289 -2009

CERTIFIED COPY OF ORDER

STATE OF MISSOURI } **ea.**
County of Boone

June Session of the April Adjourned **Term. 20** 09

In the County Commission of said county, on the 30th **day of** June **20** 09

the following, among other proceedings, were had, viz:

Now on this day the County Commission of the County of Boone does hereby **approve** the petition by Michael and Catherine Gill to vacate and re-plat lot 43A of Harper's Pointe Subdivision, Block 2, located at 5251 W Route K, Columbia

Said vacation is not to take place until the re-plat is approved.

Done this 30th day of June, 2009.

Kenneth M. Pearson
Presiding Commissioner

ATTEST:

Wendy S. Noren
Clerk of the County Commission

Karen M. Miller
District I Commissioner

Skip Elkin
District II Commissioner

290-2009

CERTIFIED COPY OF ORDER

STATE OF MISSOURI } **ea.**
County of Boone

June Session of the April Adjourned **Term. 20** 09

In the County Commission of said county, on the 30th **day of** June **20** 09

the following, among other proceedings, were had, viz:

Now on this day the County Commission of the County of Boone does hereby receive and accept the following subdivision plat and authorize the presiding commissioner to sign them:

Howland. S24-T48N-R14W. A-R. Howland Family Trust, owner. Steven R. Proctor, surveyor.

Done this 30th day of June, 2009.

Kenneth M. Pearson
Presiding Commissioner

Karen M. Miller
District I Commissioner

Skip Elkin
District II Commissioner

ATTEST:

Wendy S. Noren
Clerk of the County Commission

291 -2009

CERTIFIED COPY OF ORDER

STATE OF MISSOURI } **ea.**
County of Boone

June Session of the April Adjourned **Term. 20** 09

In the County Commission of said county, on the 30th **day of** June **20** 09

the following, among other proceedings, were had, viz:

Now on this day the County Commission of the County of Boone does hereby approve the attached "Voluntary Payroll Deduction Policy" for use by the County Clerk and County Treasurer in determining acceptable vendors, developing guidelines and setting fees for utilization of the County's payroll system in voluntary payroll deductions. The policy shall cover all future voluntary payroll deductions. The voluntary payroll deductions in effect on June 30, 2009 shall be exempt from the requirements.

Done this 30th day of June, 2009.

Kenneth M. Pearson
Presiding Commissioner

ATTEST:

Wendy S. Noren
Clerk of the County Commission

Karen M. Miller
District I Commissioner

Skip Elkin
District II Commissioner

291-2009

COUNTY OF BOONE

Voluntary Payroll Deduction Program
Policy and Procedures

All vendors who participate in the voluntary deduction program must agree to comply with these policies and procedures. Any vendor found to violate any provision of this policy may be removed from the program.

Policies

1. Only payroll deductions permitted under Missouri Revised Statutes are eligible to participate in the program, including but not limited to an authorized credit union, voluntary retirement plan, group hospital service plan, group life insurance plan, disability plan, medical service plan, health and wellness improvement plans, members of an employee collective bargaining organization, or participants of a group uniform rental etc.

2. Include as an option in the Boone County Cafeteria plan any other product eligible under Section 125 of Title 26 of the United States Code the selection of which may be solicited by a vendor on site in county facilities, subject to rules set by the administrative authority in conjunction with the County Clerk and Treasurer. This authorization shall include payments to the County by vendors providing those products for the cost of administering those deductions, as set by the County Clerk and Treasurer; and

3. Voluntary payroll vendors that have qualified for inclusion in the Boone County Cafeteria Plan under rules set forth in this section in attached Addendum 1 must meet the following criteria for solicitation of business on County property:

   (A) The vendor's product must already be qualified by the Office of the County Clerk.
   (B) The vendor may only present the products that have qualified for cafeteria plan.
   (C) The vendor must schedule solicitation visits with each administrative authority at least two weeks in advance. Building managers may make more restrictive policies regarding locations and times of visits.
   (D) The vendor must not interrupt employee work time for presentation of products or services or other solicitations.
   (E) The vendor may not utilize employee representatives to distribute product information.
   (F) All marketing materials must have prior approval by the Boone County Clerk prior to distribution.
   (G) Each vendor must state to employees that their product is not endorsed by the County of Boone as a County provided benefit and include such statement on all marketing materials.
   (H) Any vendor violating any one of these criteria may lose their payroll deduction privilege.

4. The service or program must be offered on a continuing (5 years, minimum) basis.

Payroll deductions under this policy may be reduced, suspended or discontinued by the County when an employee's net pay after all deductions is insufficient to meet court ordered wage sequestrations.

6. Vendors participating in this program are not eligible to participate in the annual open-enrollment meetings provided by the County except for those deductions that are eligible under Boone County's Cafeteria plan.

7. All mass communications, including letters and advertisements from the company to County employees must be approved by the County Clerk before distribution.

8. The vendor shall not use language that indicates or infers that the County has approved the product in any way, or is coordinating with your company in any capacity other than to provide a payroll deduction slot for your product. Language that includes "Boone County Employees" causes confusion with County-Sponsored plans and therefore is prohibited.

9. Any deduction reports or information you receive from the County of Boone shall be protected as sensitive and be disposed of by burning or shredding.

10. All voluntary payroll vendors are required to receive premium payments in electronic format directly to the bank of their choosing.

11. All voluntary payroll vendors are required to receive deduction reports via the County designated format.

12. Refunding cafeteria plan deductions directly to employees creates a violation of the IRS Code and County policy and procedures and will disqualify your company from participation in the voluntary payroll deduction program.

13. If the vendor certifies that the product is eligible for participation in the County's Cafeteria Plan under Section 125 of the US Code and supporting regulations, the vendor shall agree to indemnify the County against any subsequent adverse ruling by the IRS or Social Security Administration as to the eligibility of the product under said Code or the County's Cafeteria Plan. The vendor shall agree to provide legal defense and pay all costs(including erroneous withholding amounts and employer match), fees, fines, penalties, and forfeitures resulting from any adverse ruling.

Procedures for Obtaining a Payroll Deduction

1. The vendor shall provide the County Clerk with a request, on official company stationery, for a voluntary deduction authorization code from the County Clerk for each product or service offered. This request must be accompanied by:

a) all relevant product information and marketing materials that will be presented to County employees describing the proposed product (all changes to this material must be authorized by the County Clerk before distribution)

b) written evidence the company is in good standing with the Missouri Department of Insurance or other agency maintaining jurisdiction over the respective product or service to be offered.

Federal Tax Identification Number

Requests for payroll deduction authority must be addressed to:

Boone County Clerk
Attn: Employee Benefits Coordinator
801 E Walnut Rm 236
Columbia, Mo 65201

d) $50.00 non refundable application fee per deduction payable to the County of Boone;

2. Once the request for a payroll deduction has been received, the Office of Administration shall designate a period of 90 days for the vendor to obtain 10 signed applications for the product or service. The vendor will receive a payroll deduction code **Please do not attempt to make deductions from these applicants until you have received a deduction code and authorization from the Office of the County Clerk. Deduction codes will be issued and deductions will commence not less than 60 days after the vendor has obtained 10 signed applications for product or service or at the end of the 90 day period which ever is sooner.**

3. The vendor may request a list (formatted on Compact Disc) of names and addresses of Boone County employees who have agreed to allow their home address to be used for voluntary payroll reduction releases. The cost of this list is $15.00 and should be requested at the time of the official request for the Payroll Deduction slot.

   a.) The list of employee names provided by the County Clerk are to be used by the vendor for purposes of mailing material to the employee's residence.

   b.) Under no circumstances may the vendor go to the employee's residence or contact the employee other than through the mail without prior approval from the employee.

