CLEVELAND PUBLIC LIBRARY
Minutes of the Special Board Meeting
May 31, 2013
Trustees Room Louis Stokes Wing
11:00 a.m.

Present: Mr. Corrigan, Ms. Butts, Mr. Seifullah, Ms. Rodriguez, Mr. Hairston, Mr. Werner, Mr. Parker

Absent: None

Mr. Corrigan called the Special Board Meeting to order at 11:06 a.m.

RESOLUTION REQUESTING THE CLEVELAND MUNICIPAL SCHOOL BOARD TO SUBMIT TO THE ELECTORS OF THE CLEVELAND MUNICIPAL SCHOOL DISTRICT THE QUESTION OF A 5.8 MILLS TAX FOR THE CURRENT EXPENSES OF THE CLEVELAND PUBLIC LIBRARY
Approved

Resolution Requesting the Cleveland Municipal School Board to Submit to the Electors of the Cleveland Municipal School District the Question of A 5.8 Mills Tax for the Current Expenses of the Cleveland Public Library

Ms. Rodriguez moved approval of the following resolution. Mr. Hairston seconded the motion, which passed unanimously by roll call vote.

(R.C. Sections 5705.03, 5705.23, 5705.25)

WHEREAS, the Board of Trustees of the Cleveland Public Library, Cleveland, Ohio, is a board of library trustees appointed pursuant to R.C. Section 3375.15; and

WHEREAS, the Board of Trustees of the Cleveland Public Library desires the Cleveland Municipal School District Board of Education to submit to the electors of the Cleveland Municipal School District the question of a 5.8 mills renewal tax for the purpose of the current expenses of the Cleveland Public Library; and

WHEREAS, On May 16, 2013, the Board of Trustees of the Cleveland Public Library adopted a resolution requesting the Cuyahoga County Fiscal Officer to certify the total current tax valuation of the Cleveland Municipal School District and the amount to be generated during the first year of collection of the 5.8 mills renewal levy; and

WHEREAS, The Cuyahoga County Fiscal Officer has certified that the above-referenced tax will generate

$28,581,676 during the first year of collection, based on the current assessed valuation of the Cleveland Municipal School District of $4,927,875,020.

NOW THEREFORE BE IT RESOLVED by the Board of Trustees, two-thirds of all the members thereof concurring that:

Section 1. It is hereby declared that the amount of taxes which may be raised within the ten-mill limitation by levies on the current tax duplicate will be insufficient to provide an adequate amount for the necessary requirements of the Cleveland Public Library, and it is therefore necessary to levy a five-year 5.8 mills renewal tax in excess of such limitation for the purpose of the current expenses of the Cleveland Public Library; and

Section 2. It is hereby requested that the Cleveland Municipal School District, the taxing authority to whose jurisdiction this Board is subject, submit to the electors of the Cleveland Municipal School District at the November 5, 2013 general election the question of a 5.8 mills renewal tax for the purpose of the current expenses of the Cleveland Public Library; and

Section 3. It is hereby requested that the Board of Education of the Cleveland Municipal School District adopt a resolution under R.C. Section 5705.23, and other applicable provisions of the law, to submit to the electors of the Cleveland Municipal School District at the November 5, 2013 general election the question of a 5.8 mills renewal tax for the purpose of the current expenses of the Cleveland Public Library; and

Section 4. Such tax levy shall be for a term of five (5) years at a rate not exceeding 5.8 mills for each one dollar of valuation, which amounts to fifty-eight cents ($ .58) for each one hundred dollars of valuation; and

Section 5. Such tax levy shall be placed upon the tax list and duplicate for the current tax year beginning in 2013 if a majority of the electors voting thereon vote in favor thereof; and

Section 6 The form of the ballot to be cast at the election on the question of this tax levy shall be substantially as follows;

A renewal of a tax for the benefit of the Cleveland Public Library for the purpose of current expenses at a rate not exceeding 5.8 mills for each one dollar of

valuation, which amounts to fifty-eight cents ($.58) for each one hundred dollars of valuation, for five (5) years, commencing in the year 2013, first due in calendar year 2014.

Section 7. This Board finds, determines, and declares that the levy of the tax, if approved by the electors, is necessary to the proper furnishing and rendering of free public library services for the residents of the Cleveland Municipal School District; and

Section 8. The Fiscal Officer of this Board, acting on behalf of the Board, is hereby authorized and directed to deliver a certified copy of this resolution to the Cleveland Municipal School District Board of Education; and

Section 9. It is hereby found and determined that all formal actions of the Board concerning and relating to the adoption of this resolution were taken in an open meeting of this Board, and that all deliberations of this Board and of its committees that resulted in such formal action were conducted in meetings open to the public, in compliance with all legal requirements, including Section 121.22 of the Ohio Revised Code.

Ms. Rodriguez introduced the resolution and moved for passage;

Mr. Hairston seconded the motion and, after discussion a roll call vote was taken and
the results were

Ayes: 7

Nays: 0

CERTIFICATE

The undersigned Fiscal Officer of the Board of Trustees of the Cleveland Public Library hereby certifies that the foregoing is a true copy of a resolution duly adopted by said Board on the May 31, 2013.

_____
Carrie Krenicky, Fiscal Officer
Cleveland Public Library

A motion to amend the Resolution to substitute the word "Municipal" for "Metropolitan" when referring to the School District was made by Mr. Werner and seconded by Mr. Seifullah as was passed unanimously by role call vote. The minutes contain the correct amended resolution.

RESOLUTION ADOPTING CLEVELAND PUBLIC LIBRARY MEDICAL COST PLAN AND EMPLOYEE BENEFITS PLAN
Approved

Resolution Adopting Cleveland Public Library Medical Cost Plan and Employee Benefits Plan

(See pages 645-681)

Mr. Seifullah moved approval of the following resolution. Ms. Rodriguez seconded the motion, which passed unanimously by roll call vote.

