any Plan Year in cash or to have a portion of such Compensation applied by the County toward the Premium Conversion Account described in Subsection (b). The amount of such contributions to and the premiums that may be reimbursed from the Premium Conversion Account shall not exceed the employee-paid portion of premiums payable under the Insurance Contracts specified in the Adoption Agreement. If an Insurance Contract is offered in conjunction with a County-sponsored benefit plan, a Participant shall be eligible to make contributions to the Premium Conversion Account with respect to that Insurance Contract only if he or she is also eligible to participate in the applicable County-sponsored plan. The Account established under this Section 4.01 is intended to qualify under Code Sections 79 and 106(a) to the extent so indicated in the Adoption Agreement and shall be interpreted in a manner consistent with such Code sections. Elections for Code section 79 coverage shall be made on an after-tax basis to the extent that the premiums relate to coverage in excess of the limit described in Code section 79(a).

(b) Premium Conversion Account. Each Participant's Premium Conversion Account will be credited with amounts withheld from the Participant's Compensation and amounts paid by the County pursuant to Section 4.08; and will be debited for amounts applied to employee-paid portion of applicable premiums. However, the Plan Administrator will not direct the County to pay any premium on an Insurance Contract to the extent such payment exceeds the balance of a Participant's Premium Conversion Account.

(c) Conflicts. In the event of a conflict between the terms of this Plan and the terms of an Insurance Contract, the terms of the Insurance Contract (or the benefit plan under which it is established) shall control in defining the terms and conditions of coverage including, but not limited to, the persons eligible for insurance, the dates of their eligibility, the conditions which must be satisfied to become insured, if any, the benefits Participants are entitled to and the circumstances under which insurance terminates.

Section 4.02 HEALTH CARE REIMBURSEMENT ACCOUNTS

(a) In General. To the extent that the Adoption Agreement authorizes Health Care Reimbursement Accounts, each Participant may choose to receive his or her full Compensation for any Plan Year in cash or to have a portion of such Compensation applied by the County toward the Health Care Reimbursement Account described in Subsection (b). The amount of such contributions to and the premiums that may be reimbursed from the Premium Conversion Account shall not exceed the maximum annual limit described in the Adoption Agreement. The Account established under this Section 4.02 is intended to qualify as a health flexible spending arrangement under Code Sections 105 and 106(a) and shall be interpreted in a manner consistent with such Code sections.

(b) Health Care Reimbursement Account. Each Participant's Health Care Reimbursement Account will be credited with amounts withheld from the Participant's Compensation and amounts paid by the County pursuant to Section 4.08; and will be debited for expenses described in Subsection (c). The entire annual amount elected by the Participant on the salary reduction agreement for the Plan Year for the Health Care Reimbursement Account less any reimbursements already disbursed shall be available to the Participant at any time during the Plan Year without regard to the balance in the Health Care Reimbursement Account provided that the amounts elected in the salary reduction agreement have been paid as provided in the salary reduction agreement.

(c) Eligible Expenses. Except as otherwise provided in the Adoption Agreement, a Participant may be reimbursed from his or her Health Care Reimbursement Account for expenses that are: (i) incurred in the Plan Year (except as provided in Section 4.05(c)), (ii) incurred while the Participant participates in the Plan, and (iii) excludable under Code section 105(b); provided that such expenses that are not covered, paid or reimbursed from any other source.

(d) Limits. The maximum amount of expense that may be contributed/reimbursed in any Plan Year for the Health Care Reimbursement Account is $2,500 for plan years beginning after December 31, 2012. This limit of $2,500 will be amended and indexed for cost-of-living adjustments for plan years beginning after December 31, 2013. Therefore, for plan years beginning after December 31, 2013, the limit for Health Care Reimbursement Accounts will be the indexed amount.

Section 4.03 DEPENDENT CARE ASSISTANCE ACCOUNTS

(a) In General. To the extent that the Adoption Agreement authorizes Dependent Care Assistance Accounts, each Participant may choose to receive his or her full Compensation for any Plan Year in cash or to have a portion of such Compensation applied by the County toward the Dependent Care Assistance Account described in Subsection (b). The Account established under this Section 4.03 is intended to qualify as a dependent care assistance program under Code Section 129 and shall be interpreted in a manner consistent with such Code section which provisions are incorporated herein by reference.

(b) Dependent Care Assistance Account. Each Participant's Dependent Care Assistance Account will be credited with amounts withheld from the Participant's Compensation and amounts paid by the County pursuant to Section 4.08; and will be debited for expenses described in Subsection (c). However, the Plan Administrator will not direct the County to reimburse such expenses to the extent the reimbursement exceeds the balance of a Participant's Dependent Care Assistance Account.

(c) Eligible Expenses.

(1) In General. A Participant may be reimbursed from his or her Dependent Care Assistance Account to the extent that such reimbursement: (i) is incurred in the Plan Year (except as provided in Section 4.05(c), (ii) is incurred while the Participant participates in the Plan, and (iii) qualifies as dependent care expenses; provided that such expenses that are not covered, paid or reimbursed from any other source and the Participant does not claim a tax benefit for the same expenses.