4. With compliance with all other criteria, and upon receiving the 10 valid applications, the County Clerk may approve your payroll deduction slot. With that approval, the County Clerk will issue the vendor a payroll deduction code, which must be incorporated into the vendor's Employee Deduction Authorization form.

5. Once the vendor's new Employee Deduction Authorization form has been approved by the County Clerk, a letter will be issued authorizing the vendor to pursue and conduct business by using the County payroll deduction program. Only after such a letter has been issued, may the vendor begin making deductions through the Voluntary Payroll Deduction Program.

6. The County Clerk shall terminate voluntary payroll deduction authority for any product that does not maintain at least (10) active employee deductions. The vendor shall be notified when the number of deductions falls below 10 and shall have 30 days to add additional employees.

7. If the vendor wants their product included as an option in the County cafeteria plan, the vendor must certify that their product is eligible under Section 125 of Title 26 of the *United States Code* and is compliant with the County of Boone's cafeteria plan document.

8. Premium amounts returned by a medical or insurance provider or any benefit amount erroneously withheld and returned to the County by the Plan Administrator shall be deposited into the County Treasury account. Allowable refunds, less required federal, state and Social Security tax withholdings, shall be issued by check payable to the participant from the County Treasurer after accounts and wage reporting for tax purposes have been corrected.

7. Vendors of products included in the voluntary payroll deduction program must comply with all provisions of this order and also agree to fees for the cost of administration, as set by the County Clerk and the County Treasurer. Fess shall not be less than costs to the County under its depository agreements and cafeteria plan administration agreements. Fees shall be withheld from payments to vendors and deposited in the County General Revenue payroll fee revenue accounts.

Agreement

By signing I am authorized to make this agreement on behalf of my company and my company has read and agrees to comply with the County of Boone Voluntary Payroll Deduction Program Policy and Procedures and all applicable state and federal statutes and regulations.

_____ _____

(Signature) (Company)

_____ _____

(Printed Name) (Date)

' DDENDUM 1

PURPOSE: The County Clerk and the County Treasurer have authority to establish rules concerning deductions from employee compensation for participation in voluntary retirement plans, unions, employee associations, credit unions and other approved payroll deduction plans. This order establishes criteria for vendors and procedures which must be fulfilled prior to receiving payroll deduction authority.

Vendors and plans in effect on January 1, 2009 shall be exempt from the vendor requirements under this order.

(1) Definitions. For the purposes of this order the terms and their meanings are—

(A) Vendor—any private insurance carrier or company, a labor union, an employee association or credit union;

(B) Credit union—a financial institution located in Missouri, which has a state charter and is insured by an agency of the United States government or credit union share guarantee corporation approved by the director of the Missouri Division of Credit Unions; and

(C) Dues—a fee or payment owed by an employee to a labor organization as a result of and relating to employment in a bargaining unit covered by an existing labor agreement or a payment owed by an employee for membership in an employee association.

(2) The following requirements apply to payroll deductions:

(A) The vendor providing a product or service must have fulfilled all prescribed standards with applicable federal and state regulatory agencies;

(C) The proposed service or program must be offered on a consistent and continuing basis and must be reasonably anticipated to be available for a period of five (5) or more years;

(D) The vendor must provide the County Clerk a request for payroll deduction in writing on official company or association stationery plus all relevant product information, payroll processing requirements and marketing materials that fully describe the proposed product;

(E) Within a period of ninety (90) days, the vendor applicant for payroll deduction authority must obtain a minimum of ten (10) county employee-signed applications for the proposed product, employee association or credit union membership. The ninety (90)-day period for obtaining ten (10) employee signatures will commence on the date designated by the County Clerk's acknowledgment of a payroll deduction request required in subsection (2)(D);

(F) The County Clerk shall terminate voluntary payroll deduction authority for any product that does not maintain at least 10 active employee deductions. Employees receiving any product where the number of participants falls below ten (10) shall be notified by the vendor of the potential for loss of service. If the number of participants drops below 10 the vendor shall have 30 days prior to termination of the product to add new employees to the plan;

(G) Solicitation by a vendor of signed employee applications or memberships may not be performed in county facilities at any time with the exception that qualified vendor products for the cafeteria plan under the most recent plan document may attend meetings organized by the county where other qualified cafeteria plan products are presented. The County Clerk may include the vendor product and contact information with new employee packets;

(H) Labor unions are not required to comply with subsections (2)(D)–(F) to become a vendor and collect dues, but must be recognized as an exclusive bargaining representative by separate resolution agreement with the County Commission in accordance with Missouri statutes;

(I) Vendors must maintain a current primary point of contact with the County Clerk.

(J) The vendor's product shall not be the same product as is offered under the County Employee's Retirement Fund or the County of Boone's 401A Deferred Compensation Plan and 457 Deferred Compensation Plan.

(3) The County Clerk may reduce, suspend or discontinue an employee's voluntary deduction when the net pay, after all mandatory deductions required by law, is insufficient to meet wage garnishments, sequestrations or levies required by law or court order or when the vendor fails to fulfill the required standards prescribed by law or applicable federal and state regulatory agencies.

(4) Request for payroll deduction authority must be addressed to: Boone County Clerk, Attn: Employee Benefits, 801 E Walnut, Room 236, Columbia, Mo. 65201.

(5). The County Clerk may include as an option in the County's cafeteria plan any authorized voluntary payroll deduction product that is eligible under Section 125 of Title 26 of the United States Code and compliant with the County's Cafeteria Plan document.

(6). Fees assessed against the vendor for voluntary payroll deductions may be waived for deductions eligible under the County cafeteria plan if the County Clerk determines that the cost savings are sufficient to cover the County's expenses.

(7) Fees shall be deducted from the ACH payments made to the vendor at each bi-weekly payroll and transferred to the County's payroll fee account.

292 -2009

CERTIFIED COPY OF ORDER

STATE OF MISSOURI } **ea.**
County of Boone

June Session of the April Adjourned **Term. 20** 09

In the County Commission of said county, on the 30th **day of** June **20** 09

the following, among other proceedings, were had, viz:

Now on this day the County Commission of the County of Boone does hereby amend the Boone County Cafeteria Plan to add as "Premium Conversion Plans" covered under the agreement in Sections 3.1 (a) and 6.1 the following:

Other Premium Conversion Plan Products—This category provides for the direct payment to the insurance provider of the participant's share of the cost or premium for coverage under any qualified plan or program which provides any other qualified product eligible under Section 125 of the United States Code, to or on behalf of any employee or spouse or dependent, which plan or program is available to the employee through a payroll deduction agreement with the vendor. Vendors of products included in this plan must be approved for participation in the County's Voluntary Payroll Deduction Program and comply with the County's policies regarding voluntary payroll deductions.