WHEREAS, In January 2012, the Board of Trustees of the Cleveland Public Library ("Library") adopted a Restated Flexible Spending Plan and Plan Summary for employees of the Cleveland Public Library pursuant to Internal Revenue Code Sections 125 permitting employees to make pre-tax contributions to Health Care Spending Accounts and Dependent Care Spending Accounts for qualified out-of-pocket expenses; and

WHEREAS, For a number of years, the Library has also permitted employees to pay their share of premiums for Library sponsored medical and dental plans through pre-tax contributions pursuant to Internal Revenue Code Section 125. The Library desires to adopt an amended and restated Medical Cost Plan for this program, and to include the Library's new vision plan and to include the changes necessary to comply with the Patient Protection and Affordable Care Act of 2010; and

WHEREAS, In addition, the Library desires to adopt an Employee Benefits Plan covering the Library sponsored medical, dental and vision plans, setting forth the Library's administrative responsibilities, and establishing privacy and security provisions in compliance with the Health Insurance Portability and Accountability Act ("HIPAA")

WHEREAS, The law firm of Ogletree, Deakins has prepared these plans, and each one has been reviewed and approved by the Library Chief Legal Officer; now therefore be it

RESOLVED, That the restated and amended Medical Cost Plan, and the Employee Benefits Plan are hereby approved and adopted and are effective as of January 1, 2013;

and be it further

RESOLVED, That the Executive Director, CEO or his designee is authorized to execute the Plans and to execute such other instruments, documents, and amendments to Plans and agreements as may be necessary or appropriate to maintain and administer the Plans in the future, subject to approval of the Library's Chief Legal Counsel.

Mr. Corrigan stated that this resolution brings the library in line with the Affordable Care Act.

Joyce Dodrill, Chief Legal Officer, stated that one of the main reasons for this resolution is to include the HIPPA Privacy Act because we have the need to provide some patient protected health information to our consultant Gallagher Benefits. This information will be used in the evaluation of expenditures to compare the cost of our current plan in comparison other carriers for possible future negotiations.

Mark Nolan from Gallagher Benefit Services was in attendance to answer Board questions.

Mr. Corrigan adjourned the Special Board meeting at 11:27 a.m.

_____ _____

Thomas D. Corrigan
President

Alan Seifullah
Secretary

CLEVELAND PUBLIC LIBRARY
MEDICAL COST PROGRAM

Amended and Restated
Effective January 1, 2013

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I. PURPOSE

Cleveland Public Library (the "Employer") has maintained a program for the exclusive benefit of eligible employees by which eligible employees may elect to reduce their cash compensation and have contributions made on their behalf for the payment of all or a portion of the cost for benefits selected by the employees under certain benefit plans maintained by the Employer. The Employer has made prior amendments to this program, including changes to comply with the Patient Protection and Affordable Care Act of 2010, and now hereby amends and restates this program as the Cleveland Public Library Medical Cost Program (the "Plan") taking into account such prior amendments and making certain additional desired changes to the program.

The applicable terms of the Plan only shall apply to each benefit plan, as listed in Supplement A hereto, that provides eligible employees of the Employer to elect to reduce their cash compensation under the Plan. When made applicable to any such plan, this Plan shall provide the language constituting a separate cafeteria plan (applicable only to such plan) for purposes of Section 125 of the Internal Revenue Code of 1986, as amended (the "Code").

The Plan is intended to be a "cafeteria plan" within the meaning of Code Section 125.

II. DEFINITIONS

Whenever used in the Plan, the following words and phrases shall have the meanings set forth below, unless a different meaning is plainly required by the context:

2.1. Administrator

"Administrator" means the Cleveland Public Library or the person or persons appointed by Cleveland Public Library to administer the Plan in accordance with Article VII.

2.2. Benefits

"Benefits" mean the options, benefits or coverages available under Article VI for election by an eligible Employee.

2.3. Benefit Plan

"Benefit Plan" means any benefit plan maintained by an Employer for the benefit of employees which provides Benefits available to the eligible Employees under this Plan.

2.4. Code

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

2.5 Dependent

"Dependent" means spouse, natural or adopted children, step-children, or children for whom an employee has legal custody.

2.6 Dependent Care Assistance Benefits

"Dependent Care Assistance Benefits" means the benefits provided under the Dependent Care Assistance Program pursuant to the Cleveland Public Library Flexible Spending Account Plan.

2.7. Employee

"Employee" means any individual who is classified as an employee by an Employer.

2.8. Employer

"Employer" means Cleveland Public Library.

2.9 Medical and Dental Expense Benefits

"Medical and Dental Expense Benefits" means the benefits provided under the Health Care Reimbursement Plan pursuant to the Cleveland Public Library Flexible Spending Account Plan.

2.10. Participant

"Participant" means an eligible Employee who participates in the Plan under Article III.

2.11. Plan

"Plan" means the Cleveland Public Library Medical Cost Program.

2.12. Plan Year

"Plan Year" means the 12 consecutive month period beginning each January 1.

2.13. Reimbursement Accounts

"Reimbursement Accounts" means the accounts established pursuant to Article V with respect to a Participant who has elected to receive Medical and Dental Expense Benefits and/or Dependent Care Assistance Benefits.

III. ELIGIBILITY AND PARTICIPATION

3.1. Eligibility.

An Employee shall become eligible to participate in the Plan with respect to any of the Benefits available under the Plan upon his or her satisfaction of the conditions to receive such Benefits, as determined by the Employer.

3.2. Participation.

An eligible Employee shall become a Participant in the Plan upon the filing of a completed benefit election form with the Administrator in accordance with the requirements of Article IV.

3.3. Termination of Participation.

An individual will cease to be a Participant on the earliest to occur of the following events:

(a) the date on which he or she ceases to be eligible to participate under Section 3.1; or

(b) the date on which he or she no longer has any Benefit elections in effect as provided in Article IV.

