Agenda Item #: 3Z1

PALM BEACH COUNTY
BOARD OF COUNTY COMMISSIONERS

AGENDA ITEM SUMMARY

Meeting Date: March 11, 2014	**[X]**	**Consent**	**[ ]**	**Regular**
	[ ]	**Ordinance**	**[ ]**	**Public Hearing**

Department: Risk Management

Submitted By: Risk Management

Submitted For: Group Insurance

I. EXECUTIVE BRIEF

Motion and Title: Staff recommends motion to approve: the Palm Beach County Board of County Commissioners Section 125 Flexible Spending Plan Document, as Amended and Restated.

Summary: Following an RFP process, staff selected and the Board approved a contract with P&A Group to provide Section 125 Flexible Spending Account (FSA) administrative services for eligible County employees effective January 1, 2014. Included in the contract at no extra cost, P&A Group has provided the County with an amended and restated Section 125 Flexible Spending Plan Document, also referred to as a "Cafeteria Plan" to reflect all current IRS guidelines pertaining to the Plan. The Board has offered eligible employees a Cafeteria Plan, which allows them to use pre-tax deductions to fund certain health insurance premiums, medical, and dependent care expenses, since 1988. The Plan provides payroll tax savings dollars to employees as well as the Board. Countywide (TKF)

Background and Justification: The County 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 dependent care expenses. The Plan also allows for certain health insurance premiums to be paid on a "pre-tax" basis. 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. The Plan provides for the pre-tax payment of insurance premiums (for qualifying policies offered by the County) and contributions to 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.

Attachments:
1. Palm Beach County Board of County Commissioners Section 125 Flexible Spending Plan Document, as Amended and Restated

Recommended By: Nancy L Bolton 2/24/14
Department Director **Date**

Approved By: 3/3/14
County/Deputy/Assistant County Administrator **Date**

II. FISCAL IMPACT ANALYSIS

A. Five Year Summary of Fiscal Impact

Fiscal Years	2014	2015	2016	2017	2018
Capital Expenditures					
Operating Costs					
External Revenues					
Program Income (County)					
In-Kind Match (County)					
Net Fiscal Impact					
# ADDITIONAL FTE POSITIONS (Cumulative)	0	0	0	0	0

Is Item Included In Current Budget? Yes _____ No _____

Budget Account Exp No.: Fund _____ Dept _____ Unit _____ Obj _____

Rev No.: Fund _____ Dept _____ Unit _____ Obj _____

B. Recommended Sources of Funds/Summary of Fiscal Impact:
This item has no fiscal impact.

C. Departmental Fiscal Review: Jessica Kolis

III. REVIEW COMMENTS

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

2/25/14
2/26 2D 8/24
OFMB

2/28/14
2.28.14 Bl Newby
Contract Dev. and Control

B. Legal Sufficiency:

2/28/14
Assistant County Attorney

C. Other Department Review:

_____
Department Director

REVISED 9/03
ADM FORM 01
(THIS SUMMARY IS NOT TO BE USED AS A BASIS FOR PAYMENT.)

PALM BEACH COUNTY BOARD OF COUNTY COMMISSIONERS

SECTION 125 FLEXIBLE SPENDING PLAN

Amended and Restated

PALM BEACH COUNTY BOARD OF COUNTY COMMISSIONERS
SECTION 125 FLEXIBLE SPENDING PLAN

TABLE OF CONTENTS

ARTICLE I: INTRODUCTION

1.1 *Cafeteria Plan Status.* This Plan is intended to qualify as a "cafeteria plan" under Section 125 of the Internal Revenue Code of 1986, as amended, and is to be interpreted in a manner consistent with the requirements of Section 125 and any regulations thereunder.

1.2 *Purpose of Plan.* The purpose of this Plan is to provide employees of the Employer with a choice between cash and certain non-cash benefits under the benefit plans and arrangements of the Employer.

ARTICLE II: DEFINITIONS

Whenever used herein, the following terms have the following meanings unless a different meaning is clearly required by the context:

2.1 **"Administrator"** means the Employer or such other person or committee as may be appointed from time to time by the Employer to supervise the administration of the Plan.

2.2 **"Code"** means the Internal Revenue Code of 1986, as amended from time to time. Reference to any section or subsection of the Code includes reference to any comparable or succeeding provisions of any legislation that amends, supplements or replaces such section or subsection.

2.3 **"Compensation"** means any wages, salary or other amounts paid in cash by the Employer and reportable on a Participant's Form W-2.

2.4 **"Component Plans"** means the Insurance Plans and Flexible Spending Account Options of the Employer.

2.5 **"Deemed Election"** means the election of benefits that a Participant will be deemed to have made if he or she fails to file a completed non-election form for any Period of Coverage on or before the deadline set by the Administrator. A Participant's failure to timely file a completed election form for his or her initial Period of Coverage under the Plan shall constitute an election of all benefits under the Insurance Premium Pre-Tax Payment Option (and a corresponding agreement to a reduction in the Participant's share of the cost during such Period of Coverage of each such benefit) and an election not to receive any benefits under any of the Flexible Spending Account Options. A Participant's failure to timely file a completed election form for any subsequent Period of Coverage shall constitute (a) a re-election of the same benefits, if any, as the Participant had elected (including any benefits elected pursuant to a Deemed Election) under the Insurance Premium Pre-Tax Payment Option for the immediately preceding Period of Coverage and a corresponding agreement to a reduction in the Participant's Compensation during the Period of Coverage equal to the Participant's share of the cost of such benefits, and (b) an election to not receive any benefits under any of the Flexible Spending Account Options.

2.6 **"Dependent"** means any individual who is a dependent of the Participant as defined in Code §152, with the following exceptions:

(a) For purposes of accident or health coverage including the Medical Expense Reimbursement Account Option, (1) a dependent is defined as in Code §152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof; and (2) any child to whom Code §152(e) applies (regarding a child of divorced parents, etc., where one or both parents have custody of the child for more than half of the calendar year and where the parents together provide more than half of the child's support for the calendar year) is treated as a Dependent of both parents. For purposes of accident or health coverage, "Dependent" also includes any child of a Participant who, as of the end of the current calendar year, will not have attained age twenty-seven.