In addition the plan shall further be revised to allow for change of status of a plan to include those voluntary payroll deductions approved by the County under its "Voluntary Payroll Deduction Policy" as of the time the deductions are approved or disapproved.

Said changes shall be as detailed in the attached revised version of the Boone County Cafeteria Plan and be effective July 1, 2009.

Done this 30th day of June, 2009.

Kenneth M. Pearson
Presiding Commissioner

ATTEST:

Wendy S. Noren
Clerk of the County Commission

Karen M. Miller
District I Commissioner

Skip Elkin
District II Commissioner

292-2009

ARTICLE I INTRODUCTION

1.1 ESTABLISHMENT OF PLAN

Boone County (the "Employer") hereby establishes the Boone County Cafeteria Plan (the "Plan") effective March 1, 1994 (the "Effective Date") and subsequently amended:

1.2 PURPOSE OF THE PLAN

This Plan is designed to permit an Eligible Employee to pay his or her share of the premiums of the various insurance plans included in the Benefits list in Article III on a pre-tax Salary Reduction basis, and to contribute on a pre-tax Salary Reduction basis to an account for reimbursement of certain Medical Care Expenses and Dependent Care Expenses.

1.3 LEGAL STATUS

This Plan is intended to qualify as a "cafeteria Plan" under Code §125, and regulations issued there under and shall be interpreted to accomplish that objective.

The Health Care Reimbursement Plan is intended to qualify as a self-insured medical reimbursement plan under Code §105, and the Medical Care Expenses reimbursed are intended to be eligible for exclusion from participating Employees' gross income under Code §105(b). The Dependent Care Assistance Plan is intended to qualify as a dependent care assistance program under Code §129, and the Dependent Care Expenses reimbursed are intended to be eligible for exclusion from participating Employees' gross income under Code §129(a).

Although reprinted within this document, the Health Care Reimbursement Plan and the Dependent Care Assistance Plan are separate plans for purposes of administration and all reporting and nondiscrimination requirements imposed by Code §§105 and 129. The Health Care Reimbursement Plan is also a separate plan for purposes of applicable provision of COBRA.

ARTICLE TWO GENERAL INFORMATION

NAME OF THE PLAN	Boone County Cafeteria Plan
NAME OF EMPLOYER	Boone County
PLAN ADMINISTRATOR	Boone County
NAMED FIDUCIARY & AGENT FOR SERVICE OF LEGAL PROCESS	Boone County
TYPE OF ADMINISTRATION	The Plan is administered by the Plan Administrator with benefits provided in accordance with the provisions of the Boone County Cafeteria Plan. It is not financed by an insurance company and benefits are not guaranteed by a contract of insurance. Boone County may hire a third party to perform some of its administrative duties such as claim payments and enrollment.

BENEFIT PLAN YEAR	The twelve-month period between January 1 and December 31 of the same calendar year.
CODE AND OTHER FEDERAL COMPLIANCE	It is intended that this Plan meet all applicable requirements of the Code and other federal regulations. In the event of any conflict between this Plan and the Code or other federal regulations, the provisions of the Code and the federal regulations shall be deemed controlling, and any conflicting part of this Plan shall be deemed superseded to the extent of the conflict.
DISCRETIONARY AUTHORITY	The Plan Administrator shall perform its duties as the Plan Administrator and in its sole discretion, shall determine appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained. In particular, the Plan Administrator shall have full and sole discretionary authority to interpret all plan documents, and make all interpretive and factual determinations as to whether any individual is entitled to receive any benefit under the terms of this Plan. Any construction of the terms of any plan document and any determination of fact adopted by the Plan Administrator shall be final and legally binding on all parties. Any interpretation shall be subject to review only if it is arbitrary, capricious, or otherwise an abuse of discretion. Any review of a final decision or action of the Plan Administrator shall be based only on such evidence presented to or considered by the Plan Administrator at the time it made the decision that is the subject of review. Accepting any benefits or making any claim for benefits under this Plan constitutes agreement with and consent to any decisions that the Plan Administrator makes in its sole decision and further constitutes agreement to the limited standard and scope of review described by this section.
FIDUCIARY LIABILITY	To the extent permitted by law, the Plan Administrator and other parties assuming a fiduciary or decision making role shall not incur any liability for any acts or for failure to act except for their own willful misconduct or willful breach of this Plan. The standard shall be one of Ordinary Care.

ARTICLE III BENEFITS OFFERED AND METHOD OF FUNDING

3.1 BENEFITS OFFERED

Each Eligible Employee may elect one or more of the following Employer sponsored Benefits:

a)Premium Conversion Plans:

(1) Group Term Life Insurance
(2) Medical Insurance
(3) Dental Insurance
(4) Other Premium Conversion Plan Products—This category provides for the direct payment to the insurance provider of the participant's share of the cost or premium for coverage under any qualified plan or program which provides any other qualified product eligible under Section 125 of the United States Code, to or on behalf of any employee or spouse or dependent, which plan or program is available to the employee through a payroll deduction agreement with the vendor. Vendors of products included in this plan must be approved for participation in the County's Voluntary Payroll Deduction Program and comply with the County's policies regarding voluntary payroll deductions and also agree to fees for the cost of administration, set by the County Clerk and County Treasurer.

b) Health Care Reimbursement Plan

c) Dependent Care Assistance Plan

or d) elect to receive his or her entire compensation in cash.

Benefits under the Plan shall not be provided in the form of deferred compensation.

3.2 EMPLOYER AND PARTICIPANT CONTRIBUTIONS

(a) **Employer Contributions.** The Employer may contribute a portion of the premium to fund Premium Conversion Plan benefits. There are no Employer contributions for the Health Care Reimbursement Plan or the Dependent Care Assistance Plan.

(b) **Participant Contributions.** The Employer shall withhold from a Participant's Compensation on a pre-tax Salary Reduction basis or with after-tax deductions (as elected by the Participant and permitted under the Plan) an amount equal to the contributions required from the Participant for the Benefits elected by the Participant under this Plan. Amounts withheld from a Participant's Compensation, whether on a pre-tax Salary Reduction basis or with after-tax deductions, shall be applied to fund Benefits as soon as administratively feasible. The maximum amount of Salary Reductions (or after-tax deductions, as applicable) shall not exceed the aggregate cost of the Benefits elected. Participants who elect any of the Benefits may pay for their required contributions, if any, on a pre-tax Salary Reduction basis, or with after-tax deductions, by completing an Election Agreement.

3.3 COMPUTING SALARY REDUCTION CONTRIBUTIONS

(a) **Salary Reductions per Pay Period.** The Salary Reduction for a pay period for a Participant is an amount equal to the annual premium for such Benefits divided by the number of pay periods in the Period of Coverage, or an amount otherwise agreed upon between the Employer and the Participant, or an amount deemed appropriate by the Administrator.

If a Participant increases his or her election under the Health Care Reimbursement Plan or Dependent Care Assistance Plan as permitted under Section 9.4, the Salary Reductions per pay period will be, for the Benefits affected, an amount equal to the new annual amount elected pursuant to Section 9.4, less the aggregate premiums (if any) for the period prior to such election change, divided by the number of pay periods in the balance of the Period of Coverage commencing with the election change, or an amount otherwise agreed upon between the Employer and the Participant, or an amount deemed appropriate by the Administrator.