(2) Dependent Care Expenses. Dependent care expenses are defined as expenses incurred for the care of a qualifying individual. A qualifying individual is either: (i) a dependent who is under age 13, or (ii) the Participant's spouse or dependent who lives with the Participant and is physically or mentally incapable of caring for himself/herself. However, these expenses are dependent care expenses only if they allow the Participant to be gainfully employed. Dependent care expenses include expenses for household services and expenses for the care of a qualifying individual. Such term shall not include any amount paid for services outside the Participant's household at a camp where the qualifying individual stays overnight. Expenses described in this Subsection which are incurred for services outside the Participant's household are not taken into account if they are incurred on behalf of the Participant's spouse or dependent who is physically or mentally incapable of caring for himself/herself unless such individual lives at least 8 hours per day in the Participant household. Expenses incurred at a dependent care center are taken into account only if such center complies with all applicable laws and regulations of a state or local government, the center provides care for more than six individuals, and the center receives a fee, payment, or grant for providing services for any of the individuals.

(3) Limits. The maximum amount of expense that may be contributed/reimbursed in any Plan Year for the Dependent Care Assistance Account is $5,000 ($2,500 if the Participant is married and filing a separate return). The amount payable may also not be greater than the amount of the Participant's earned income or the earned income of his or her spouse. In the case of a spouse who is a student or a qualifying individual, such spouse shall be deemed to earn $250 per month (one qualifying individual) or $500 per month (more than one qualifying individual).

Section 4.04 ADOPTION ASSISTANCE ACCOUNTS

This Plan Document shall not include the adoption of an Adoption Assistance Account.

Section 4.05 FORFEITURES/TRANSFERS

(a) Forfeitures. Any balance remaining in a Participant's Account at the end of any Plan Year (or after the grace period if Subsection (c) applies) shall be forfeited and shall remain the property of the County. Except as expressly provided herein, any balance remaining in a Participant's Account on his date of Termination shall be forfeited and shall remain the property of the County. However, no forfeiture shall occur until all payments and reimbursements hereunder have been made on claims submitted within the time period specified in Section 6.01(b).

(b) Transfers. Amounts may not be transferred between Accounts.

(c) Grace Period. If the Adoption Agreement provides for a 2-1/2 month grace period, effective for grace periods beginning on or after the date specified in the Adoption Agreement and notwithstanding anything to the contrary in the Plan, the unused contributions that remain in a Participant's Account at the end of a Plan Year may be used to reimburse expenses that are incurred during the grace period. The grace period shall commence on the first day of the subsequent Plan Year and shall end on the fifteenth day of the third calendar month of the subsequent Plan Year. Unless otherwise provided in the Adoption Agreement, the grace period shall apply to all Accounts in which the Participant is eligible to Participate. Payment or reimbursement of unused benefits shall be subject to the following terms and conditions:

(1) Same Account. Unused contributions remaining at the end of a Plan Year relating to a particular Account may only be used to reimburse expenses incurred with respect to that Account.

(2) No Cash Out. Unused contributions remaining at the end of a Plan Year may not be cashed-out or converted to any other taxable or nontaxable benefit.

(3) No Carry-forward. Any unused contributions remaining at the end of a Plan Year that exceed the expenses for a particular Account that are incurred during the grace period may not be carried forward to any subsequent period (including any subsequent Plan Year) and shall be forfeited.

(4) Construction. This Section 4.05(c) is to be construed in accordance with IRS Notice 2005-42 and any superseding guidance.

Section 4.06 ELECTIONS

(a) New Participants. The Plan Administrator shall provide, where possible, an election form/electronic enrollment option to a Participant before such Participant meets the eligibility requirements of Article 3. In order to participate in the Plan in the initial Plan Year, the Participant must return the completed election form to the Plan Administrator, or complete electronic enrollment, on or before such date as specified by the Plan Administrator. However, any election shall not be effective until a pay period following the later of such Participant's effective date of participation pursuant to Article 3 or the date of the receipt of the election form by the Plan Administrator -, or the date of completion of electronic enrollment by the Participant and shall be limited to the expenses incurred after the effective date of the election.

(b) Continuing Participants. Prior to the commencement of each Plan Year, the Plan Administrator shall provide an election form/electronic enrollment option to each Participant and to each other individual who is expected to become a Participant at the beginning of such Plan Year. In order to participate in the Plan in the applicable Plan Year, the Participant must return the completed election form to the Plan Administrator, or complete electronic enrollment, on or before such date specified in the Adoption Agreement, which date shall be no later than the beginning of the first pay period for which the individual's Compensation reduction agreement will apply.

(c) Failure to Return Election Form/Complete Electronic Enrollment. The failure of a Participant described in Subsection (a) to return a completed election form to the Plan Administrator, or complete electronic enrollment, on or before the specified due date shall constitute an election to receive his or her full Compensation in cash for the remainder of the Plan Year. The failure of a Participant described in Subsection (b) to return a completed election form to the Plan Administrator, or complete electronic enrollment, on or before the specified due date shall constitute an election not to participate for the applicable Plan Year unless a default election is otherwise specified in the Adoption Agreement or under Subsection (d).