Notwithstanding the foregoing, the Medical Expense Reimbursement Account Option will provide benefits in accordance with the applicable requirements of any qualified medical support order (as defined under applicable federal law) even if the child does not meet the definition of "Dependent".

(b) For purposes of the Dependent Care Assistance Account Option, a Dependent means a "qualifying individual" as defined in Code §21(b)(1) with respect to the Participant, and in the case of divorced parents, a qualifying individual who is a child shall, as provided in Code §21(e)(5), be treated as a qualifying individual of the custodial parent (within the meaning of Code §152(e)(1)) and shall not be treated as a qualifying individual with respect to the non-custodial parent.

2.7 **"Dependent Care Service Provider"** means a person who provides dependent care, but shall not include (a) a Dependent care center (as defined in Section 21(b)(2)(D) of the Code), unless the requirements of Code Section 21(b)(2)(C) are satisfied, or (b) a related individual described in Section 129(c) of the Code.

2.8 **"Effective Date"** means June 1, 1988, the original effective date of the plan and the January 1, 2014 restatement of it.

2.9 **"Eligible Employee"** means an Employee who is of the type, category or classification that is eligible to make an election of benefits under the Plan upon satisfying the Minimum Service Requirement, if any, and the Minimum Age Requirement, if any, under the Plan. The Employees who are Eligible Employees are all Employees who regularly are scheduled to perform a minimum of thirty hours of services per week for the Employer and who are not classified by the Employer as Temporary Employees, Seasonal/Student Employees or On-call Employees.

2.10 **"Employee"** means an individual that the Employer classifies as a common-law employee and who is on the Employer's W-2 payroll, but does not include any leased employee (including, but not limited to those individuals defined in Code Section 414(n)), or an individual classified by the Employer as a contract worker, independent contractor, temporary employee, short-term employee or casual employee, whether or not any such persons are on the Employer's W-2 payroll, or any individual who performs services for the Employer but is paid by a temporary or other employment agency such as "Kelly," "Manpower," etc.

2.11 **"Employer"** means the Palm Beach County Board of County Commissioners and any other agency, corporation, partnership, firm or business which, with the permission of the County of Palm Beach, adopts the Plan, provided, however, that when the Plan provides that the Employer has a certain power (e.g., the appointment of a Plan Administrator, entering into a contract with a third party insurer, or amendment or termination of the Plan), the term "Employer" shall mean only the Palm Beach County Board of County Commissioners. Other parties that adopt the Plan shall be bound by the Plan as adopted and subsequently amended unless they clearly withdraw from participation therein.

2.12 **"Flexible Spending Account Option"** means the Medical Expense Reimbursement Account Option or Dependent Care Assistance Account Option described in Article V.

2.13 **"Inactive Participant"** means an individual whose status as a Participant in a Flexible Spending Account Option has terminated, but who continues to have certain rights to reimbursement under that Plan, in accordance with Article V of the Plan.

2.14 **"Insurance Plan"** means the plans, programs and arrangements made available by or through the Employer pursuant to which Employees may obtain insurance (or Health Maintenance Organization) coverage by paying some portion of the applicable premiums, which are of the following types: medical, dental and term life.

2.15 **"Insurance Premium Pre-tax Payment Option"** means the option afforded a Participant under the Plan to elect to pay, on a pre-tax basis, his or her share of the cost of coverage under the Insurance Plans.

2.16 **"Key Employee"** means any person who is a key employee, as defined in Section 416(i)(1) of the Code, with respect to the Employer.

2.17 **"Minimum Age Requirement"** means the age, if any, that an Eligible Employee must attain as a condition to becoming a Participant. The Plan does not have a Minimum Age Requirement.

2.18 **"Minimum Service Requirement"** means the period of continuous employment with the Employer that an Eligible Employee must complete as a condition to becoming a Participant, which is sixty days.

2.19 **"Participant"** means any Eligible Employee who has satisfied the Minimum Service Requirement, if any, and the Minimum Age Requirement, if any, and whose Participant Commencement Date has occurred.

2.20 **"Participation Commencement Date"** means the date on which an Eligible Employee becomes a Participant, which is the first day of the month following the month within which he or she satisfies the Minimum Service Requirement. Notwithstanding the foregoing, any individual who was an Eligible Employee on the Effective Date and who had completed his or her "new hire waiting period" as of that date shall become a Participant on that date.

2.21 **"Period of Coverage"** means the Plan Year, except as follows: (i) The Period of Coverage for a first-time Participant shall be the period commencing on his or her Participation Commencement Date and ending on the last day of the Plan Year within which his or her Participation Commencement Date occurs, and (ii) The Period of Coverage for a Participant whose participation ceases in accordance with Section 3.2 shall be the period from the first day of the Plan Year within which his or her participation ceases and ending on the date his or her participation ceases.

2.22 **"Plan"** means the Palm Beach County Board of County Commissioners Section 125 Flexible Spending Plan as set forth herein, together with any and all amendments and supplements hereto.

2.23 **"Plan Year"** means the period on which the records of the Plan are based, which is the twelve-month period commencing on January 1 and ending on the following December 31.

2.24 **"Qualifying Dependent Care Expense"** mean an expense incurred by a Participant which (a) is incurred for the care of a Qualifying Individual or for related household services, (b) is paid or payable to a Dependent Care Service Provider, and (c) is incurred to enable the Participant to be gainfully employed for any period for which there are one or more Qualifying Individual (s) with respect to the Participant. "Qualifying Dependent Care Expense" shall not include an expense incurred for (i) services outside the Participant's household for the care of a Qualifying Individual, unless such Qualifying Individual is described in "(a)" or regularly spends at least eight hours each day in the Participant's household, or (ii) services at a camp where the Qualifying Individual stays overnight.

2.25 **"Qualifying Expense"** means a Qualifying Dependent Care Expense or Qualifying Medical Care Expense.

2.26 **"Qualifying Individual"** means (a) a Participant's Dependent who is under the age of thirteen (and meets other conditions imposed by the definition of Dependent, such as a requirement that he or she have the same principal place of abode as the Participant); (b) a Participant's Dependent who is physically or mentally incapable of self-care, has the same principal place of abode as the Participant for more than half of the year, and meets other conditions imposed by the definition of Dependent and (c) a Participant's Spouse who is physically or mentally incapable of self-care, and who has the same principal place of abode as the Participant for more than half of the year.