(b) **Considered Employer Contributions for Certain Purposes.** Salary Reductions that the Employer will apply to pay for the Participant's share of the premiums for benefits elected for the purposes of this Plan and the Code, are considered to be Employer contributions.

(c) **Salary Reduction Balance Upon Termination of Coverage.** If, as of the date that any elected coverage under this Plan terminates, a Participant's year-to-date Salary Reductions exceed or are less than the Participant's required contributions for the coverage, then the Employer will, as applicable, either return the excess to the Participant as additional taxable wages or recoup the due Salary Reduction amounts from any remaining Compensation.

3.4 FUNDING THIS PLAN

All of the amounts payable under this Plan shall be paid from the general assets of the Employer, but Premium Conversion Plan Benefits are paid as provided in the applicable insurance policy. Nothing herein will be construed to require the Employer or the Administrator to maintain any fund or to 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 Employer from which any payment under this Plan may be made. There is no trust or other fund from which Benefits are paid. While the Employer has complete responsibility for the payment of Benefits out of its general assets (except for Premium Conversion Plan Benefits paid as provided in the applicable insurance policy or other document that constitutes the employee's participation agreement), it may hire an unrelated third party paying agent to make Benefit payments on its behalf. The maximum contributions that may be made under this Plan for a Participant is the total of the maximums that may be elected as Employer and Participant Contributions for Premium Conversion Plan Benefits, and as described in the Health Care Reimbursement Plan and the Dependent Care Assistance Plan.

Article IV Eligibility And Participation

4.1 ELIGIBILITY TO PARTICIPATE

An individual is eligible to participate in this Plan if the individual is an Employee who is regularly scheduled to work 19.0 hours or more per week; and has been employed by the Employer for 0 days, counting the Participant's Employment Commencement Date as the first such day.

The Employee may begin participation on the 1st of the month coincident with or next following the date on which the Employee has met the Plan's eligibility requirements or in accordance with the open enrollment requirements each year. For new Premium Conversion Plan Benefits approved under the County's Voluntary Payroll Deduction Policy, the open enrollment period shall be the 90 day period following approval of the vendor's application for Voluntary Payroll Deductions by the County Clerk.

4.2 TERMINATION OF PARTICIPATION

A Participant will cease to be a Participant in this Plan upon the earlier of:

(a) The expiration of the Period of Coverage for which the Employee has elected to participate (unless during the Open Enrollment Period for the next Plan Year the Employee elects to continue participating);

(b) The termination of this Plan;

(c) The date on which the Employee ceases (because of retirement, termination of employment, layoff, reduction in hours, or any other reason) to be an Eligible Employee, provided that eligibility may continue beyond such date for purposes of COBRA coverage, as may be permitted by the Administrator on a uniform and consistent basis (but not beyond the end of the current Plan Year).

(d) The termination of a Premium Conversion Plan Benefit because the vendor's rights to participate and sell a product to Boone County Employees has been terminated under the "Boone County Voluntary Payroll Deduction Policy" adopted by the County Commission.

Termination of participation in this Plan will automatically revoke the Participant's elections and terminate the Premium Conversion Plan Benefits as of the date specified in the appropriate insurance Plan(s) or employee participation agreement with a vendor. Reimbursements from the Health Care Reimbursement Account and the Dependent Care Assistance Account after termination of participation will be made according to the individual plans.

4.3 PARTICIPATION FOLLOWING TERMINATION OF EMPLOYMENT OR LOSS OF ELIGIBILITY

If a Participant separates from service with the Employer for any reason, including (but not limited to) disability, retirement, layoff, leave of absence without pay, or voluntary resignation, and then is rehired within 30 days or less of the date of a termination of employment, the Employee will be reinstated with the same elections that the Participant had before termination. If the Employer rehires a former Participant more than 30 days following termination of employment and the

Participant is otherwise eligible to participant in the Plan, then the individual may make new elections as a new hire.

4.4 FMLA Leaves Of Absence

Health Benefits. Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying leave under the FMLA, then to the extent required by the FMLA, the Employer will continue to maintain the Participant's Health Care Reimbursement Account on the same terms and conditions as if the Participant were still an active Employee. In the event of unpaid FMLA leave, a Participant may elect to continue his or her Health Care Reimbursement Account during the leave. If the Participant elects to continue coverage while on FMLA leave, then the Participant may pay his or her share of the premium with after-tax dollars, by sending monthly payments to the Employer by the due date established by the Employer; with pre-tax dollars, by having such amounts withheld from the Participant's ongoing Compensation (if any, including unused sick days and vacation days).

Coverage under a participant's Health Care Reimbursement Account will terminate if premium payments are not received by the due date established by the Employer. If a Participant's Health Care Reimbursement Account or Dependent Care Assistance Account coverage ceases while on FMLA leave for any reason (including for non-payment of premiums), the Participant will be entitled to re-enter the Health Care Reimbursement Account or the Dependent Care Assistance Account upon return from such leave on the same basis as the Participant was participating in the Plan prior to the leave, or as otherwise required by the FMLA. A Participant whose coverage under the Health Care Reimbursement Account or the Dependent Care Assistance Account ceased will be entitled to elect whether to be reinstated in the Health Care Reimbursement Account or the Dependent Care Assistance Account at the same coverage level as in effect before the FMLA leave (with increased contributions for the remaining period of coverage) or at a coverage level that is reduced pro-rata for the period of FMLA leave during which the Participant did not pay premiums. If a Participant elects a coverage level that is reduced pro-rata for the period of FMLA leave, the amount withheld from a Participant's Compensation on a payroll-by-payroll basis for the purpose of paying for his or her Health Care Reimbursement Account premiums or his or her Dependent Care Assistance Account premiums will be equal to the amount withheld prior to the period of FMLA leave.

Non-FMLA leaves of absences

If a Participant goes on an unpaid leave of absence that does not affect Eligibility, then the Participant will continue to participate and the premiums due for the Participant will be paid by pre-payment before going on leave, by after-tax contributions while on leave or with catch up contributions after the leave ends, as may be determined by the Plan Administrator.

If a Participant goes on an unpaid leave that affects eligibility, the election change rules set forth by this Plan will apply. To the extent COBRA applies, the Participant may continue coverage under COBRA.

Article V Method And Timing Of Elections

5.1 Elections When First Eligible

An Employee who first becomes eligible to participate in the Plan mid-year will commence participation after the eligibility requirements have been satisfied on the earlier of the following: the 1st of the month coincident with or next following the Administrator's receipt and approval of an Election Agreement signed by the Employee or the 1st of the month coincident with or next following 30 days from the date on which the Employee first becomes eligible. Eligibility for Benefits shall be subject to the additional requirements, if any, specified in the applicable Benefit plan or policy. The provisions of this Plan are not intended to override any exclusions, eligibility requirements or waiting periods specified in the applicable Benefit plan or policies.