3.4. Participation During Leaves of Absence.

(a) A Participant who is not at work because of an unpaid FMLA leave, an approved unpaid leave or suspension, or due to an unpaid period of duty in the uniformed services (within the meaning of the Uniformed Services Employment and Reemployment Rights Act of 1994) lasting more than 31 days, may, at the Participant's option, continue any or all Benefits under the Plan, subject to the terms of the Benefit Plans listed in Exhibit A, that the Participant elected during the period of absence so long as the Participant continues to make any required contributions for such Benefits. During the absence, the Participant may choose to make these contributions by paying an Employer for the amounts that became due during the leave out of the Participant's compensation payable after his or her return from the leave.

(b) Subject to any specific limitations for any particular Benefit which the Participant has elected, an individual who is on a paid leave of absence shall continue to be a Participant during such leave of absence.

(c) Except as otherwise provided in paragraph (a), an individual's participation shall be suspended (i) during an unpaid leave of absence or suspension or (ii) during a period in which he or she ceases to be eligible for a Benefit that he or she has elected; provided that the individual continues to be an Employee during such period. Notwithstanding the foregoing, nothing in this Section shall prevent a participant on unpaid leave from receiving any available Medical and Dental Expense Benefits or Dependant Care Assistance Benefits as if such Participant were otherwise actively employed by the Employer.

IV. BENEFIT ELECTIONS

4.1. Election of Benefits.

(a) An eligible Employee may elect under this Plan (i) to receive one or more of the Benefits available under Article VI for any Plan Year or (ii) to waive Benefits available under this Plan for any Plan Year and receive his or her full compensation in cash.

(b) An eligible Employee who elects to receive Medical and Dental Expense Benefits shall specify the dollar amount of coverage elected for the Plan Year, which amount shall not exceed $2,500.

(c) An Employee who elects to receive Dependent Care Assistance Benefits shall specify the dollar amount of coverage elected for the Plan Year, which amount shall not exceed $5,000, or, if the Employee is married and files a separate tax return, $2,500.

4.2. Compensation Reduction.

Each Participant who elects to receive one or more of the Benefits shall agree to a reduction in his or her cash compensation for the Plan Year on a pre-tax basis in an amount equal to –

(a) the Participant's share of the cost of such Benefits as determined pursuant to Section 6.2,

(b) the amount of Medical and Dental Expense Benefits coverage elected for the Plan Year, if any, and

(c) the amount of Dependent Care Assistance Benefits coverage elected for the Plan Year, if any.

4.3. Initial Benefit Election Period.

(a) An Employee who is eligible to participate and who wishes to receive one or more of the Benefits available under the Plan shall elect such Benefit(s) under the method determined and communicated by the Administrator on or before such date as the Administrator shall specify.

(b) A Benefit election by an Employee pursuant to this Section 4.3 shall be effective, subject to Section 4.4, for the period beginning on the first full payroll period beginning after the date as of which the benefit election is properly made and ending on the last day of the Plan Year.

(c) An eligible Employee who fails to properly complete a Benefit election may not elect any Benefits under the Plan until the next annual benefit election period as described in Section 4.4 or until an event that would permit a benefit election change under Section 4.5.

4.4. Annual Benefit Election Period.

(a) For any Plan Year beginning after an eligible Employee's initial election period under Section 4.3, such Employee may make a new election or change a prior election to receive one or more of the Benefits available under Article VI for such Plan Year by making a proper election with the Administrator on or before such date as the Administrator shall specify, which date shall be no later than the last day of the preceding Plan Year.

(b) An eligible Employee who fails to complete and file a benefit election form with the Administrator before the specified due date shall be deemed –

(i) With respect to Medical and Dental Expense Benefits and Dependent Care Assistance Benefits, to have elected not to receive any such Benefits for the Plan Year; and

(ii) With respect to all other Benefits, to have made the same election as was in effect immediately prior to the end of the preceding Plan Year.

4.5. Benefit Election Changes by Participant During Plan Year.

Except as provided in this Section 4.5, a Participant's election (or deemed election) under this Article IV for any Plan Year may not be changed or revoked by the Participant during such Plan Year.

(a) HIPAA Special Enrollment. A Participant may revoke an election for accident (if any) or health coverage during the Plan Year and make a new election that corresponds with the HIPAA special enrollment rights provided in Section 9801(f) of the Code.

(b) Changes in Status. A Participant may prospectively change or revoke his or her benefit election during the Plan Year if the Administrator, in the sole discretion, determines that such benefit election change or revocation is on account of, and is consistent with, a "change in status" event described in clause (i) below.

(i) A "change in status" is one of the following events:

(A) Legal Marital Status. An event that changes the Participant's legal marital status, including marriage, death of spouse, divorce, dissolution, legal separation, or annulment.

(B) Number of Dependents. An event that changes the Participant's number of Dependents, including birth, death, adoption, placement for adoption, of a Dependent.

(C) Employment Status. Any of the following events that change the employment status of the Employee or the Employee's Dependent: a termination or commencement of employment; a strike or lockout; the commencement or return from an unpaid leave of absence; or any other change in employment status that causes the Employee or Dependent to become, or cease to be, eligible for a Benefit (such as a switch between part-time and full-time status).

(D) Change in Dependent's Eligibility. An event that causes a Participant's Dependent to satisfy, or cease to satisfy the requirements for coverage due to attainment of age, student status, or any similar circumstance under a Benefit Plan that qualifies or disqualifies a Dependent for coverage, including coverage under another benefit option or plan.

(E) Residence. A change in the place of residence of the Employee or Dependent.

(ii) A Participant's change or revocation of his or her benefit election shall be subject to the following rules:

(A) The Benefit election change must be made within 30 days before or after the date of the Change in Status event.

(B) A Participant may not cancel coverage for an individual who has become eligible for coverage under another plan unless and until the individual actually becomes covered under the other plan.