2.27 **"Qualifying Medical Care Expense"** means an expense incurred by a Participant, or by the Spouse or Dependent of such Participant, for medical care as defined in Section 213(d) of the Code (including, without limitation, amounts paid for hospital bills, doctor, dental or vision care bills and drugs), but only to the extent that the Participant or other person incurring the expense is not reimbursed (or entitled to reimbursement) for the expense through insurance or otherwise (other than under the Plan); provided, however, "Qualifying Medical Care Expense" shall not include any premium paid for health coverage or any expense incurred for drugs or medications obtained without a prescription, other than insulin.

2.28 **"Spouse"** means an individual who is treated as a spouse under the Code.

ARTICLE III: PARTICIPATION

3.1 *Commencement of Participation.* An Eligible Employee shall become a Participant, thus entitling him or her to make an election of benefits under the Plan, on his or her Participation Commencement Date.

3.2 *Cessation of Participation.* A Participant shall cease to be a Participant as of the earlier of (a) the date on which the Plan terminates or (b) the date on which he or she ceases to be an Eligible Employee. Except to the limited extent provided at Article V, any election made under this Plan (including any Deemed Election) shall automatically terminate on the date on which the Participant ceases to be a Participant in the Plan, although coverage or benefits under a Component Plan may continue if and to the extent provided by such Component Plan.

3.3 *Reinstatement of Former Participant.* A former Participant will become a Participant again if and when he or she becomes an Eligible Employee. However, in the case of a former Participant whose election terminates due to separation from service with the Employer, if such person should return to service within thirty days thereafter, he or she will be prohibited from making a new benefit election for the remainder of the Plan Year.

3.4 *Leaves of Absence.* Subject to any specific limitations for any particular benefit which the Participant has elected:

(a) A Participant's election shall remain in force during a paid leave of absence, i.e., one for which the Participant continues to receive Compensation from the Employer.

(b) A Participant who takes an unpaid leave of absence may revoke his or her existing election and execute a new election for the remainder of the Plan Year to the extent permitted by Section 4.5 below.

(c) Notwithstanding any provision to the contrary in the Plan, if a Participant goes on a qualifying unpaid leave under the Family and Medical Leave Act of 1993 ("FMLA"), to the extent required by FMLA, the Employer shall continue to maintain the Participant's benefits under any "group health plan" as defined in Code Section 5000(b)(1) on the same terms and conditions as though he or she were still an active

Employee (i.e., the Employer must continue to pay its share of the premium to the extent the Employee elects to continue his or her coverage). If the Employee elects to continue his or her coverage, the Employee may pay his or her share of the premium with after-tax dollars while on leave (or pre-tax dollars to the extent the Employee receives Compensation during the leave), or the Employee may be given the option to prepay all or a portion of the Employee's share of the premium for the anticipated duration of the leave through a pre-tax salary reduction out of the Employee's pre-leave Compensation by making a special election to that effect prior to the date such Compensation normally would be made available to him or her (provided, however, that pre-tax dollars may not be utilized to fund coverage during the next year), or through other arrangements agreed upon by the Employee and the Administrator (e.g., the Administrator may fund coverage during the leave and withhold amounts upon the Employee's return). Upon return from such leave, the Employee will be permitted to reenter the Plan and to participate on the same basis as prior to taking leave or as otherwise required by the FMLA, and shall have whatever rights as shall be applicable under Section 4.5.

ARTICLE IV: BENEFIT OPTIONS

4.1 *Benefit Options.* Each Participant may choose among the non-cash options and cash options available under the Plan. The non-cash options shall consist of benefits under one or more of the Component Plans, as described below. The cash benefits shall consist of the Participant's Compensation, without reduction to pay for non-cash benefits.

4.2 *Insurance Premium Pre-Tax Payment Option; Description of Benefits under the Insurance Plans.* The benefits directly available to Participants under this Plan relative to the Insurance Plans are limited to the Insurance Premium Pre-Tax Payment Option. The types and amounts of insurance benefits available, the eligibility requirements and the other terms and conditions of coverage under the Insurance Plans are as set forth from time to time in those Plans and in the group insurance contracts and prepaid health plan contracts that may constitute (or may be incorporated by reference in) those Plans.

4.3 *Election Procedure.*

(a) *New Participants.* The Administrator shall provide an Eligible Employee with a Flexible Compensation Enrollment Form and Salary Deduction Agreement (or "election form") before, or as soon as practicable after, his or her Participation Commencement Date (or he or she qualifies to make a new election of benefits pursuant to Section 3.3). The Eligible Employee shall specify on the election form those benefits he or she elects for the Period of Coverage to which the election form relates and shall indicate the aggregate amount to be allocated to each of the Component Plans with respect to the Period of Coverage.

(b) *Annual Enrollment and Election Changes.* Before the beginning of each Plan Year, the Administrator shall provide an election form to each Eligible Employee who is scheduled to be a Participant on the first day of that Plan Year. This election form shall enable the Participant to make a new election of benefits under the Plan as of the first day of the Plan Year. The Participant shall specify on the election form those benefits that he or she elects for the Plan Year and shall agree to a reduction in his or her Compensation to the extent necessary to pay for the cost on benefits elected under the Component Plans.

(c) *Deadline for Return of Election Form.* Each election form must be completed and returned to the Administrator on or before such date as the Administrator shall specify, which date shall be no later than the beginning of the first pay period to which the election form is to apply.

(d) *Failure to Return Election Forms-Deemed Election.* A Participant's failure to return a completed election form to the Administrator on or before the specified due date shall constitute a Deemed Election of benefits under the Plan.

4.4 *Election of Component Plan Benefits in Lieu of Cash.* If a Participant elects benefits for a Period of Coverage under any of the Component Plans, his or her Compensation for the Period of Coverage shall be reduced to pay for those benefits in accordance with his or her election form. In the case of benefits elected under any Insurance Plan, the Compensation reduction shall equal the Participant's share of the cost of coverage under that Plan. In the case of benefits elected under any Flexible Spending Account Option, the Compensation reduction shall equal the amount of benefits elected by the Participant under that Plan.