5.2 Elections During Open Enrollment Period

During each Open Enrollment Period with respect to a Plan Year, the Administrator shall provide an Election Agreement to each Employee who is eligible to participate in this Plan. The Election Agreement shall enable the Employee to elect to participate in the various Components of this Plan for the next Plan Year, and to authorize the necessary Salary Reductions to pay for the benefits elected. The Election Agreement must be returned to the Administrator on or before the last day of the Open Enrollment Period. If an Eligible Employee makes an election to participate during an Open Enrollment Period, then the Employee will become a Participant on the first day of the next Plan Year.

5.3 Failure Of Eligible Employee To File An Election Form/Salary Reduction Agreement

If an Eligible Employee fails to file an Election Agreement within the time period described in Sections 5.1 and 5.2 as applicable, then the Employee will be deemed to be participating in the Premium Conversion Plan and to have elected to reduce his or her Compensation to the extent he or she has eligible insurance premiums. Such Employee may not make a different election to participate in the Plan: (a) until the next Open Enrollment Period; or (b) until an event occurs that would justify a mid-year election change.

5.4 Irrevocability Of Elections

Unless an exception applies (as described in Article IX.), a Participant's election under the Plan is irrevocable for the duration of the Period of Coverage to which it relates.

Article VI Premium Conversion Plan

6.1 Benefits

An Eligible Employee may:

Elect benefits under the Premium Conversion Plan by electing to pay the premiums on a pre-tax Salary Reduction basis for
Group Term Life Insurance Benefits;
Medical Insurance Benefits;
Dental Insurance Benefits;
Other Premium Conversion Plan Products—This category provides for the direct payment to the insurance provider of the participant's share of the cost or premium

for coverage under any qualified plan or program which provides any other qualified product eligible under Section 125 of the United States Code, to or on behalf of any employee or spouse or dependent, which plan or program is available to the employee through a payroll deduction agreement with the vendor. Vendors of products included in this plan must be approved for participation in the County's Voluntary Payroll Deduction Program and comply with the County's policies regarding voluntary payroll deductions and also agree to fees for the cost of administration, set by the County Clerk and County Treasurer;

or

Elect no benefits under the Premium Conversion Plan, and pay the premiums, if any, for Premium Conversion Plan Benefits with after-tax deductions outside of this Plan except that Premium Conversion Plan Products deductions approved under the County's Voluntary Payroll Dedcution Program shall not be eligible to be paid with after-tax deductions outside of this plan.

Unless an exception applies (as described in Article IX), the election is irrevocable for the duration of the Period of Coverage to which it relates.

6.2 INSURANCE COVERAGE NOT PROVIDED BY THIS PLAN

The only Insurance Benefits that are offered under the Premium Conversion Plan are benefits under the applicable insurance plan(s) listed in Section 3.1. The Insurance Benefits are subject to the terms and conditions of the applicable insurance Plan(s).

6.3 BENEFIT PREMIUMS

The annual premium for a Premium Conversion Plan Benefit is equal to the amount as set by The Employer or not more than the expected sum of the total cost or premium during the Plan Year in the case of any other product or products eligible under Section 125 of Title 26 of the United States Code, as described in Section 3.1 of this Plan.

In the event of any change in the permissible premium amount, the resulting new permissible amount must be nondiscriminatory (as defined in Section 125 of the Internal Revenue Code) in its application to participants. In the case of the insurance benefits or products described in the sections 6.1 the permissible amount must be consistent with the actual rate in effect at the start of the coverage period or it will automatically be changed to reflect the actual rate in effect at the start of the coverage period.

ARTICLE VII HEALTH CARE REIMBURSEMENT PLAN

7.1 BENEFITS

An Eligible Employee can elect to participate in the Health Care Reimbursement Plan by electing to receive benefits in the form of reimbursements for Medical Care Expenses (Health Care Reimbursement Benefits). Benefits elected will be funded by Participant contributions as provided in Section 3.2.

Unless an exception applies (as described in Article IX), such election is irrevocable for the duration of the Period of Coverage to which it relates.

7.2 BENEFIT PREMIUMS

The annual premium for a Participant's Health Care Reimbursement Account is equal to the annual benefit amount elected by the Participant.

7.3 ELIGIBLE MEDICAL CARE EXPENSES

Under the Health Care Reimbursement Plan, a Participant may receive reimbursement for Medical Care Expenses incurred during the Period of Coverage for which an election is in force.

(a) **Incurred.** A Medical Care Expense is incurred at the time the medical care or service giving rise to the expense is provided, and not when the Participant is formally billed for, is charged for, or pays for the medical care.

(b) **Medical Care Expenses.** Medical Care Expenses means expenses incurred by a Participant or Spouse or Dependents for medical care, as defined in Code §213(d), other than expenses that are excluded by this Plan in (c) below, but only to the extent that the Participant or other person incurring the expense is not reimbursed for the expense through any other accident or health Plan.

(c) **Medical Expenses that are not reimbursable.** Insurance premiums and long-term care expenses are not reimbursable from the Health Care Reimbursement Plan.

7.4 MAXIMUM BENEFITS

(a) **Maximum Reimbursement Available** (Uniform Coverage). The maximum dollar amount elected by the Participant for reimbursement of Medical Care Expenses incurred during a Period of Coverage (reduced by prior reimbursements during the Period of Coverage) shall be available at all times during the Period of Coverage, regardless of the actual amounts credited to the Participant's Health Care Reimbursement Account. Notwithstanding the foregoing, no reimbursements will be available for Medical Care Expenses incurred after coverage under this Plan has terminated. Payment shall be made to the Participant in cash as reimbursement for Medical Care Expenses incurred during the Period of Coverage for which the Participant's election is effective, provided that the other requirements of this Article VII have been satisfied.

(b) **Maximum Dollar Limits.** The maximum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Medical Care Expenses incurred in any Period of Coverage shall be $5,000.00. Reimbursements due for Medical Care Expenses incurred by the Participant's Spouse or Dependents shall be charged against the Participant's Health Care Reimbursement Account.

(c) **Effect on Maximum Benefits If Election Change Permitted.** Any change in an election affecting annual contributions to the Health Care Reimbursement Plan will also change the maximum reimbursement benefits for the balance of the Period of Coverage commencing with the election change effective date. Such maximum reimbursement benefits for the balance of the Period of Coverage shall be calculated by adding (1) the aggregate premium for the period prior to such election change to (2) the total premium for the remainder of such Period of Coverage to the Health Care Reimbursement Account, reduced by (3) all reimbursements made during the entire Period of Coverage.

7.5 Establishment of Account

The Administrator will establish and maintain a Health Care Reimbursement Account with respect to each Participant who has elected to participate in the Health Care Reimbursement Plan, but will not create a separate fund or otherwise segregate assets for this purpose. The Account so established will merely be a record keeping account with the purpose of keeping track of contributions and determining forfeitures.

(a) **Crediting of Accounts.** A Participant's Health Care Reimbursement Account will be credited following each salary reduction actually made during each Period of Coverage with an amount equal to the salary reduction actually made.

(b) **Debiting of Accounts.** A Participant's Health Care Reimbursement Account will be debited during each Period of Coverage for any reimbursement of Medical Care Expenses incurred during the Period of Coverage.

(c) **Available Amount Not Based on Credited Amount.** The amount available for reimbursement of Medical Care Expenses is the Participant's annual benefit amount, reduced by prior reimbursements during the Period of Coverage. It is not based on the amount credited to the Health Care Reimbursement Account at a particular point in time.