(d) Premium Conversion Special Election Rules. If elected in the Adoption Agreement, a Participant shall be deemed to elect to contribute the entire amount of any premiums payable by the Participant for the benefits described in Section 4.01 unless he or she affirmatively elects otherwise before such date specified by the Plan Administrator. If elected in the Adoption Agreement, a Participant's election for benefits described in Section 4.01 shall be automatically adjusted for any change in the cost of insurance pursuant to the terms of Treas. Reg. 1.125-4.

(e) Form of Elections. All elections shall be made in written form unless the Plan Administrator provides procedures for such elections to be made in electronic and/or telephonic format to the extent that such alternative format is permitted under applicable law.

(f) Leave of Absence/FMLA/USERRA. If the Plan is subject to FMLA or the Adoption Agreement provides that the Plan is subject to FMLA, the Plan Administrator shall permit a Participant taking unpaid leave under the FMLA to continue medical benefits under such applicable law unless otherwise specified in the Adoption Agreement. To the extent provided in the Adoption Agreement, the Plan Administrator shall also permit a Participant taking unpaid Non-FMLA leave to continue the benefits specified in the Adoption Agreement. Participants continuing participation pursuant to the foregoing shall pay for such coverage (on a pre-tax or after-tax basis) under a method as determined by the Plan satisfying Treas. Reg. 1.125-3 Q&A-3. Any Participant on FMLA leave who revoked coverage shall be reinstated to the extent required by Treas. Reg. 1.125-3. If the Participant's coverage under the Plan terminates while the Participant is on FMLA leave, the Participant is not entitled to receive reimbursements for claims incurred during the period when the coverage is terminated. Upon reinstatement into the Plan upon return from FMLA leave, the Participant has the right to (i) resume coverage at the level in effect before the FMLA leave and make up the unpaid premium payments, or (ii) resume coverage at a level that is reduced by the amount of unpaid premiums and resume premium payments at the level in effect before the FMLA leave. The Plan Administrator shall also permit Participants to continue benefit elections as required under the Uniformed Services Employment and Reemployment Rights Act and shall provide such reinstatement rights as required by such law. The Plan shall also permit Participants to continue benefit elections as required under any other applicable state law to the extent that such law is not pre-empted by federal law.

(g) COBRA. If the Plan is subject to COBRA (Code section 4980B and other applicable state law) or the Adoption Agreement provides that the Plan is subject to COBRA, a Participant shall be entitled to continuation coverage with respect to his or her Health Care Reimbursement Account as prescribed in Code Section 4980B (and the regulations thereunder) or such applicable state statutes.

(h) Procedures. A Participant shall make the elections described in this Section in such form and manner as may be prescribed by the Plan and at such time in advance as the Plan may require. Such procedures may include, without limitation, a minimum annual and per-pay period contribution amount, a maximum contribution per pay-period amount consistent with applicable annual limits, and the ability of a Participant to make after-tax contributions to the Plan.

Section 4.07 REVOCATION OF ELECTIONS

(a) By Participant. Any election made under this Article 4 shall be irrevocable by the Participant during the Plan Year unless revocation is required by the provisions of the Federal Family and Medical Leave Act or other applicable law and is permitted under Treas. Reg. 1.125-4 and the provisions of the Adoption Agreement. If the Adoption Agreement provides that elections may be modified at any time permitted under Treas. Reg. section 1.125-4, elections may be modified upon the occurrence of any of the following events:

(1) HIPAA Special Enrollment Rights. Participant may revoke an election for coverage under a group health plan during a period of coverage and make a new election that corresponds with the special enrollment rights provided in Code section 9801(f).

(2) Change in Status. A Participant may revoke an election during a period of coverage with respect to a qualified benefits plan (as defined in Treas. Reg. 1.125-4(i)(8)) and make a new election for the remaining portion of the period if, under the facts and circumstances: (i) a change in status described in Subsections (A)-(F) occurs; and (ii) the election change is on account of and corresponds with a change in status that affects eligibility for coverage under a qualified benefits plan.

(A) Legal Marital Status. Events that change a Participant's legal marital status, including the following: marriage; death of spouse; divorce; legal separation; and annulment.

(B) Number of Dependents. Events that change a Participant's number of dependents, including the following: birth; death; adoption; and placement for adoption.

(C) Employment Status. Any of the following events that change the employment status of the Participant, the Participant's spouse, or the Participant's dependent: a termination or commencement of employment; a strike or lockout; a commencement of or return from an unpaid leave of absence; a change in worksite and, the extent permitted in Treas. Reg. 1.125-4 and Section 3.03, change in employment status resulting in gaining or losing eligibility under the Plan.