4.5 *Irrevocability of Elections.* A Participant may not revoke any election made under the Plan during the Period of Coverage to which it pertains, except as follows:

(a) A Participant may change his or her election for the balance of the Period of Coverage if, under the facts and circumstances, a Change in Status occurs and the change of election satisfies the applicable consistency requirement, as set forth below. For this purpose, a "Change in Status" consists of one of the following events:

(1) A change in the Participant's legal status, including marriage, death of the Participant's Spouse, divorce, legal separation or annulment.

(2) A change in the number of Dependents that the Participant has for federal income tax purposes, as determined under Code Section 152, due to events that include birth, adoption, placement for adoption or death.

(3) A termination or commencement of the employment of the Participant or of the Spouse or Dependent of the Participant.

(4) A reduction or increase in the hours of employment of the Participant or the Spouse or Dependent of the Participant, including a switch between part-time and full-time, a strike or lockout and commencement or return from an unpaid leave of absence. In addition, if the eligibility conditions of this Plan, of any other employee benefit plan of the Employer or of any cafeteria plan or other employee benefit plan of the employer of the Participant's Spouse or Dependent depend on the employment status of that individual and there is a change in that individual's employment status with the consequence that the individual becomes or ceases to be eligible under the plan, that change constitutes a Change in Status.

(5) An event that causes the Participant's Dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age, student status or any similar circumstance as provided in the accident or health plan under which the Participant receives coverage.

(6) A change in the place of residence or work of the Participant or of the Spouse or Dependent of the Participant.

A Participant's change of election is consistent with a Change in Status only if, (i) the Change in Status results in the Participant or the Participant's Spouse or Dependent gaining or losing eligibility under an employee benefit plan, and (ii) the change of election corresponds with that gain or loss of coverage, or if the Change of Status affects Qualifying Dependent Care Expenses. If the Change of Status is a Participant's divorce, annulment or legal separation, the death of a Participant's Spouse or Dependent, or a Dependent ceasing to satisfy the eligibility requirements for coverage, an election by the Participant to cancel accident or health coverage for any individual other than the Spouse involved in the divorce, annulment or legal separation, the deceased Spouse or Dependent or the Dependent that ceased to satisfy the eligibility requirements for coverage, as the case may be, would fail to correspond with that Change in Status. If a Dependent dies or ceases to satisfy the eligibility requirements for coverage, the

election to cancel accident or health coverage for any other Dependent, for the Participant or for the Participant's Spouse also would fail to correspond with that Change in Status. In addition, if a Participant, Spouse or Dependent gains eligibility for coverage under this Plan, another cafeteria plan or any other plan providing benefits that are qualified benefits under Code Section 125 as a result of a change in marital status or a change in employment status described above, an election under this Plan to cease or decrease coverage for that individual corresponds with that Change in Status only if coverage for that individual becomes applicable or is increased under the plan from which eligibility for coverage has been gained. However, an election to increase or decrease term life insurance coverage may correspond with any Change in Status.

If the Participant or the Spouse or Dependent of a Participant becomes eligible for continuation coverage under a group health plan of the Employer as provided in Section 4980B of the Code or any similar state law, the Participant may elect to increase payments under this Plan to pay for the continuation coverage.

(b) A Participant may change his or her election for the balance of the Period of Coverage and file a new election that corresponds with special enrollment rights that the Participant exercises under Section 9801(f) of the Code.

(c) In the event of a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody, including a qualified medical child support order that requires accident or health coverage for a Participant's child or for a foster child who is a Dependent of a Participant, the Participant may:

(1) change his or her election to provide coverage for the child if the judgment, decree or order requires coverage under the Employer's accident or health plan; or

(2) make a change of election to cancel coverage for the child if the order requires the Spouse or any other person to provide coverage for the child.

(d) If a Participant who is enrolled in an accident or health plan of the Employer or the Spouse or Dependent of such a Participant becomes entitled to coverage under Part A or Part B of Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid) other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines), the Participant may make a prospective change of election to cancel the coverage under the accident or health plan of the Employer of such person. In addition, if a Participant, Spouse or Dependent who has been entitled to coverage under Medicare or Medicaid loses eligibility for such coverage, the Participant may make a prospective change of election to commence or to increase coverage for that person under the accident or health plan of the Employer.

(e) A change of cost or change of coverage with respect to benefits under any Component Plan may be the basis for a change of election in accordance with the following:

(1) The rules under this Section "(e)" shall not apply to benefits under the Medical Expense Reimbursement Account Option.

(2) If the cost of a Participant's benefits under any Component Plan increases or decreases during a Period of Coverage and, under the terms of that Component Plan, Employees are required to make a corresponding change in their payments, a corresponding adjustment shall be made to the Participant's elective contributions under this Plan, subject, however, to (3) below.

(3) If the cost of a Participant's benefits under a Component Plan significantly increases during a period of coverage, the Participant may elect either to increase his or her contributions to

pay for the increased cost or may revoke his or her election and, in lieu thereof, receive on a prospective basis, coverage under another benefit option available under the Component Plan. If the cost of any benefit or benefit option significantly decreases during a period of coverage for which a Participant has elected that benefit or benefit option, a Participant may make a new election of that benefit or benefit option. If a Participant has an election in effect at that time for that type of benefit (e.g., medical insurance coverage) but under a benefit option other than the one the cost of which has significantly decreased, he or she may revoke that existing election and elect that benefit option that has significantly decreased in cost.

(4) Notwithstanding the foregoing, a cost change shall only provide the basis for an election change with respect to dependent care assistance benefits if the cost change is imposed by a dependent care provider who is not a "relative" of the Participant as that term is defined under Code Section 152.

(5) If a Participant's coverage under any Component Plan is significantly curtailed or ceases during a Period of Coverage, the Participant may revoke his or her existing election of the coverage and may make a new election on a prospective basis of any other coverage option available under that Component Plan. Coverage under an accident or health plan shall be considered as curtailed only if there is an overall reduction in coverage provided under the plan so as to constitute reduced coverage to Participants generally.

(6) A Participant may make a prospective election change that is on account of and corresponds with a change made under the plan of the Participant's Spouse, former Spouse or Dependent if that plan allows for election changes based on a change in cost or coverage consistent with the foregoing rules and if that plan permits participants to make an election for a period of coverage under the cafeteria or other plan that is different than that under this Plan.