7.6 Unused Year End Balance

If any balance remains in the Participant's Health Care Reimbursement Account after all reimbursements have been made for the Period of Coverage, it shall not be carried over to reimburse the Participant for Medical Care Expenses incurred during a subsequent Plan Year. The remaining amounts will be used by the Plan in the following ways: (a) first, to offset any losses experienced by Boone County during the Plan Year as a result of making reimbursements with respect to any Participant in excess of the premiums paid by such Participant through Salary Reductions; (b) second, to reduce the cost of administering the Health Care Reimbursement Plan during the Plan Year or the subsequent Plan Year (all such administrative costs shall be documented

by the Administrator); and (c) to provide increased benefits or compensation to Participants in subsequent years in any weighted or uniform fashion that the Administrator deems appropriate, consistent with applicable regulations. In addition, any Health Care Reimbursement Plan benefit payments that are unclaimed by the close of the Plan Year following the Period of Coverage in which the Medical Care Expense was incurred shall be applied as described above.

7.7 Reimbursement Procedure

(a) **Timing**. Within 30 days after receipt by the Administrator of a reimbursement claim from a Participant, the Employer will reimburse the Participant for the Participant's Medical Care Expenses (if the Administrator approves the claim), or the Administrator will notify the Participant that a claim has been denied. This time period may be extended for an additional 15 days for matters beyond the control of the Administrator, including in cases where a reimbursement claim is incomplete. The Administrator will provide written notice of any extension, including the reasons for the extension, and will allow the Participant 45 days in which to complete an incomplete reimbursement claim.

(b) **Claims Substantiation**. A Participant who has elected to receive Health Care Reimbursement Benefits for a Period of Coverage may apply for reimbursement by submitting an application to the Administrator in such form as the Administrator may prescribe, by no later than a date set each year by the Administrator which such date shall not be earlier than March 31st following the close of the Plan Year in which the Medical Care Expense was incurred, setting forth:

(1) The person or persons on whose behalf Medical Care Expenses have been incurred;

(2) The nature and date of the Expenses incurred;

(3) The amount of the requested reimbursement; and

(4) A statement that such Expenses have not otherwise been reimbursed and the Participant will not seek reimbursement through any other source.

The application shall be accompanied by bills, invoices, or other statements from an independent third party showing that the Medical Care Expenses have been incurred and the amounts of such Expenses, together with any additional documentation that the Administrator may request.

(c) **Claims Denied**. For reimbursement claims that are denied, see Section 10.2.

7.8 Reimbursements After Termination; Limited COBRA Continuation

The Participant will not be able to receive reimbursements for Medical Care Expenses incurred after his or her participation terminates. However, such Participant (or the Participant's estate) may claim reimbursement for any Medical Care Expenses incurred during the Period of Coverage

prior to termination, provided that the Participant (or the Participant's estate) files a claim by the date established in Section 7.7(b) following the close of the Plan Year in which the Medical Care Expense arose.

Notwithstanding any provision to the contrary in this Plan, to the extent required by COBRA, a Participant and his or her Spouse and Dependents, whose coverage terminates under the Health Care Reimbursement Plan because of a COBRA qualifying event, shall be given the opportunity to continue the same coverage that he or she had under the Health Care Reimbursement Plan the day before the qualifying event for the periods prescribed by COBRA (subject to all conditions and limitations under COBRA). The premiums for such continuation coverage will be equal to the cost of providing the same coverage to an active employee taking into account all costs incurred by the employee and the employer plus two percent (2%). Specifically, an individual will be eligible for COBRA continuation coverage only if, under Section 7.5(c), the participant's remaining available amount is greater than the participant's remaining premium payments as calculated in this paragraph. Such individuals will be notified if they are eligible for COBRA continuation coverage. If COBRA is elected, it will be available only for the remainder of the Plan Year in which the qualifying event occurs; such COBRA coverage for the Health Care Reimbursement Plan will cease at the end of the Plan Year and cannot be continued for the next Plan Year. Coverage may terminate sooner if the premium payments for a period of Coverage are not received by the due date established by the Administrator for that period of Coverage. Continuation coverage is only granted after the Administrator has received the premium payment for that period of coverage.

7.9 Named Fiduciary; Compliance With COBRA, HIPAA, etc.

(a) **Laws Applicable to Group Health Plans.** The Health Care Reimbursement Plan shall be provided in compliance with COBRA, HIPAA, etc.

(b) **Coordination of Benefits.** Health Care Reimbursement Plans are intended to pay benefits solely for Medical Care Expenses not previously reimbursed or reimbursable elsewhere. Accordingly, the Health Care Reimbursement Plan shall not be considered a group health plan for coordination of benefits purposes, and the Health Care Reimbursement Plan shall not be taken into account when determining benefits payable under any other plan.

Article XIII Dependent Care Assistance Plan

8.1 Benefits

An Eligible Employee can elect to participate in the Dependent Care Assistance Plan by electing to receive benefits in the form of reimbursements for Dependent Care Expenses (Dependent Care Assistance Benefits). Benefits elected will be funded by Participant contributions as provided in Section 3.2.

Unless an exception applies (as described in Article IX), such election is irrevocable for the duration of the Period of Coverage to which it relates.

8.2 BENEFIT PREMIUMS

The annual premium for a Participant's Dependent Care Assistance Benefit is equal to the annual benefit amount elected by the Participant.

8.3 ELIGIBLE DEPENDENT CARE EXPENSES

Under the Dependent Care Assistance Plan, a Participant may receive reimbursement for Dependent Care Expenses incurred during the Period of Coverage for which an election is in force.

(a) **Incurred.** A Dependent Care Expense is incurred at the time the Qualifying Dependent Care Services giving rise to the expense are furnished, and not when the Participant is formally billed for, is charged for, or pays for the Qualifying Dependent Care Services.

(b) **Dependent Care Expenses.** Dependent Care Expenses means expenses that are considered to be employment-related expenses under Code §21(b)(2) (relating to expenses for the care of a Qualifying Individual necessary for gainful employment of the Employee and Spouse), and expenses for incidental household services, if incurred by the Eligible Employee to obtain Qualifying Dependent Care Services, but only to the extent that the Participant or other person incurring the expense is not reimbursed for the expense through any other Plan. If only a portion of a Dependent Care Expense has been reimbursed elsewhere, the Dependent Care Assistance Plan can reimburse the remaining portion of such Expense if it otherwise meets the requirements of this Article.

(c) **Qualifying Individual.** Qualifying Individual means:

(1) A Participant's Dependent who is under the age of 13;

(2) A Participant's Dependent who is mentally or physically incapable of self-care; or

(3) A Participant's Spouse who is mentally or physically incapable of self-care.

(d) **Qualifying Dependent Care Services.** Qualifying Dependent Care Services means the following: services that both relate to the care of a Qualifying Individual that enable the Participant and Spouse to remain gainfully employed after the date of participation in the DCAP and during the Period of Coverage; and are performed:

(1) In the Participant's home; or

(2) Outside the Participant's home for
   (i) The care of a Participant's Dependent who is under age 13; or
   (ii) The care of any other Qualifying Individual who regularly spends at least 8 hours per day in the Participant's household. In addition, if the expenses are incurred for services provided by a facility that provides care for more than 6 individuals not residing at the facility

and that receives a fee, payment or grant for such services, then the facility must comply with all applicable state and local laws and regulations.