(D) Dependent Satisfies or Ceases to Satisfy Eligibility Requirements. Events that cause a Participant's dependent to satisfy or cease to satisfy eligibility requirements for coverage on account of attainment of age, student status, or any similar circumstance.

(E) Residence. A change in the place of residence of the Participant, spouse, or dependent.

(3) Judgment, Decree, or Order. A Participant may modify an election pursuant to a judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order as defined in ERISA section 609) that requires accident or health coverage for a Participant's child or for a foster child who is a dependent of the Participant; provided that the modification:

(A) changes the Participant's election to provide coverage for the child if the order requires coverage for the child under the Plan; or

(B) cancels coverage for the child if the order requires the spouse, former spouse, or other individual to provide coverage for the child; and that coverage is, in fact, provided.

(4) Entitlement to Medicare or Medicaid. A Participant may modify an election for benefits attributable to a County-sponsored accident or health plan if the Participant, spouse, or dependent becomes entitled to coverage under Medicare or Medicaid (other than coverage consisting solely of benefits under the program for distribution of pediatric vaccines). The Participant may make a prospective election change to cancel or reduce coverage of that Participant, spouse, or dependent under the accident or health plan. Corresponding rights to commence or increase benefits under the accident or health plan shall be granted in the case of loss of coverage under Medicare or Medicaid.

(5) Significant Cost or Coverage Changes. A Participant may modify an election for benefits, other than those provided in Section 4.02, as a result of changes in cost or coverage pursuant to Treas. Reg. section 1.125-4.

(6) FMLA. A Participant taking leave under the FMLA may revoke an existing election of accident or health plan coverage and make such other election for the remaining portion of the period of coverage as may be provided for under the FMLA.

(b) By Plan Administrator. If the Plan Administrator determines that the Plan may fail to satisfy any nondiscrimination requirement or any limitation imposed by the Code, the Plan Administrator may modify any election in order to assure compliance with such requirements or limitations. Any act taken by the Plan Administrator under this Subsection shall be carried out in a uniform and non-discriminatory manner.

(c) Automatic Termination of Election. Any election made under this Section shall automatically terminate on the date specified in Sections 3.02 or 3.03.

(d) Plan Administrator Discretion. The Plan Administrator reserves the right to determine whether a Participant has experienced an event that would permit an election change under this Section 4.07 and whether the Participant's requested election change is consistent with such event.

Section 4.08 EMPLOYER CONTRIBUTIONS

The County may contribute to the Plan to the extent provided in the Adoption Agreement. Such contributions shall be credited to the applicable Account at such time as determined by the County. Notwithstanding the foregoing, County contribution to a Participant's Health Care Reimbursement Account may not exceed the amount of Participant's contribution to such Account.

ARTICLE 5
LIMITATIONS ON CONTRIBUTIONS

Section 5.01 NONDISCRIMINATION

(a) Cafeteria Plan. The Plan may not discriminate in favor of highly compensated employees (within the meaning of Code section 125(e)) as to benefits provided or eligibility to participate.

(b) Group Term Life. The Plan may not discriminate in favor of key employees (within the meaning of Code section 416(i)(1)) as to benefits provided or eligibility to participate with respect to any group term life insurance offered pursuant to Section 4.01.

(c) Health Care Reimbursement Accounts. The Plan may not discriminate in favor of highly compensated employees (within the meaning of Code section 105(h) (5)) as to benefits provided or eligibility to participate with respect to the Account described in Section 4.02.

(d) Dependent Care Assistance Accounts. The Plan may not discriminate in favor of highly compensated employees (within the meaning of Code section 414(q)) as to benefits provided or eligibility to participate with respect to the Account described in Section 4.03.

Section 5.02 LIMITATIONS ON CONTRIBUTIONS

The County shall not contribute to the participant's Flexible Spending Account.

ARTICLE 6
REIMBURSEMENTS

Section 6.01 PROCEDURES FOR REIMBURSEMENT

(a) Benefits Provided by Insurance. All claims for benefits that are provided under Insurance Contracts shall be made by the Participant to the insurance company issuing such contract.

(b) Timing of Claims. Reimbursements and/or payments shall only be made for expenses incurred in the applicable Plan Year while the Participant participates in the Plan. Except as otherwise expressly provided herein, no reimbursement and/or payment shall be made for any expenses relating to services rendered before participation or after Termination of Employment for any reason. All claims for reimbursement and/or payment must be made within the time periods specified in the Adoption Agreement.

(c) Documentation. A Participant or any other person entitled to benefits from the Plan (a "Claimant") may apply for such benefits by completing and filing a claim with the Plan Administrator. Any such claim shall include all information and evidence that the Plan Administrator deems necessary to properly evaluate the merit of and to make any necessary determinations on a claim for benefits. The Plan Administrator may request any additional information necessary to evaluate the claim.