(f) A Participant may revoke a prior election and make a new election where there has been a significant change in the benefit plan coverage of the Participant, the Spouse of the Participant or a Dependent of the Participant that is attributable to the employment of the Spouse or Dependent, provided such change of election is determined by the Administrator to be consistent with the change in benefit plan coverage.

(g) A Participant taking leave under the FMLA may revoke an existing election of group 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.

(h) The Change in Status rules do not apply with respect to elective contributions under a qualified cash or deferred arrangement as defined in Code Section 401(k).

Any change of election authorized by this Section must be submitted to the Plan within thirty days after the occurrence of the event to which the election change relates. In the case of an election described in subsection (b) above, the thirty-day period shall commence on the date that the Participant first becomes eligible to exercise special enrollment rights. Notwithstanding the foregoing, if the election corresponds to the exercise of special enrollment rights described in Section 9801(f)(3) of the Code, such election must be submitted to the Plan within sixty days after the Participant or a Dependent of the Participant is determined to be eligible for coverage or loses coverage, as the case may be, under a Medicaid plan as described at Title XIX of the Social Security Act or a State child health plan as described at Title XXI of the Social Security Act.

Any revocation and new election under this Section shall be effective at such time as the Administrator shall prescribe, but not earlier than the first pay period beginning after the revocation and new election.

Notwithstanding any provision herein to the contrary, no Participant may reduce his or her election for benefits under any Flexible Spending Account Option below the amount already reimbursed under that Flexible Spending Account Option for the Period of Coverage.

4.6 *Changes by Administrator.* If the Administrator determines, before or during any Plan Year, that the Plan may fail to satisfy for such Plan Year any nondiscrimination requirement imposed by the Code or any limitation on benefits provided to Key Employees, the Administrator shall take such action as the Administrator deems appropriate, under rules uniformly applicable to similarly situated Participants, to assure compliance with such requirement or limitation. Such action may include, without limitation, a modification of elections by highly compensated Employees (as defined by the Code for purposes of the nondiscrimination requirement in question) or Key Employees without the consent of such Employees.

4.7 *Maximum Employer Contributions.* The maximum amount of employer contributions under the Plan for any Participant shall be the sum of (i) the costs from time to time of the most expensive benefits available to the Participant under the Insurance Premium Pre-Tax Payment Option, and (ii) the maximum amount that may be contributed for benefits under the Flexible Spending Account Options.

ARTICLE V: FLEXIBLE SPENDING ACCOUNT BENEFITS

5.1 *Flexible Spending Account Options.*

(a) *Health Care.* There is hereby created a self-insured medical expense reimbursement plan as defined at Section 105(h) of the Code (the "Medical Expense Reimbursement Account Option"). The purpose of the Medical Expense Reimbursement Account Option shall be to provide Participants with reimbursements of Qualifying Medical Care Expenses that are excludable from income.

(b) *Dependent Care.* There is hereby created a dependent care assistance program as defined at Section 129 of the Code (the "Dependent Care Assistance Account Option"). The purpose of the Dependent Care Assistance Account Option shall be to provide Participants with reimbursements of Qualifying Dependent Care Expenses that are excludable from income.

5.2 *Status as Flexible Spending Arrangements.* Each Flexible Spending Account Option shall operate in all respects in accordance with the rules applicable to a "Flexible Spending Arrangement" as set forth in Proposed Treasury Regulation Section 1.125-5(a) and any successor IRS regulations and guidance.

5.3 *Establishment of Accounts.* If a Participant elects benefits under a Flexible Spending Account Option for any Period of Coverage, the Administrator shall establish an Account on the books of the Plan with respect to his or her election and shall maintain the Account in accordance with the rules set forth below in this Article V. Any such Account is for record-keeping purposes only and does not involve any actual segregation of assets.

5.4 *Crediting of Accounts.*

(a) *Medical Expense Reimbursement Account.* The Account of a Participant that is established on account of an election of benefits under the Medical Expense Reimbursement Account Option (a "Medical Expense Reimbursement Account") shall be credited with an amount equal to his or her benefit election for that Period of Coverage. This amount shall be credited to the Participant as of the first day of the Period of Coverage.

(b) *Dependent Care Assistance Account.* The Account of a Participant that is established on account of an election of benefits under the Dependent Care Assistance Account Option (a "Dependent Care Assistance Account") shall be credited with the amount of contributions that are made to that Account in accordance with Article IV at the time the contributions occur.

5.5 *Maximum Electable Benefit Amounts.* The maximum (and minimum, where applicable) amount of benefits for a Period of Coverage that a Participant may elect in lieu of full, unreduced Compensation is as follows:

(a) *Medical Expense Reimbursement Account Option*: The maximum shall be $2,500. The minimum shall be $260.

(b) *Dependent Care Assistance Account Option:* The maximum shall be $5,000.

5.6 *Code Limits on Dependent Care Assistance.* The maximum amount that a Participant may receive for reimbursement of Qualifying Dependent Care Expenses in any calendar year shall be the least of (a) the Participant's earned income for the calendar year (after all reductions in compensation including the reduction related to dependent care assistance), (b) the actual or deemed earned income of the Participant's Spouse for the calendar year, if the Participant is married, or (c) $5,000 (or, if the Participant does not certify to the Administrator's satisfaction that he or she is either unmarried or will file a joint Federal income tax return for the year, $2,500). In the case of a Spouse who is a full-time student at an educational institution or is physically or mentally incapable of caring for himself or herself, such Spouse shall be deemed to have earned income of not less than $250 per month if the Participant has one Qualifying Individual and $500 per month if the Participant has two or more Qualifying Individuals. In the case of two Participants who are married to each other and who file a joint Federal income tax return for the calendar year, the $5,000 limit in (c) above shall be reduced for each such Participant by the amount received for the year under this Plan by the Participant's Spouse. For purposes of this Section, "earned income" shall have the meaning given it by Section 32(c)(2) of the Code, and a Participant shall not be treated as married if the Participant is not considered as married under the special rules of Code Section 21(e)(3) and (4).

5.7 *Debiting of Accounts.* A Participant's Account under a Flexible Spending Account Option shall be reduced by the amount of claims paid from the Account.