(C) A Benefit election change must be made on account of, and correspond with, a change in status that affects eligibility for coverage under a Benefit Plan. A change in status that affects eligibility under a Benefit Plan includes a change in status that results in an increase or decrease in the number of an Employee's family members or Dependents who may benefit from coverage under that plan.

(D) A Participant may make an election change with respect to Dependent Care Assistance Benefits if a Change of Status affects his or her qualified employment-related expenses under Section 129 of the Code.

(c) Changes in Cost. A Participant may prospectively change or revoke his or her Benefit election during the Plan Year if the Administrator, in its sole discretion, determines that such benefit election change or revocation is on account of a change in cost for benefits. Notwithstanding the foregoing, no change may be made under this subsection during the Plan year with respect to a Participant's election of Medical and Dental Expense Benefits.

(i) Automatic Changes. If the cost of a Benefit increases or decreases during a Plan Year and, under the terms of that plan, Participants are required to make a corresponding change in their payments, the Administrator will automatically make a prospective increase (or decrease) in any affected Participants' elective contributions for this Plan.

(ii) Significant Cost Changes. If the cost charged to a Participant for a Benefit option significantly increases or significantly decreases during a Plan Year, the affected Participant may make a corresponding change in his or her benefit election under this Plan.

(A) Changes that may be made include commencing participation in this Plan in a particular Benefit option with a decrease in cost, or, in the case of an increase in cost, revoking an election for that coverage and, instead, either receiving on a prospective basis coverage under another Benefit option providing similar coverage or dropping coverage if no other benefit package option providing similar coverage is available.

(B) If the cost of an indemnity option under an accident or health plan significantly increases during a period of coverage, Employees who are covered by the indemnity option may make a corresponding prospective increase in their payments or may instead elect to revoke their election for the indemnity option and, instead, elect coverage under another Benefit option including an HMO option (if then offered through this Plan), or drop coverage under the accident or health plan if no other benefit package option is offered.

(iii) Applicable Cost Changes. For purposes of this section, a "cost increase or decrease" refers to an increase or decrease in the amount of the elective contributions under this Plan, whether that increase or decrease results from an action taken by the Employee (such as switching between full-time and part-time status) or from an action taken by the Employer (such as reducing the amount of employer contributions for a class of employees).

(iv) Dependent Care Assistance Benefits. A Participant's prior election with respect to Dependent Care Assistance Benefits may be altered only if the cost change is imposed by a dependent care provider who is not a relative of the Employee (within the meaning of Section 152 of the Code).

(d) Significant Changes in Coverage. A Participant may prospectively change or revoke his or her benefit election during the Plan Year if the Administrator, in its sole discretion, determines that such benefit election change or revocation is on account of a change in coverage. Notwithstanding the foregoing, no change may be made under this subsection during the Plan Year with respect to a Participant's election of Medical and Dental Expense Benefits.

(i) Significant Curtailment of Coverage. If a Participant (or the Participant's Dependent) has a significant curtailment of a Benefit during a Plan Year that is not a loss of coverage described in clause (ii) below (e.g., there is a significant increase in the deductible, the required copayments, or the out-of-pocket cost sharing limit under a group health plan), such Participant may revoke his or her election for that coverage and, instead, elect to receive on a prospective basis coverage under another Benefit option providing similar coverage. For this purpose, coverage is "significantly curtailed" only if there is an overall reduction in coverage so as to constitute reduced coverage generally.

(ii) Loss of Coverage. If a Participant (or the Participant's Dependent) has a loss of coverage with respect to a particular Benefit, the Participant may revoke his or her Benefit election and, in lieu thereof, to elect either to receive on a prospective

basis coverage under another Benefit option providing similar coverage or to drop coverage if no similar benefit option is available.

A "loss of coverage" means a complete loss of coverage under the benefit package option or other coverage option (including the elimination of a Benefit option, and HMO ceasing to be available in the area where the individual resides, or the individual losing all coverage under the option by reason of an overall lifetime or annual limitation). A loss of coverage includes (A) a substantial decrease in the medical care providers available under the option; (B) a reduction in the benefits for a specific type of medical condition or treatment with respect to which the Employee or the Employee's Dependent is currently in a course of treatment; or (C) any other similar fundamental loss of coverage.

(iii) Addition or Improvement of Benefit Option. If a Benefit Plan adds a new Benefit option or other coverage option, or if coverage under an existing Benefit or other coverage option is significantly improved during a period of coverage, eligible Employees (whether or not they have previously made an election under the Plan or have previously elected the Benefit option) may revoke their election under the Plan and, in lieu thereof, make an election on a prospective basis for coverage under the new or improved Benefit option.

(e) Medicare or Medicaid Entitlement. If a Participant or the Participant's Dependent becomes enrolled for general benefits under Medicare or Medicaid (i.e., benefits in addition to pediatric vaccinations), the Participant may revoke coverage for such individual. If the Participant or Dependent loses coverage under Medicare or Medicaid, the Participant may make a prospective election to begin or increase coverage of that individual under an Employer's accident (if any) or health plan.

(f) Court Ordered Coverage.

(i) If a participant is required to provide health insurance coverage for a Dependent child or foster child as a result of a divorce, dissolution, legal separation, annulment, or change in legal custody (for example, under the Child Support Performance and Incentive Act), the Plan may change the Participant's election during a Plan Year unilaterally to comply with the legal instrument mandating coverage.

(ii) A Participant may make an election change to cancel coverage for a Dependent child or foster child if (A) the order requires the spouse, former spouse, or other individual to provide coverage for the child, and (B) that coverage is, in fact, provided.

(g) **FMLA Leave.** A Participant who takes FMLA leave shall have the right to make any election change under an Employer-sponsored group health plan option as may be provided for under FMLA.