(d) Payment. To the extent that the Plan Administrator approves the claim, the Plan Administrator shall: (i) reimburse the Claimant, or (ii) at the option of the Plan Administrator, pay the service provider directly for any amounts payable from the Accounts established hereunder. The Plan Administrator shall establish a schedule, not less frequently than annually, for the payment of claims. The Plan Administrator may provide that payments/reimbursements of less than certain amount may be carried forward and aggregated with future claims until the reimbursable amount is greater than such minimum, provided, however, that the entire amount of payments/reimbursements outstanding at the end of the Plan Year shall be reimbursed without regard to the minimum payment amount.

(f) Death. If a Participant dies, his beneficiaries or his estate may submit claims for expenses or benefits for the portion of the Plan Year preceding the date of the Participant's death. A Participant may designate a specific beneficiary for this purpose. If no such beneficiary is specified, the Plan Administrator may pay any amount due hereunder to the Participant's spouse, one or more of his or her dependents or a representative of the Participant's estate. Such payment shall fully discharge the Plan Administrator and the County from further liability on account thereof.

(g) Form of Claim/Notice. All claims and notices shall be made in written form unless the Plan Administrator provides procedures for such claims and notices to be made in electronic and/or telephonic format to the extent that such alternative format is permitted under applicable law.

(h) Refunds/Indemnification. If the Plan Administrator determines that any Claimant has directly or indirectly received excess payments/reimbursements or has received payments/reimbursements that are taxable to the Claimant, the Plan Administrator shall notify the Claimant and the Claimant shall repay such excess amount (or at the option of the Plan Administrator, the Claimant shall repay the amount that should have been withheld or paid as payroll or withholding taxes) as soon as possible, but in no event later than 30 days after the date of notification. A Claimant shall indemnify and reimburse the County for any liability the County may incur for making such payments, including but not limited to failure to withhold or pay payroll or withholding taxes from such payments or reimbursements. If the Claimant fails to timely repay an excess amount and/or make sufficient indemnification, the County may: (i) to the extent permitted by applicable law, offset the Claimant's salary or wages, and/or (ii) offset other benefits payable hereunder.

(i) Debit, Credit or Other Stored Value Cards. To the extent provided in the Adoption Agreement, the County may enter into an agreement with a financial institution to provide each Participant a debit, credit or other stored value card to provide immediate payment of reimbursements available under Section 4.02 provided that: (i) such card imposes a limit no greater than the coverage available under Section 4.02, (ii) the Plan Administrator requires each Participant to certify upon enrollment that the card will only be used for eligible medical care expenses and that any medical expense paid with the card has not been reimbursed and the Participant will not seek reimbursement under any other plan covering health benefits, (iii) the card is usable only at a merchant or service provider with a specified merchant code relating to health care, (iv) the County agrees to be liable for all charges made with the card and the merchant or service provider is paid the full amount of the charge by the sponsoring financial institution, and (v) the Plan Administrator utilizes adequate substantiation methods consistent with IRS Revenue Ruling 2003-43. County shall treat all charges to the card as conditional pending confirmation of the medical expense. If the claim is approved, the Participant's maximum available coverage under Section 4.02 is reduced by that amount and the County shall repay the financial institution. If the Participant fails to provide substantiation of the medical expense or the claim is denied, the County shall repay the financial institution and the Participant shall be liable to the County for the charge pursuant to Section 6.01(h). A Participant may obtain benefits under Section 4.02 without the use of the card.

(k) Plan Administrator Procedures. The Plan Administrator may establish procedures regarding the documentation to be submitted in a claim for reimbursement and/or payment and may also establish any other procedures regarding claims for reimbursement and/or payment provided that the procedures do not violate ERISA section 503 (where applicable by law). Such procedures may include, without limitation, requirements to submit claims periodically throughout the Plan Year.

Section 6.02 CLAIMS PROCEDURE FOR HEALTH CARE REIMBURSEMENT ACCOUNT

(a) This Section 6.02 shall apply for any claim for benefits under the Health Care Reimbursement Account.

(b) Timing of Notice of Denied Claim. The Plan Administrator shall notify the Claimant of any adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the

Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

(c) Content of Notice of Denied Claim. If a claim is wholly or partially denied, the Plan Administrator shall provide the Claimant with a notice identifying (1) the reason or reasons for such denial, (2) the pertinent Plan provisions on which the denial is based, (3) any material or information needed to grant the claim and an explanation of why the additional information is necessary, (4) an explanation of the steps that the Claimant must take if he wishes to appeal the denial: (A) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Claimant upon request; or (B) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

(d) Appeal of Denied Claim. If a Claimant wishes to appeal the denial of a claim, he shall file an appeal with the Plan Administrator on or before the 180th day after he receives the Plan Administrator's notice that the claim has been wholly or partially denied. The appeal shall identify both the grounds and specific Plan provisions upon which the appeal is based. The Claimant shall be provided, upon request and free of charge, documents and other information relevant to his claim. An appeal may also include any comments, statements or documents that the Claimant may desire to provide. The Plan Administrator shall consider the merits of the Claimant's presentations, the merits of any facts or evidence in support of the denial of benefits, and such other facts and circumstances as the Plan Administrator may deem relevant. In considering the appeal, the Plan Administrator shall:

(1) Provide for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

(2) Provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

(3) Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

(4) Provide that the health care professional engaged for purposes of a consultation under Subsection (2) shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

The Plan Administrator shall notify the Claimant of the Plan's benefit determination on review within 60 days after receipt by the Plan of the Claimant's request for review of an adverse benefit determination. The Claimant shall lose the right to appeal if the appeal is not timely made.