5.8 *Claims for Reimbursement.* A debit card payment option is provided under this plan. A Participant may also obtain reimbursement of a Qualifying Expense by submitting a claim on a form provided by the Plan. Each claim must include:

(a) a description of the Qualifying Expense, the amount of the Expense and the date on which the Expense was incurred.

(b) the person paid or to be paid.

(c) the name of the person who incurred the Expense.

(d) bills, invoices, receipts or other documentation showing the amounts of the expenses incurred.

(e) if the expense is a Qualifying Medical Care Expense, a certification that the expense has not already been reimbursed by another health plan and is not eligible for reimbursement under any other health plan.

(f) if the expense is a Qualifying Dependent Care Expense, the name, address and taxpayer identification number of the dependent care provider.

5.9 *When an Expense is Incurred.* A claim may be submitted before or after the Participant has paid a Qualifying Expense, but not before the Expense has been incurred. A Qualifying Expense shall be deemed incurred at the time the services giving rise to the Expense are rendered.

5.10 *Direct Payment Option.* The Administrator may, at its option, pay any Qualifying Expense directly to the person providing or supplying the services that gave rise to the Expense, in lieu of reimbursing the Participant.

5.11 *Amount Available For Payment of Claims.*

(a) *Medical Expense Reimbursement Account Option Claims.* The amount available to reimburse a Participant for Qualifying Medical Care Expenses shall, at all times during a Period of Coverage, be equal to the amount of his or her benefit election for that Period of Coverage reduced by the amount of previous reimbursements.

(b) *Claims under the Dependent Care Assistance Account Option.* The amount available to reimburse a Participant for Qualifying Expenses under the Dependent Care Assistance Account Option shall be limited to his or her Account balance.

(c) *Grace Period.* If an individual with a Flexible Spending Account on the last day of a Plan Year continues to have a positive balance credited to the Account on that date after all reimbursements for Qualifying Expenses incurred during the Plan Year have been made, such remaining balance may be used to reimburse the Participant for Qualifying Expenses incurred on or before the fifteenth day of the third calendar month in the following Plan Year. Such two-and-a-half-month period following a Plan Year is referred to below as the "Grace Period" with respect to that Plan Year.

5.12 *Deadline for Claims Submission.* A Participant must submit a claim for reimbursement from his or her Flexible Spending Account by April 30th of the Plan Year following the Plan Year with respect to which the Account was established. This includes any claims that may be reimbursable from that Account under the Grace Period provision described at Section 5.11(c). The Administrator shall not pay any claim submitted after that date.

5.13 *Code Limitations on Reimbursements to Certain Participants.* Each of the Flexible Spending Account Options is intended not to discriminate as to eligibility to participate or benefits in favor of highly compensated individuals or highly compensated employees, as the case may be as those terms are defined in the applicable provisions of the Code. If, in the judgment of the Administrator, the operation of the Plan in any Plan Year would result in such discrimination, the Administrator may take such remedial action as the Administrator deems necessary or appropriate to assure that the Plan does not discriminate, including but not limited to, restricting the amounts reimbursed to such persons or excluding such persons altogether from participation. Such remedial actions may be taken whether or not to do so would result in a forfeiture of any Account balance.

5.14 *Forfeiture of Unused Account Balances.* If a Participant has a balance remaining in his or her Account under a Flexible Spending Account Option after all authorized reimbursements for the corresponding Period of Coverage and applicable Grace Period have been made, such balance shall not be carried over to reimburse the Participant for Qualifying Expenses incurred during a subsequent Period of Coverage and shall not be available to the Participant in any other form or manner, but shall remain the property of the Employer, and the Participant shall forfeit all rights with respect to such balance. The Employer may use any forfeited account balances to pay any administrative expenses of the Plan or in any other manner that does not violate any applicable law or regulation. For this purpose, "administrative expense" shall include any amount by which the benefits paid to any Participant under the Medical Expense Reimbursement Account Option for any Period of Coverage exceeded the Participant's contributions to the Medical Expense Reimbursement Account Option for that Period of Coverage.

5.15 *Inactive Participant Status.* Except as hereinafter provided, an individual shall cease to be a Participant in a Flexible Spending Account Option and become an Inactive Participant in that Flexible Spending Account Option when he or she ceases to be a Participant under the Flexible Benefits Plan pursuant to Section 3.2 or when his or her election for benefits under that Flexible Spending Account Option expires, whichever first occurs. An individual who has the status of Inactive Participant with respect to any Flexible Spending Account Option may submit further claims for reimbursement of Qualifying Expenses under that Flexible Spending Account Option only in accordance with the following:

(a) An Inactive Participant who had established a Flexible Spending Account for the Plan Year within which he or she became an Inactive Participant and who had a positive balance credited to that Account on the date he or she became an Inactive Participant may submit claims for the reimbursement from that Account of any Qualifying Expenses incurred during the Period of Coverage ending on the date that he or she became an Inactive Participant. Any such claims must be submitted within thirty days after that date.

(b) Section 5.12 shall apply to the submission of any outstanding Grace Period claims by the Inactive Participant.

5.16 *Continuation Coverage under the Consolidated Omnibus Reconciliation Act of 1985 ("COBRA").* The Plan shall comply with the requirements of COBRA or any other applicable federal or state law granting continuation benefits upon termination of coverage to the extent applicable.

ARTICLE VI: ADMINISTRATION OF PLAN

6.1 *Plan Administrator.* The Administrator shall administer the Plan in accordance with its terms without discriminating among the Participants. The Administrator shall have full power to administer the Plan in all of its details, subject to applicable requirements of law. For this purpose, the Administrator's powers shall include, but shall not be limited to, the following authority, in addition to all other powers provided by this Plan:

(a) To make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of the Plan;

(b) To interpret the Plan, its interpretation thereof in good faith to be final and conclusive on all persons claiming benefits under the Plan;

(c) To decide all questions concerning the Plan and the eligibility of any persons to participate in the Plan;

(d) To appoint such agents, counsel, accountants, consultants and other persons as may be required to assist in administering the Plan; and

(e) To allocate and delegate its responsibilities under the Plan and to designate other persons to carry out any of its responsibilities under the Plan, any such allocation, delegation or designation to be in writing.

Notwithstanding the foregoing, any claim which arises under any of the Insurance Plans shall not be subject to review under this Plan, and the Administrator's authority under this Section 6.1 shall not extend to any matter as to which an administrator under any such other plan is empowered to make determinations under such plan.