(h) **Other Permitted Changes.** A Participant may prospectively change or revoke his or her Benefit election during the Plan Year if the Administrator, in its sole discretion, determines that such benefit election change or revocation is on account of, and consistent with, a change permitted under IRS Regulation Section 1.125-4 (or any successor regulation thereto) or IRS rulings under Section 125 of the Code.

(i) **When Benefit Election Change Becomes Effective.** Any new election under this Section 4.5 shall be effective at such time as the Administrator shall prescribe, but not earlier than the first pay period beginning after the Benefit election form is completed and returned to the Administrator.

4.6. Changes to Comply with Nondiscrimination Rules.

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 any Participant who is considered to be "highly compensated" within the meaning of Section 125(e) of the Code, or is otherwise a "Key Employee" within the meaning of Section 416(i)(1) of the Code, the Administrator shall take such action as it 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 any elections made by highly compensated Employees or Key Employees with or without the consent of such Employees.

4.7. Automatic Termination of Election.

(a) A Participant's election with respect to a Benefit under this Plan (or deemed to be made) shall automatically terminate upon the occurrence of either of the following events occurs:

(i) the date of which the Participant ceases to be eligible for such Benefit; or

(ii) the Participant fails to make required contributions for such Benefit, unless the Participant makes such delinquent contributions current within 30 days after the date on which such contributions first became delinquent.

(b) If a Participant's Benefit election is terminated pursuant to this Section 4.7, the Participant may not make a new election with respect to such Benefit until the next annual enrollment period.

V. REIMBURSEMENT ACCOUNTS

5.1 Establishment of Reimbursement Accounts.

For each Plan Year, the Administrator shall establish unfunded memorandum accounts for each Participant who elects to receive Medical and Dental Expense Benefits and/or Dependent Care Assistance Benefits. Such accounts shall be used to record amounts which are available for reimbursement as Medical and Dental Expense Benefits and Dependent Care Assistance Benefits. No money shall actually be allocated to any Reimbursement Account and 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 as a result of the establishment of such Account.

5.2 Crediting and Debiting Reimbursement Accounts.

(a) During a Plan Year, a Participant's Reimbursement Accounts shall be credited as follows:

(i) the Participant's Medical and Dental Expense Benefit Reimbursement Account shall be credited with an amount equal to the dollar amount of coverage elected by the Participant for the Plan Year; and

(ii) the Participant's Dependent Care Assistance Benefit Reimbursement Account shall be credited with the amounts with which his or her compensation has actually been reduced during the Plan Year.

(b) A Participant's Reimbursement Accounts shall be debited with amounts which have been paid as Medical and Dental Expense Benefits or Dependent Care Assistance Benefits during the Plan Year.

(c) No interest or earnings will be credited to or paid on amounts credited to any Reimbursement Account.

5.3 Forfeiture of Unused Account Balance.

(a) For each Plan Year, any balance remaining in a Participant's Reimbursement Accounts after payment of all reimbursements claimed and approved as Medical and Dental Expense Benefits or Dependent Care Assistance Benefits for such Plan Year and applicable Extended Grace Period (as defined in the Cleveland Public Library Flexible Spending Account Plan) shall be forfeited and the Accounts shall be reduced to zero.

(b) A Participant shall not be entitled to any additional compensation as a result of such forfeiture.

(c) Such forfeitures may be used for any purpose that the Administrator deems appropriate, including, without limitation, the payment of reasonable and necessary expenses of the Plan.

VI. BENEFITS

6.1. Available Benefits.

The Benefits available for election by a Participant under this Plan shall be provided pursuant to the Benefits Plans set forth in Supplement A.

6.2. Determination of Cost for Benefits.

The Administrator shall determine from time to time the applicable amount of the premiums required to be paid by Participants for Benefits available under Section 6.1.

6.3. Governing Benefit Provisions.

The type, amount and duration of Benefits available pursuant to Section 6.1, the conditions and requirements for participating in such Benefits, and any other terms and conditions for coverage with respect to such Benefits shall be determined solely on the basis of the terms and provisions of the applicable Benefit Plan providing such Benefits, as embodied in the plan documents comprising such Benefit Plan. The benefit descriptions in such Benefit Plans, as in effect from time to time, are hereby incorporated by reference into this Plan.

VII. ADMINISTRATION

7.1. Plan Administrator.

The Plan shall be administered by the Employer or such other person or committee as may be appointed from time to time by the Employer.

7.2. Administrator's Authority and Powers.

The Administrator shall have full authority and power to administer and construe the Plan, subject to applicable requirements of law. Without limiting the generality of the foregoing, the Administrator shall have the following powers and duties:

(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 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 person to participate in, and receive benefits under, 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 determine the cost for Benefits available to any person under the provisions of the Plan and the amount of cash compensation to be paid in lieu of benefits, if any.

Notwithstanding the foregoing, any claim for Benefits shall not be subject to review under this Plan, and the Administrator's authority under this Section 7.2 shall not extend to any matter as to which an administrator under the Benefit Plan providing such Benefits is empowered to make determination under such plan.

7.3. Delegation of Duties.

The Administrator may delegate such of its duties and may engage such experts and other persons as it deems appropriate in connection with administering the Plan. The Administrator shall be entitled to rely conclusively upon and shall be fully protected in any action taken by the Administrator in good faith in reliance upon any opinions or reports furnished them by any such experts or other persons.

7.4. Expenses.

All expenses incurred prior to the termination of the Plan that shall arise in connection with the administration of the Plan, including, without limitation, administrative expenses and compensation and other expenses and charges of any actuary, counsel, accountant, specialist or

other person who shall be employed by the Administrator in connection with the administration of the plan, shall be paid by the Employer.