(e) Denial of Appeal. If an appeal is wholly or partially denied, the Plan Administrator shall provide the Claimant with a notice identifying (1) the reason or reasons for such denial, (2) the pertinent Plan provisions on which the denial is based, (3) a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits,. The determination rendered by the Plan Administrator shall be binding upon all parties.

Section 6.03 CLAIMS PROCEDURES FOR NON-HEALTH BENEFITS

(a) This Section 6.03 shall apply for any claim for benefits under Accounts other than the Health Care Reimbursement Account.

(b) Timing of Notice of Denied Claim. The Plan Administrator shall notify the Claimant of any adverse benefit determination within a reasonable period of time, but not later than 90 days after receipt of the claim. This period may be extended one time by the Plan for up to 90 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 90-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

(c) Content of Notice of Denied Claim. If a claim is wholly or partially denied, the Plan Administrator shall provide the Claimant with a written notice identifying (1) the reason or reasons for such denial, (2) the pertinent Plan provisions on which the denial is based, (3) any material or information needed to grant the claim and an explanation of why the additional information is necessary, and (4) an explanation of the steps that the Claimant must take if he wishes to appeal the denial including a statement that the Claimant may bring a civil action under ERISA.

(d) Appeal of Denied Claim. If a Claimant wishes to appeal the denial of a claim, he shall file a written appeal with the Plan Administrator on or before the 60th day after he receives the Plan Administrator's written notice that the claim has been wholly or partially denied. The written appeal shall identify both the grounds and specific Plan provisions upon which the appeal is based. The Claimant shall be provided, upon request and free of charge, documents and other information relevant to his claim. A written appeal may also include any comments, statements or documents that the Claimant may desire to provide. The Plan Administrator shall consider the merits of the Claimant's written presentations, the merits of any facts or evidence in support of the denial of benefits, and such other facts and circumstances as the Plan Administrator may deem relevant. The Claimant shall lose the right to appeal if the appeal is not timely made. The Plan Administrator shall ordinarily rule on an appeal within 60 days. However, if special circumstances require an extension and the Plan Administrator furnishes the Claimant with a written extension notice during the initial period, the Plan Administrator may take up to 120 days to rule on an appeal.

(e) Denial of Appeal. If an appeal is wholly or partially denied, the Plan Administrator shall provide the Claimant with a notice identifying (1) the reason or reasons for such denial, (2) the pertinent Plan provisions on which the denial is based, (3) a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits. The determination rendered by the Plan Administrator shall be binding upon all parties.

Section 6.04 MINOR OR LEGALLY INCOMPETENT PAYEE

If a distribution is to be made to an individual who is either a minor or legally incompetent, the Plan Administrator may direct that such distribution be paid to the legal guardian. If a distribution is to be made to a minor and there is no legal guardian, payment may be made to a parent of such minor or a responsible adult with whom the minor maintains his residence, or to the custodian for such minor under the Uniform Transfer to Minors Act, if such is permitted by the laws of the state in which such minor resides. Such payment shall fully discharge the Plan Administrator and the County from further liability on account thereof.

Section 6.05 MISSING PAYEE

If the Plan Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such Participants or other person after reasonable efforts have been made to identify or locate such person, such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited one year after the date any such payment first became due.

ARTICLE 7
PLAN ADMINISTRATION

Section 7.01 PLAN ADMINISTRATOR

(a) Designation. The Plan Administrator shall be specified in the Adoption Agreement. In the absence of a designation in the Adoption Agreement, the Plan Sponsor shall be the Plan Administrator. If a Committee is designated as the Plan Administrator, the Committee shall consist of one or more individuals who may be Employees appointed by the Plan Sponsor and the Committee shall elect a chairman and may adopt such rules and procedures as it deems desirable. The Committee may also take action with or without formal meetings and may authorize one or more individuals, who may or may not be members of the Committee, to execute documents in its behalf.

(b) Authority and Responsibility of the Plan Administrator. The Plan Administrator shall have total and complete discretionary power and authority:

(i) to make factual determinations, to construe and interpret the provisions of the Plan, to correct defects and resolve ambiguities and inconsistencies therein and to supply omissions thereto. Any construction, interpretation or application of the Plan by the Plan Administrator shall be final, conclusive and binding;

(ii) to determine the amount, form or timing of benefits payable hereunder and the recipient thereof and to resolve any claim for benefits in accordance with Article 6;

(iii) to determine the amount and manner of any allocations hereunder;

(iv) to maintain and preserve records relating to the Plan;

(v) to prepare and furnish all information and notices required under applicable law or the provisions of this Plan;

(vi) to prepare and file or publish with the Secretary of Labor, the Secretary of the Treasury, their delegates and all other appropriate government officials all reports and other information required under law to be so filed or published;

(vii) to hire such professional assistants and consultants as it, in its sole discretion, deems necessary or advisable; and shall be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions and reports which are furnished by same;

(viii) to determine all questions of the eligibility of Employees and of the status of rights of Participants;

(ix) to adjust Accounts in order to correct errors or omissions;

(x) to determine the validity of any judicial order;

(xi) to retain records on elections and waivers by Participants;

(xii) to supply such information to any person as may be required;

(xiii) to perform such other functions and duties as are set forth in the Plan that are not specifically given to any other fiduciary or other person.