6.2 *Examination of Records.* The Administrator shall make available to each Participant such of his or her records under the Plan as pertain to the Participant, for examination at reasonable times during normal business hours.

6.3 *Reliance on Tables, etc.* In administering the Plan, the Administrator shall be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions and reports which are furnished by, or in accordance with the instructions of, the administrators of the Component Plans, or by accountants, counsel or other experts employed or engaged by the Administrator.

ARTICLE VII: CLAIMS

7.1 *Filing of Claims.* The Employer has retained P&A Administrative Services, Inc. of Buffalo, New York (the "Claims Administrator") to process all claims. Information regarding incurred expenses eligible for reimbursement under this Plan shall be submitted directly to the Claims Administrator to determine the amount of any benefits payable hereunder.

7.2 *Scope of Claims Review under this Plan.* Except to the extent otherwise specifically provided herein, any claim for benefits under an Insurance Plan shall be governed by the claims procedures that are included in the plan documents pursuant to which that Plan is maintained. The claims procedures in this Article shall apply to (i) any partial or total denial of benefits under any Flexible Spending Account Option, and (ii) any denial of benefits due to an issue germane to the claimant's coverage under the Flexible Benefits Plan (e.g., whether an Eligible Employee has satisfied any Minimum Service Requirement or whether a Change in Status has occurred).

7.3 *Claims Procedure.*

(a) Any person who believes that he or she is entitled to a benefit shall have the right to file with the Claims Administrator a written notice of claim for such benefit. The Claims Administrator shall either grant or deny such claim within thirty days after the receipt of such written notice of claim (or within such other period as may be mutually agreed to by the parties); provided, however, if circumstances beyond its control so dictate. The Claims Administrator may extend that time by a maximum of fifteen days by giving the claimant written notice of such extension within the initial thirty-day period. Such notice shall identify the reason for the extension and the date by which the Claims Administrator expects to make its decision. If the reason is a lack of complete information, the notice shall identify the additional information needed, shall grant the claimant forty-five days from the date of the extension notice to furnish that information, and further shall advise the claimant that the tolling of the limitation period for the Claims Administrator's response shall be suspended until the Claims Administrator receives the information. Any delay on the part of the Claims Administrator in arriving at a decision shall not adversely affect benefits payable under a granted claim.

(b) In the case of a denied claim, the Claims Administrator shall provide written notice to the claimant setting forth:

(1) The specific reason for such denial;

(2) Specific reference to the pertinent Plan provisions on which the denial is based;

(3) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; and

(4) An explanation of the Plan's claim review procedures described below.

7.4 *Review of Denied Claim.*

(a) Any person whose claim is denied may appeal in writing to the Benefits Manager of the Claims Administrator at any time within one hundred eighty days after the claimant receives written notice of such denial. The appeal should include the reason or reasons the claimant believes the Claims Administrator's claim denial to have been in error. In the event of such appeal, the Benefits Manager of the Claims Administrator shall afford the claimant or his or her duly authorized representative the opportunity:

(1) To review documents pertinent to the claim;

(2) To submit issues and comments in writing; and

(3) To discuss such documents and issues with the Benefits Manager of the Claims Administrator.

(b) The final decision of Benefits Manager of the Claims Administrator shall be made not later than sixty days after its receipt from the claimant of a request for review, unless there are special circumstances, such as the need to hold a hearing, or an extension of time for processing, in which case a decision shall be made as soon as possible but not later than one hundred twenty days after receipt of a request for review. If the decision on appeal affirms the initial denial, the claimant shall be furnished with a written notice to that effect that shall include the following:

(1) The specific reasons for decision on appeal;

(2) The specific Plan provisions on which the decision is based;

(3) Statement of the right to review, upon request and at no charge, such Plan documents as the claimant shall deem relevant; and

(4) A description of any internal rule, guideline, protocol or similar criterion that was relied on in reaching the decision and a statement that a copy of same is available upon request and at no charge.

7.5 *Use of Electronic Payment Card System.*

If approved and implemented by the Administrator, Participants may use electronic payment cards to obtain payment of benefits to which they are entitled under the Medical Expense Reimbursement Account Option and/or the Dependent Care Assistance Account Option. Any use of electronic payment cards in connection with this Plan shall comply with all pertinent laws, regulations and then current guidance from the Internal Revenue Service.

ARTICLE VIII: AMENDMENT AND TERMINATION OF PLAN

The Palm Beach County Board of County Commissioners may amend or terminate the Plan at any time by an action of its governing body or by a written instrument executed by its Supervisor. Any other adopting Employer may terminate the eligibility of its employees for Plan participation.

ARTICLE IX: MISCELLANEOUS PROVISIONS

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

9.2 *Limitation of Rights.* Neither the establishment of the Plan nor any amendment thereof, nor the payment of any benefits, will be construed as giving to any Participant or other person any legal or equitable right against the Employer or Administrator, except as provided herein.

9.3 *Benefits Solely From General Assets.* Except as may otherwise be required by law:

(a) Any amount by which a participant's compensation is reduced under this Plan will remain part of the general assets of the Employer;

(b) Nothing herein will be construed to require the Employer or the Administrator to maintain any fund or segregate any amount for the benefit of any Participant; and

(c) No Participant or other person shall have any claim against, right to or security or other interest in, any fund, account or asset of the Employer from which any payment under the Plan may be made.

9.4 *Use and Disclosure of Protected Health Information.*

(a) Members of the Employer's workforce have access to the individually identifiable health information of Participants for Plan administrative functions. When this information is provided by the Plan to the Employer, it is "protected health information" ("PHI"). The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and its implementing regulations restrict the Employer's ability to use and disclose PHI. The following definition of PHI applies for purposes of this Section 9.4:

> *Protected Health Information.* Protected health information means information that is created or received by the Plan and relates to the past, present or future physical or mental health or condition of a participant; the provision of health care to a participant; or the past, present or future payment for the provision of health care to a participant; and that identifies the participant or for which there is a reasonable basis to believe the information can be used to identify the participant. Protected health information includes information of persons living or deceased.