7.5. Indemnification of Administrator.

To the extent required by law, the Employer agrees to indemnify and to defend any Employee serving as the Administrator or as a member of a committee designated as Administrator (including any Employee or former Employee who formerly served as Administrator or as a member of such committee) against all liabilities, damages, costs and expenses (including attorneys' fees and amounts paid in settlement of any claims approved by the Employer) directly resulting from by any act or omission to act in connection with the Plan, if such act or omission is in good faith, is not manifestly outside the scope of employment, and is not the result of the Administrator's willful misconduct or willful breach of the Plan.

7.6. Liability.

To the extent permitted by law, neither the Administrator nor any other person shall incur any liability for any acts or for any failure to act except for liability arising out of such person's own willful misconduct or willful breach of the Plan or acts manifestly outside the scope of employment or in bad faith.

VIII. AMENDMENT OR TERMINATION OF PLAN

8.1. Right to Amend or Modify Plan.

The Employer's Board of Trustees may at any time and from time to time (and retroactively, if necessary or appropriate to meet the requirements of the Code) modify or amend, in whole or in part, any or all provisions of the Plan.

8.2. Right to Terminate Plan.

The Employer, by action of its Board of Trustees, may discontinue or terminate the Plan at any time.

8.3. Effective Date of Amendment or Termination.

Any amendment, discontinuance or termination of the Plan shall be effective as of the date determined by the Employer.

IX. GENERAL PROVISIONS

9.1. No Right to Continued Employment.

Neither the Plan nor any action taken with respect to it shall confer upon any person the right to continue in the employ of an Employer.

9.2. Governing Laws.

The provisions of the Plan shall be construed, administered and enforced according to applicable Federal law and the laws of the State of Ohio.

9.3. Severability.

The provisions of the Plan are severable. If any provision of the Plan is deemed legally or factually invalid or unenforceable to any extent or in any application, then the remainder of the provision and the Plan, except to such extent or in such application, shall not be affected, and each and every provision of the Plan shall be valid and enforceable to the fullest extent and in the broadest application permitted by law.

IN WITNESS WHEREOF, Cleveland Public Library has adopted this Amended and Restated Plan as of the ____ day of _____, 2013.

CLEVELAND PUBLIC LIBRARY

By:

Name:

Title

SUPPLEMENT A: BENEFIT PLANS

As of January 1, 2013:

1. Employee premiums required for coverage under the health care, dental and vision coverages made available by or through the Employer.

2. The Cleveland Public Library Flexible Spending Account Plan

    - Health Care Reimbursement Plan
    - Dependent Care Assistance Program

CLEVELAND PUBLIC LIBRARY
EMPLOYEE BENEFITS PLAN

Effective January 1, 2013

CLEVELAND PUBLIC LIBRARY
EMPLOYEE BENEFITS PLAN

WHEREAS, Cleveland Public Library (the "Plan Sponsor") maintains various types of employee welfare benefit plans; and

WHEREAS, effective January 1, 2013, the Plan Sponsor wishes to consolidate such plans into one plan in order to clarify that such plans are provided under a single plan, program, or arrangement.

NOW, THEREFORE, the Plan Sponsor does hereby adopt the Cleveland Public Library Employee Benefits Plan (the "Plan"), effective January 1, 2013.

ARTICLE I
PURPOSE OF PLAN

The Plan is an employee welfare plan designed to provide certain welfare benefits for the eligible employees of the Plan Sponsor.

ARTICLE II
DEFINITIONS

As used in this Plan, the following terms, when capitalized, shall have the meaning specified below unless the context clearly indicates to the contrary:

2.1 "Covered Benefit" shall mean any employee welfare benefit designated in Schedule I attached hereto, which may be revised from time to time without amendment to the Plan.

2.2 "Effective Date" of the Plan as set forth herein shall mean January 1, 2013.

2.3 "Employee" shall mean any person employed by the Employer, other than (i) a person who is classified by the employer as an independent contractor regardless of whether such person is later determined by the employer or otherwise to be a common law employee of the employer; (ii) an individual who is classified by the employer as a leased employee regardless of whether the individual is later determined by the employer or otherwise to be a common law employee of the employer; (iii) an employee classified by the employer as a temporary employee regardless of the hours such person works for the employer or duration of employment with the employer; (iv) a nonresident alien with no income from sources within the United States, or (v) a self-employed individual (within the meaning of Code Section 401(c)).

2.4 "Employer" means Cleveland Public Library.

2.5 "Participant" shall mean an Employee of the Plan Sponsor who has satisfied the eligibility and enrollment requirements applicable to a Covered Benefit and has not ceased to be eligible for coverage with respect to such Covered Benefit.

2.6 "Plan Administrator" shall mean the Plan Sponsor.

2.7 "Plan Sponsor" shall mean Cleveland Public Library and its successors.

2.8 "Plan Year" shall mean each 12 consecutive month period beginning on January 1 and ending on the next following December 31.

ARTICLE III
BENEFITS AND COSTS

3.1 The Covered Benefits under this Plan shall be those set forth in Schedule I. The type and amount of benefits available, the requirements for participation, and the other terms, conditions and limitations of coverage and benefits shall be as set forth in the Summary Plan Description, contracts, policies, or other written instruments governing the Covered Benefits. The terms of such contracts, policies or other written instruments, as amended from time to time, are incorporated into this Plan by reference.

3.2 Notwithstanding anything to the contrary in this Plan, including the provisions of any underlying contracts, policies or written instruments governing the Covered Benefits, the cost of the Covered Benefits shall be paid by the Plan Sponsor alone, jointly by the Plan Sponsor and eligible employees, or by eligible employees alone, as provided in Schedule II attached hereto.