(c) Procedures. The Plan Administrator may adopt such rules and procedures as it deems necessary, desirable, or appropriate for the administration of the Plan. When making a determination or calculation, the Plan

Administrator shall be entitled to rely upon information furnished to it. The Plan Administrator's decisions shall be binding and conclusive as to all parties.

(d) Allocation of Duties and Responsibilities. The Plan Administrator may designate other persons to carry out any of his duties and responsibilities under the Plan.

(e) Compensation. The Plan Administrator shall serve without compensation for its services.

(f) Expenses. All direct expenses of the Plan, the Plan Administrator and any other person in furtherance of their duties hereunder shall be paid or reimbursed by the County.

(g) Allocation of Fiduciary Duties. A Plan fiduciary shall have only those specific powers, duties, responsibilities and obligations as are explicitly given him under the Plan. It is intended that each fiduciary shall not be responsible for any act or failure to act of another fiduciary. A fiduciary may serve in more than one fiduciary capacity with respect to the Plan.

Section 7.02 Indemnification

Indemnification under this Plan Document is limited to that which is permitted by Florida Law.

Section 7.03 HIPAA PRIVACY RULES

(a) Application. This Section 7.03 shall only apply in the event that this Plan constitutes a group health plan as defined in section 2791(a)(2) of the Public Health Service Act or if the Adoption Agreement provides that the Plan is subject to the HIPAA privacy rules.

(b) Privacy Policy. The Plan shall adopt a HIPAA privacy policy, the terms of which are incorporated herein by reference.

(c) Business Associate Agreement. The Plan will enter into a business associate agreement with any persons as may be required by applicable law as determined by the Plan Administrator.

(d) Notice of Privacy Practices. The Plan will provide each Participant with a notice of privacy practices to the extent required by applicable law.

(e) Disclosure to the County.

(1) In General. This Subsection permits the Plan to disclose protected health information ("PHI"), as defined in the HIPAA privacy rules, to the County to the extent that such PHI is necessary for the County to carry out its administrative functions related to the Plan.

(2) Permitted Disclosure. The Plan may disclose the PHI to the County that is necessary for the County to carry out the following administrative functions related to the Plan: eligibility determinations, enrollment and disenrollment activities, and Plan amendments or termination. The County may use and disclose the PHI provided to it from the Plan only for the administrative purposes described in this Subsection.

(3) Limitations. The County agrees to the following limitations and requirements related to its use and disclosure of PHI received from the Plan:

(A) Use and Further Disclosure. The County shall not use or further disclose PHI other than as permitted or required by the Plan document or as required by all applicable law, including but not limited to the HIPAA privacy rules. When using or disclosing PHI or when requesting PHI from the Plan, the County shall make reasonable efforts to limit the PHI to the minimum amount necessary to accomplish the intended purpose of the use, disclosure or request.

(B) Agents and Subcontractors. The County shall require any agents, including subcontractors, to whom it provides PHI received from the Plan to agree to the same restrictions and conditions that apply to the County with respect to such information.

(C) Employment-Related Actions. Except as permitted by the HIPAA privacy rules and other applicable federal and state privacy laws, the County shall not use PHI for employment-related actions and decisions, or in connection with any other employee benefit plan of the County.

(D) Reporting of Improper Use or Disclosure. The County shall promptly report to the Plan any improper use or disclosure of PHI of which it becomes aware.

(E) Adequate Protection. The County shall provide adequate protection of PHI and separation between the Plan and the County by: (i) ensuring that only those employees who work in the County's Risk Management Department, the County Attorney Office, and the Finance Department on issues related to the healthcare components of the Plan will have access to the PHI provided by the Plan; (ii) restricting access to and use of PHI to only the employees identified in clause (i) above and only for the administrative functions performed by the County on behalf of the Plan that are described herein; (iii) requiring any agents of the Plan who receive PHI to abide by the Plan's privacy rules; and (iv) using the County 's established disciplinary procedures to resolve issues of noncompliance by the employees identified in clause (i) above.

(F) Return or Destruction of PHI. If feasible, the County shall return or destroy all PHI received from the Plan that the County maintains in any form, and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If such return or destruction is not feasible, the County shall limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

(G) Participant Rights. The County shall provide Participants with the following rights: (i) the right to access to their PHI in accordance with 45 C.F.R. §164.524; (ii) the right to amend their PHI upon request (or the County will explain to the Participant in writing why the requested amendment was denied) and incorporate any such amendment into a Participant's PHI in accordance with 45 C.F.R. §164.526; and (iii) the right to an accounting of all disclosures of their PHI in accordance with 45 C.F.R. §164.528.