(e) **Exclusions.** Dependent Care Expenses do not include amounts paid to or for:

(1) An individual with respect to whom a personal exemption is allowable under Code §151(c) to a Participant or Participant's Spouse;

(2) A Participant's Spouse; or

(3) A Participant's child who is under 19 years of age at the end of the year in which the expenses were incurred.

(4) a Participant's Spouse's child who is under l9 years of age at the end of the year in which the expenses were incurred.

(5) Overnight camps.

(6) Instructional or sport specific camps; e.g. Ballet camp, soccer camp, summer school.

(7) Kindergarten or other educational expenses.

8.4 MAXIMUM BENEFITS

Maximum Reimbursement Available and Statutory Limits. The maximum dollar amount elected by the Participant for reimbursement of Dependent Care Expenses incurred during a Period of Coverage (reduced by prior reimbursements during the Period of Coverage) shall only be available during the Period of Coverage to the extent of the actual amounts credited to the Participant's Dependent Care Assistance Account less amounts debited to the Participant's Dependent Care Assistance Account pursuant to Section 8.5. Payment shall be made to the Participant in cash as reimbursement for Dependent Care Expenses incurred during the Period of Coverage for which the Participant's election is effective, provided that the other requirements of this Article VIII have been satisfied. Notwithstanding the foregoing, no reimbursement otherwise due to a Participant hereunder shall be made to the extent that such reimbursement, when combined with the total amount of reimbursements made to date for the Plan Year, would exceed the applicable statutory limit. The applicable statutory limit for a Participant is the smallest of the following amounts:

(a) the Participant's Earned Income for the calendar year;

(b) the Earned Income of the Participant's Spouse for the calendar year (a Spouse who (1) is not employed during a month in which the Participant incurs a Dependent Care Expense, and (2) is either physically or mentally incapable of self-care or a full-time Student shall be deemed to have Earned Income in the amount of $250 per month per Qualifying Individual for whom the Participant incurs Dependent Care Expenses, up to a maximum amount of $500 per month); or

(c) $5,000 for the calendar year or,

(d) $2,500 for the calendar year if the Participant is married and resides with the Spouse, but files a separate federal income tax return.

Maximum Dollar Limits. The maximum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Dependent Care Expenses incurred in any Period of Coverage shall be $5,000.00 (subject to the other limitations described above).

8.5 Establishment Of Account

The Administrator will establish and maintain a Dependent Care Assistance Account with respect to each Participant who has elected to participate in the Dependent Care Assistance Plan, but will not create a separate fund or otherwise segregate assets for this purpose. The Account so established will merely be a record keeping account with the purpose of keeping track of contributions and determining forfeitures under Section 8.6.

(a) **Crediting of Accounts.** A Participant's Dependent Care Assistance Account will be credited following each salary reduction actually made during each Period of Coverage with an amount equal to the salary reduction actually made.

(b) **Debiting of Accounts.** A Participant's Dependent Care Assistance Account will be debited during each Period of Coverage for any reimbursement of Dependent Care Expenses incurred during the Period of Coverage.

(c) **Available Amount is Based on Credited Amount.** The amount available for reimbursement of Dependent Care Expenses may not exceed the year-to-date amount credited to the Participant's Dependent Care Assistance Account, less any prior reimbursements.

(d) **Effect on Maximum Benefits If Election Change Permitted.** Any change in an election under Article IX affecting annual contributions to the Dependent Care Assistance Plan also will change the maximum reimbursement benefits for the balance of the Period of Coverage (commencing with the election change effective date), as further limited above. Such maximum reimbursement benefits for the balance of the Period of Coverage shall be calculated by adding (1) the aggregate premium for the period prior to such election change to (2) the total premium for the remainder of such Period of Coverage to the Dependent Care Assistance Account, reduced by (3) reimbursements during the entire Period of Coverage.

8.6 Unused Year End Balance

If any balance remains in the Participant's Dependent Care Assistance Account after all reimbursements have been made for the Period of Coverage, it shall not be carried over to reimburse the participant for Dependent Care Expenses incurred during a subsequent Plan Year. The remaining amounts will be used by the Plan in the following ways: (a) first, to reduce the cost of administering the Dependent Care Assistance Plan during the Plan Year or the subsequent Plan Year (all such administrative costs shall be documented by the Administrator); and (b) to increase the

Employer's general revenues consistent with applicable regulations. In addition, any Dependent Care Assistance Plan benefit payments that are unclaimed by the close of the Plan Year following the Period of Coverage in which the Dependent Care Expense was incurred shall be applied as described above.

8.7 REIMBURSEMENT PROCEDURE

(a) **Timing.** Within 30 days after receipt by the Administrator of a reimbursement claim from a Participant, the Employer will reimburse the Participant for the Participant's Dependent Care Expenses (if the Administrator approves the claim), or the Administrator will notify the Participant that a claim has been denied. This time period may be extended for an additional 15 days for matters beyond the control of the Administrator, including in cases where a reimbursement claim is incomplete. The Administrator will provide written notice of any extension, including the reasons for the extension, and will allow the Participant 45 days in which to complete and incomplete reimbursement claim.

(b) **Claims Substantiation.** A Participant who has elected to receive Dependent Care Assistance Plan Benefits for a Period of Coverage may apply for reimbursement by completing, signing, and returning an application to the Administrator in such form as the Administrator may prescribe, by no later than a date set each year by the Administrator which such date shall not be earlier than March 31st following the close of the Plan Year in which the Dependent Care Expense was incurred, setting forth:

(1) The person or persons on whose behalf Dependent Care Expenses have been incurred;

(2) The nature and date of the Expenses so incurred;

(3) The amount of the requested reimbursement;

(4) The name of the person, organization or entity to whom the Expense was or is to be paid; and

(5) A statement that such Expenses have not otherwise been reimbursed and the Participant will not seek reimbursement through any other source.

The Participant shall include bills, invoices, or other statements from an independent third party showing that the Dependent Care Expenses have been incurred and the amounts of such Expenses, together with any additional documentation that the Administrator may request.

(c) **Claims Denied.** For reimbursement claims that are denied, see the Section 10.2.

8.8 Reimbursements After Termination

When a Participant ceases to be a Participant, the Participant's Salary Reductions will terminate, as will the Participant's election to receive reimbursements, subject to the following: such Participant (or the Participant's estate) may claim reimbursement for any Dependent Care Expenses incurred during the Period of Coverage prior to termination, including expenses incurred during the Plan Year following termination, provided that the Participant (or the Participant's estate) files a claim by the date established by the Administrator in Section 8.7(b).

8.9 Report To Participants

On or before January 31 of each year, the Administrator shall furnish to each Participant who has received reimbursement for or made premium payments for Dependent Care Expenses during the prior calendar year a written statement showing the Dependent Care Expenses paid during such year with respect to the Participant, or showing the Salary Reductions for the year for the Dependent Care Assistance Plan, as the Administrator deems appropriate.