ARTICLE IV
PLAN ADMINISTRATION

4.1 Plan Administrator. The administration of the Plan shall be under the supervision of the Plan Administrator. It shall be a principal duty of the Plan Administrator to see that the Plan is carried out in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan. The Plan Administrator will have full power and discretion to administer the Plan in all of its details subject, however, to the applicable requirements of law. For this purpose, the Plan Administrator's powers and the powers of any claims fiduciary will include, but will not be limited to, the following discretionary 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 determine all questions concerning the Plan, including the eligibility of any person to participate in the Plan and the status and rights of any Participant; provided, further, that any such determination shall be final and conclusive;

(d) to compute the amount of benefits which will be payable to any Participant or other person in accordance with the provisions of the Plan, and to determine the person or persons to whom such benefits will be paid;

(e) to authorize the payment of benefits;

(f) to appoint such agents, counsel, accountants, consultants and actuaries as may be required to assist in administering the Plan; and

(g) 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 by written instrument and in accordance with applicable requirements of law.

4.2 Examination of Records. The Plan Administrator will make available to each Participant such of his records as pertain to him, for examination at reasonable times during normal business hours.

4.3 Fiduciary.

(a) The Plan Administrator will be a fiduciary with authority to control and manage the operation and administration of the Plan.

(b) For purposes of the determination of the amount of, and entitlement to, Covered Benefits provided under insurance contracts, the respective insurer is the fiduciary under the Plan, with the full power to interpret and apply the terms

of the Plan as they relate to the Covered Benefit provided under the applicable insurance contract.

4.4 Plan Administrators Decision Final. Subject to applicable law, any interpretation of the provisions of the Plan and any decisions on any matter within the discretion of the Plan Administrator made by the Plan Administrator in good faith shall be binding on all persons. A misstatement or other mistake of fact shall be corrected when it becomes known and the Plan Administrator shall make such adjustment on account thereof as it considers equitable and practicable. The Plan Administrator shall not be liable in any manner for any determination of fact made in good faith.

4.5 Claims and Review Procedures.

(a) To obtain benefits from the insurer of a Covered Benefit program, a Participant shall follow the claims procedures under the applicable insurance contract, which may require the Participant to submit a claim in the manner prescribed by the insurer. In such case, the claim form may be available from the Plan Administrator.

(b) The claims review procedure adopted by the Plan is set forth in the summary plan description for the Plan.

ARTICLE V
GENERAL PROVISIONS

5.1 Amendment and Termination of Plan. The Plan Sponsor specifically reserves to itself the right at any time, and from time to time, to amend or terminate this Plan and any Covered Benefit in whole or in part at any time without any liability whatsoever for such amendment or termination. The Plan Sponsor's right to amend or terminate includes, without limitation, the right to amend or terminate Covered Benefits provided to any class of Participants under this Plan. In the event of a dissolution, merger, consolidation, or reorganization of the Plan Sponsor, the Plan shall terminate unless it is continued by a successor to the Plan Sponsor. In the event the Plan Sponsor decides to amend or terminate this Plan, such decision shall be evidenced in writing via a written resolution of the Board of Trustees of the Plan Sponsor, or by signature of an officer with the authority to adopt amendments on behalf of the Plan Sponsor, except with respect to changes to Schedule I, which may be revised without plan amendment. In the event the Plan, or any Covered Benefit, is amended or terminated, any amounts that became payable under the terms of the Plan prior to the date of termination shall be paid in accordance with the terms of the Plan as in effect immediately prior to the date of such termination or amendment.

5.2 Cost of Administration. The costs and expenses incurred by the Plan Administrator in administering the Plan may be paid by the Plan Sponsor or by a trust established to fund any of the Covered Benefits, as may be determined by the Plan Administrator.

5.3 Funding and Payment of Benefits. The Covered Benefits provided under the Plan shall be paid solely from insurance contracts or from the general assets of the Plan Sponsor or from a trust established to fund any of the Covered Benefits. Benefits may be paid in part through contributions made to the Plan by the Plan Sponsor or by Participants on either a pre-tax or after-tax basis. Nothing herein shall be construed to require the Plan Sponsor to maintain any fund or segregate any amount for the benefit of any Participant, and 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 Plan Sponsor from which any payment under the Plan may be made, unless required by applicable law.

5.4 Facility of Payment. When a person entitled to benefits under the Plan is under legal disability, or, in the Plan Administrator's opinion, is in any way incapacitated so as to be unable to manage his financial affairs, the Plan Administrator may direct that benefits be paid to such person's legal representative, or to a relative or friend of such person for such person's benefit, or the Plan Administrator may direct the application of such benefits for the benefit of such person. Any payment made in accordance with the preceding sentence shall be a full and complete discharge of any liability for such payment under the Plan.

5.5 Waiver of Notice. Any notice required under the Plan may be waived by the person entitled to such notice.

5.6 Participants' Rights. This Plan shall not be deemed to constitute a contract between the Plan Sponsor and any Participant or employee or to be a consideration or an inducement for the employment of any Participant, and nothing contained in this Plan shall be deemed to give any Participant the right to be retained in the service of the Plan Sponsor, or to interfere with the right of the Plan Sponsor to discharge any Participant at any time regardless of the effect which such discharge will have on any Participant. Furthermore, nothing contained in the Plan shall give a Participant any right, title or interest in any property of the Plan Sponsor, and neither the establishment of this Plan nor any amendment hereof nor the payment of any benefits, shall be construed as giving to any Participant or any other person any legal or equitable rights against the Plan Sponsor or the Plan Administrator, except as expressly provided under the terms of the Plan.

5.7 Non-Assignment. Neither a Participant nor beneficiary in this Plan has any right to assign his rights or benefits or any cause of action arising at anytime against the Plan or Plan Sponsor to any third party. Any assignments of rights, benefits or causes of action under the Plan will be void and unenforceable.

5.8 Governing Law. This Plan shall be construed and enforced according to the laws of the State of Ohio, to the extent not preempted by federal law.

ARTICLE VI

PRIVACY AND SECURITY PROVISIONS APPLICABLE TO MEDICAL, DENTAL AND VISION BENEFITS

6.1 Providing Protected Health Information to Plan Sponsor.

(a) Disclosing Protected Health Information to Designated Classes of Employees of the Plan Sponsor. The Plan shall disclose Protected Health Information to designated classes of employees of the Plan Sponsor only upon the receipt of a certification of the Plan Sponsor that the Plan has been amended to incorporate the provisions of 45 CFR §164.504(f)(2)(ii), and that the Plan Sponsor agrees to the conditions of disclosure set forth in paragraph 4 of this Section.