(H) Cooperation with HHS. The County shall make its books, records, and internal practices relating to the use and disclosure of PHI received from the Plan available to HHS for verification of the Plan's compliance with the HIPAA privacy rules.

(4) Certification. By executing the accompanying Adoption Agreement, the County hereby certifies that the Plan documents have been amended in accordance with 45 C.F.R. §164.504(f), and that the County protect the PHI as described in Subsection 3 herein.

(5) Security Standards Requirement. To comply with the Security Standards regulations that were published on February 21, 2003, the County must:

(A) implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic PHI that it creates, receives, maintains or transmits on behalf of the Plan;

(B) ensure that the adequate separation required by 45 C.F.R. 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;

(C) ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information; and

(D) report to the Plan any security incident of which it becomes aware.

(6) Amendment. Notwithstanding any other provision of the Plan, this Section may be amended in any way and at any time by the County's Privacy Officer.

(7) Effective Dates. Subsections (1) – (4) and Subsection (6) apply to the Plan no later than April 14, 2003, or such other date that the HIPAA Privacy Regulations apply to the Plan. Section (5) applies to the Plan no later than April 20, 2005, or such other date that the HIPAA Security Regulations apply to the Plan.

Section 7.04 MEDICAL CHILD SUPPORT ORDERS

In the event the Plan Administrator receives a medical child support order (within the meaning of ERISA section 609(a)(2)(B)), the Plan Administrator shall notify the affected Participant and any alternate recipient identified in the order of the receipt of the order and the Plan's procedures for determining whether such an order is a qualified medical child support order (within the meaning of ERISA section 609(a)(2)(A)). Within a reasonable period the Plan Administrator shall determine whether the order is a qualified medical child support order and shall notify the Participant and alternate recipient of such determination.

ARTICLE 8
AMENDMENT AND TERMINATION

Section 8.01 AMENDMENT

The provisions of the Plan may be amended in writing at any time and from time to time by the Plan Sponsor.

Section 8.02 TERMINATION

(a) It is the intention of the Plan Sponsor that this Plan will be permanent. However, the Plan Sponsor reserves the right to terminate the Plan at any time for any reason.

(b) Each entity constituting the County reserves the right to terminate its participation in this Plan. Each such entity constituting the County shall be deemed to terminate its participation in the Plan if: (i) it is a party to a merger in which it is not the surviving entity and the surviving entity is not an affiliate of another entity constituting the County, or (ii) it sells all or substantially all of its assets to an entity that is not an affiliate of another entity constituting the County.

ARTICLE 9
MISCELLANEOUS

Section 9.01 NONALIENATION OF BENEFITS

No Participant or Beneficiary shall have the right to alienate, anticipate, commute, pledge, encumber or assign any of the benefits or payments which he may expect to receive, contingently or otherwise, under the Plan.

Section 9.02 NO RIGHT TO EMPLOYMENT

Nothing contained in this Plan shall be construed as a contract of employment between the County, the Participant, or as a right of any Employee to continue in the employment of the County, or as a limitation of the right of the County to discharge any of its Employees, with or without cause.

Section 9.03 NO FUNDING REQUIRED

Except as otherwise required by law:

(a) Any amount contributed by a Participant to provide benefits hereunder shall remain part of the general assets of the County and all payments of benefits under the Plan shall be made solely out of the general assets of the County.

(b) The County shall have no obligation to set aside any funds, establish a trust, or segregate any amounts for the purpose of making any benefit payments under this Plan. However, the County may in its sole discretion, set aside funds, establish a trust, or segregate amounts for the purpose of making any benefit payments under this Plan.

(c) No person shall have any rights to, or interest in, any Account other than as expressly authorized in the Plan.

Section 9.04 GOVERNING LAW

The Plan shall be construed in accordance with and governed by the laws of the state of Florida to the extent not preempted by Federal law.

Section 9.05 TAX EFFECT

The County does not represent or guarantee that any particular federal, state or local income, payroll, personal property or other tax consequence will result from participation in this Plan. A Participant should consult with professional tax advisors to determine the tax consequences of his or her participation.

Section 9.06 SEVERABILITY OF PROVISIONS

If any provision of the Plan shall be held invalid or unenforceable, such invalidity or unenforceability shall not affect any other provisions hereof, and the Plan shall be construed and enforced as if such provisions had not been included.

Section 9.07 HEADINGS AND CAPTIONS

The headings and captions herein are provided for reference and convenience only, shall not be considered part of the Plan, and shall not be employed in the construction of the Plan.

Section 9.08 GENDER AND NUMBER

Except where otherwise clearly indicated by context, the masculine and the neuter shall include the feminine and the neuter, the singular shall include the plural, and vice-versa.