The Employer shall have access to PHI from the Plan only as permitted under this Section or as otherwise required or permitted under HIPAA. HIPAA and the implementing regulations were modified by the Health Information Technology for Economic and Clinical Health Act ("HITECH"), the statutory provisions of which are incorporated herein by reference.

(b) The Plan may disclose to the Employer whether a particular individual is a Participant.

(c) The Plan may disclose Summary Health Information to the Employer, provided that the Employer requests it for the purpose of modifying, amending or terminating the Plan. For this purpose, "Summary Health Information" means information (a) that summarizes the claims history, claims expenses or type of claims experienced by individuals for whom for whom a plan sponsor had provided health benefits under a health plan, and (b) from which the information described in 42 CFR section 164.514(b)(2)(i) has been deleted, except that the geographic information described in 42 CFR section 164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit zip code.

(d) Unless otherwise permitted by law, and subject to the conditions of disclosure described in (e) below, and obtaining written certification in accordance with (g) below, the Plan may disclose PHI to the Employer, provided that the Employer uses or discloses It only for Plan administration purposes. "Plan administration purposes" means administrative functions performed by the Employer on behalf of the Plan, such as quality assurance, claims processing, auditing and monitoring. The term does not include functions performed by the Employer in connection with any other benefit plan or any employment-related functions.

Notwithstanding any provision of this Plan to the contrary, in no event shall the Employer be permitted to use or disclose PHI in a manner that is inconsistent with 45 CFR section 164.504(f).

(e) The Employer agrees that with respect to any PHI disclosed to it by the Plan (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions), the Employer shall:

(1) not use or further disclose the PHI other than as permitted or required by the Plan or as required by law;

(2) ensure that any agent, including a subcontractor, to whom the Employer provides PHI received from the Plan agrees to the same restrictions and conditions that apply to the Employer with respect to PHI;

(3) not use or disclose the PHI for employment-related actions and decisions or in connection with any other employee benefit plan of the Employer;

(4) report to the Plan any unauthorized use or disclosure of PHI that it becomes aware of;

(5) make PHI available to comply with HIPAA's rights to access in accordance with 45 CFR section 164.524;

(6) make PHI available for amendment and incorporate any amendments to PHI in accordance with 45 CFR section 164.526;

(7) make available the information required to provide an accounting of disclosures in accordance with 45 CFR section 164.528;

(8) make its internal practices, books and records relating to the use and disclosure of HRA received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with HIPAA's privacy requirements;

(9) If feasible, return or destroy all PHI received from the Plan that the Employer still maintains in any form, and retain no copies of that PHI when no longer needed for the purpose for which it disclosure was made, except that, if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible; and

(10) ensure that the adequate separation between the Plan and the Employer (the "firewall") required by 45 CFR section 504(f)(2)(iii) is maintained.

The Employer further agrees that if it creates, receives, maintains or transmits any electronic PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) on behalf of the Plan, it will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic PHI, and it will ensure that any agents (including subcontractors) to whom it provides such electronic PHI agree to implement reasonable and appropriate security measures to protect the information. The Employer will report to the Plan any security incident of which it becomes aware.

(f) The Employer shall allow the following persons access to PHI: its Group Insurance Manager and any other Employee who needs access to PHI to perform Plan administration functions that the Employer performs for the Plan (such as quality assurance, claims processing, auditing, monitoring, payroll and appeals) No other persons shall have access to PHI. These specified employees shall only have access to and use PHI to the extent necessary to perform the plan administration functions that the Employer performs for the Plan. In the event that any of these specified employees does not comply with the

provisions of this Section, that employee shall be subject to disciplinary action by the Employer for non-compliance pursuant to the Employer's disciplinary and termination procedures.

The Employer shall ensure that the provisions of this (f) are supported by reasonable and appropriate security measures.

(g) The Plan shall disclose PHI to the Employer only upon the receipt of a certification by the Employer that the Plan incorporates the provisions of 45 CFR section 504(f)(2)(ii) and that the Employer agrees to the conditions of disclosure set forth in (e) above.

9.5 *Governing Law.* This Plan shall be construed, administered and enforced according to the laws of the State of Florida.

9.6 *Complete Document.* This document contains all of the operative provisions of this Plan. Any conflict between the provisions of this document and any other Employer document purporting to explain the rights, benefits, or obligations of the parties hereunder shall be resolved in favor of this Plan document. In the event that a tribunal of competent jurisdiction shall determine in a final judgment or decree that one or more of the provisions of this Plan is invalid due to the provisions of applicable law, this Plan shall be interpreted as if the offending language had been stricken from its provisions, and the remainder of the Plan document shall continue in full force and effect.

9.7 *Coordination of Benefits.* Notwithstanding any other provision herein to the contrary, should a Participant incur an eligible expense for purposes of both this Plan and any health reimbursement arrangement or similar type of supplemental self-insured medical expense reimbursement plan or arrangement, he or she shall be obligated to submit a claim for reimbursement of that expense by the other plan or arrangement and may only submit the expense for reimbursement by this Plan if the other plan or arrangement fails to fully reimburse him or her for the expense.

9.8 *Effect of Mistake.* If a mistake occurs as to the eligibility or participation of an Employee, the allocations made to the account of any Participant, or the amount of benefits paid or to be paid to a Participant or other person, the Administrator shall, to the extent that it deems administratively feasible and otherwise permissible under Code Section 125 or the regulations issued thereunder, cause to be allocated or cause to be withheld or accelerated or otherwise make adjustment of, such amounts as it will in its judgment accord to such Participant or other person the credits to the account or distributions to which he or she is properly entitled under the Plan. Such action by the Administrator may include withholding of any amounts due to the Plan or the Employer from Compensation paid by the Employer.

IN WITNESS WHEREOF, the Employer has adopted this Plan as of the Effective Date. In signing below, the Employer hereby certifies that the Plan incorporates the provisions of 45 CFR section 164.504(f)(2)(ii) as set forth in Section 9.4(e) above and agrees to the limitations on the disclosure of PHI described therein.

ATTEST:
SHARON R. BOCK
PALM BEACH COUNTY
CLERK AND COMPTROLLER

By: _____
Deputy Clerk

BOARD OF COUNTY COMMISSIONERS:

By: _____
Mayor Priscilla A. Taylor

APPROVED AS TO FORM
AND LEGAL SUFFICIENCY

By: _____
County Attorney