(b) Adequate Separation Between Plan and Plan Sponsor. The Plan Sponsor has designated the following classes of employees as those eligible to receive Protected Health Information: the Payroll Manager, Chief Financial Officer, and Human Resources Director. These classes of employees only shall have access to and use Protected Health Information to the extent necessary to perform the Plan Administration Function that the Plan Sponsor performs for the Plan. In the event that any of these specified employees do not comply with the provisions of this Section, that employee shall be subject to disciplinary action by the Plan Sponsor for non-compliance pursuant to the Plan Sponsor's employee discipline and termination procedures.

(c) Notwithstanding the foregoing and Sections 6.2 and 6.3, effective January 1, 2013, the Plan shall not disclose Protected Health Information to the Plan Sponsor or any employees of the Plan Sponsor.

(d) The Plan may disclose PHI to an individual and/or entity who is a "business associate" under the Health Insurance Portability and Accountability Act of 1996, as amended, and for whom the Plan and the individual/entity has entered into an agreement regarding such duties as a business associate. Any such business associate shall only use PHI for the purposes specified under the terms of the agreement.

6.2 Conditions of Disclosure. The Plan Sponsor agrees that with respect to any Protected Health Information disclosed to it by the Plan, Plan Sponsor shall:

(a) Not use or further disclose the Protected Health Information other than as permitted or required by the Plan or as required by law.

(b) Ensure that any agents, including a subcontractor, to whom it provides Protected Health Information received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to Protected Health Information not use or disclose the Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

(c) Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware.

(d) Make available Protected Health Information in accordance with 45 CFR §164.524.

(e) Make available Protected Health Information for amendment and incorporate any amendments to Protected Health Information in accordance with 45 CFR §164.526.

(f) Make available the information required to provide an accounting of disclosure in accordance with 45 CFR §164.528. Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with subpart E of 45 CFR §164.

(g) If feasible, return or destroy all Protected Health Information received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction of the information is infeasible, the Plan Sponsor shall maintain the information only for the purpose that makes return or destruction infeasible.

(h) Ensure that the adequate separation between Plan and Plan Sponsor, required in 45 CFR §504(f)2)(iii), is satisfied, and that such separation is supported by reasonable and appropriate security measures.

(i) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the covered entity.

(j) Ensure that any agent, including a subcontractor, to whom it provides Protected Health Information agrees to implement reasonable and appropriate safeguards to protect it.

(k) Report to the Plan any security incident of which it becomes aware.

6.3 Definitions.

(a) Covered Entity means (i) a Health Plan, (ii) a health care clearinghouse, or (iii) a health care provider who transmits any Health Information in electronic form in connection with a Transaction.

(b) Electronic PHI is PHI that is maintained in or transmitted by electronic media. Electronic storage media includes memory devices in computers (hard drives), removable/ transportable digital memory medium, such as magnetic tape or disk, optical disk, or digital memory card. Electronic transmission media include any media used to exchange information already in electronic storage media, such as the Internet (wide-open), extranet (using Internet technology to link a business with information accessible only to collaborating parties), leased lines, dial-up lines, private networks, and physically moving removable/ transportable electronic storage media. Fax

machines and telephones are not considered electronic transmission media unless they transmit information stored in an electronic format (i.e. faxes that send information directly to a computer or from a computer, or telephones that send information via the internet).

(c) Health Information means any information, whether oral or recorded in any form or medium that (i) is created or received by a health care provider, Health Plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and (ii) relates to the past, present or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual.

(d) Health Plan means any individual or group plan that provides or pays the cost of medical care (as defined in Section 28\79(1)(2) of the PHS Act, 42 U.S.C. §300gg-91(a)(2).

(e) Individually Identifiable Health Information means a subset of Health Information, including demographic information collected from an individual, and (i) is created or received by a health care provider, Health Plan, employer or health care clearinghouse; and (ii) relates to the past, present or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual; and (iii) either identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

(f) Plan Administration Function means administration functions performed by the Plan Sponsor on behalf of the Plan, excluding functions performed by the Plan Sponsor in connection with any other benefit or benefit plan of the Plan Sponsor.

(g) Protected Health Information means Individually Identifiable Health Information that is (i) transmitted by electronic media; (ii) maintained in any media described in the definition of electronic media at 42 CFR §16.103; or (iii) transmitted or maintained in any other form or medium. Notwithstanding the preceding, Protected Health Information does not include Individually Identifiable Health Information in (i) education records covered by the Family Educational Rights and Privacy Act, as amended, 20 U.S.C. §1232g; (ii) records described at 20 U.S.C. §1232g(a)(4)(B)(iv); and (iii) employment records held by a Covered Entity in its role as employer.

(h) Summary Health Information means information that (i) summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor had provided health benefits under a Health Plan; and (ii) from which the information described at 42 CFR §164.514(b)(2)(i) has been deleted, except that the geographic information described in 42 CFR §164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit zip code.

(i) Transaction means the transmission of information between two parties to carry out financial or administrative activities related to health care.

IN WITNESS WHEREOF, the Plan Sponsor has caused this Plan to be executed by its duly authorized officer on this _____day of _____, 20____.

CLEVELAND PUBLIC LIBRARY

By: _____

Its: _____

SCHEDULE I

COVERED BENEFITS

1. Medical
2. Dental
3. Vision
4. Dependent Care Assistance Program
5. Health Care Reimbursement Plan

SCHEDULE II

COST OF COVERED BENEFITS

As described in the materials provided to each participant in the Cleveland Public Library Employee Benefits Plan during each open enrollment.