Article IX Irrevocability Of Elections and Exceptions

9.1 Irrevocability of Elections

A Participant's election under the Plan is irrevocable for the duration of the Period of Coverage to which it relates except as described in this Article.

9.2 Procedure for Making New Election If Exception to Irrevocability Applies

(a) **Timing for Making New Election if Exception to Irrevocability Applies.** A Participant may make a new election within 60 days of the occurrence of an event described in Section 9.4, as applicable, but only if the election under the new Election Agreement is made on account of and corresponds to the event.

(b) **Effective Date of New Election.** Elections made pursuant to this Section shall be effective on the 1st of the month coincident with or next following the event and the Administrator's receipt and approval of the election request for the balance of the Period of Coverage following the change of election unless a subsequent event allows for a further election change. Except as provided in Section 9.4(e) for HIPAA special enrollment rights in the event of birth, adoption, or placement for adoption, all election changes shall be effective on a prospective basis only (i.e., election changes will become effective no earlier than the 1st of the month coincident with or next following the date that the election change was filed, but, as determined by the Administrator, election changes may become effective later to the extent the coverage in the applicable Benefit Package Option commences later).

(c) **Changes; No Pro ration.** For subsequent Plan Years, the maximum dollar limit may be changed by the Administrator and shall be communicated to Employees through the Election Agreement or another document. If a Participant enters the Dependent Care Assistance Plan or the Health Care Reimbursement Plan mid-year, or wishes to increase his or her election mid-year as permitted under Section 9.4,

the Participant may elect coverage up to the maximum dollar limit or may increase coverage up to the maximum dollar limit for either plan, as applicable.

(d) **Effect on Maximum Benefits.** Any change in an election affecting annual contributions to the Health Care Reimbursement Plan or the Dependent Care Assistance Plan also will change the maximum reimbursement benefits for the balance of the Period of Coverage commencing with the election change. Such maximum reimbursement benefits for the balance of the Period of Coverage shall be calculated by adding (1) the contributions made by the Participant (if any) as of the end of the portion of the Period of Coverage immediately preceding the change in election, to (2) the total contributions scheduled to be made by the Participant during the remainder of such Period of Coverage to the Health Care Reimbursement Plan or the Dependent Care Assistance Plan, reduced by (3) all reimbursements made during the entire Period of Coverage.

9.3 CHANGE IN STATUS DEFINED

A Participant may make a new election that corresponds to and is on account of a gain or loss of eligibility and coverage under a benefit under this plan or under any other plan maintained by the Employer or a plan of the Spouse's or Dependent's employer that was caused by the occurrence a Change in Status. A Change in Status is any of the events described below, as well as any other events included under subsequent changes to Code § 125 or regulations issued there under, which the Administrator, in its sole discretion and on a uniform and consistent basis, determines are permitted under IRS regulations and under this Plan:

(a) **Legal Marital Status.** A change in a Participant's legal marital status, including marriage, death of a Spouse, divorce, legal separation or annulment;

(b) **Number of Dependents.** Events that change a Participant's number of Dependents, including birth, death, adoption, and placement for adoption. In the case of the Dependent Care Assistance Plan, a change in the number of qualifying individuals as defined in Code § 21(b)(1);

(c) **Employment Status.** Any of the following events that change the employment status of the Participant (as limited by Section 4.3) or Spouse or Dependents:

(1) A termination or commencement of employment;

(2) A strike or lockout;

(3) A commencement of or return from an unpaid leave of absence;

(4) A change in worksite; and

(5) If the eligibility conditions of this Plan or other employee benefit Plan of the Participant or Spouse or Dependents depend on the employment status of that individual and there is a change in that individual's status with the

consequence that the individual becomes (or ceases to be) eligible under this Plan or other employee benefit Plan, such as if a plan only applies to salaried employees and an employee switches from salaried to hourly-paid, union to non-union, or full-time to part-time (or vice versa), with the consequence that the employee ceases to be eligible for the Plan;

(d) **Dependent Eligibility Requirements.** An event that causes a Dependent to satisfy or cease to satisfy the Dependent eligibility requirements for a particular benefit, such as attaining a specified age, Student status, or any similar circumstance; and

(e) **Change in Residence.** A change in the place of residence of the Participant or Spouse or Dependents.

9.4 EVENTS PERMITTING EXCEPTION TO IRREVOCABILITY RULE

A Participant may change an election as described below upon the occurrence of the stated events for the applicable Benefit Plan:

(a) **Open Enrollment Period** (*Applies to Premium Conversion Plan, Health Care Reimbursement Plan and Dependent Care Assistance Plan Benefits*). A Participant may change an election during the Open Enrollment Period.

(b) **Termination of Employment** *(Applies to Premium Conversion Plan, Health Care Reimbursement Plan and Dependent Care Assistance Plan Benefits).* A Participant's election will terminate upon termination of employment as described in eligibility and participation.

(c) **Leaves of Absence** *(Applies to Premium Conversion Plan, Health Care Reimbursement Plan and Dependent Care Assistance Plan Benefits).* A Participant may change an election upon leave as described in Article IV.

(d) **Change in Status** *(Applies to Premium Conversion Plan, Health Care Reimbursement Plan as limited below and Dependent Care Assistance Plan as limited below).* A Participant may change the actual or deemed election under the Plan upon the occurrence of a Change in Status (as defined in Section 9.3), but only if such election change is made on account of and corresponds with a gain or loss of eligibility and coverage under a plan of the Employer or a plan of the Spouse's or Dependent's employer caused by that Change in Status that affects eligibility for coverage (referred to as the general consistency requirement). Any increase or decrease to Group Term Life Insurance under this Plan or products provided 6.1 of this plan that were approved under the County's Voluntary Payroll Deduction Policy and are authorized for premium conversion under Section 125 of the U.S. Code will be deemed to satisfy this general consistency requirement.

(e). Coverage changes. If the coverage under a plan is significantly curtailed or ceases during a period of coverage, affected employees may evoke his/her election under the plan and may make a new election on a prospective basis for coverage under another plan option providing similar coverage. Coverage under an accident or health plan is significantly curtailed only if there is an overall reduction in coverage

provided to participants under the plan so as to constitute reduced coverage to participants generally. For example, the loss of a participant's primarycare physician would not be a significant curtailment because it does not affect participants in general.

(f). Addition (or elimination) of a plan option providing similar coverage. If during a period of coverage the plan adds a new plan option or other coverage option (or eliminates an existing plan option or other coverage option) under the County's Voluntary Payroll Deduction Policy or by order the Employer the affected employees may elect the newly-added option (or elect another option if an option has been eliminated) prospectively and make corresponding election changes with respect to other plan options providing

A Change in Status that affects eligibility for coverage under a plan of the Employer or a plan of the Spouse's or Dependent's employer includes a Change in Status that results in an increase or decrease in the number of an Employee's family members (i.e., a Spouse and/or Dependents) who may benefit from the coverage.

The Administrator, on a uniform and consistent basis, shall determine, based on prevailing IRS guidance, whether a requested change satisfies the general consistency requirement. Assuming that the general consistency requirement is satisfied, a requested election change must also satisfy the following specific consistency requirements in order for a Participant to be able to alter elections based on the specified Change in Status:

(1) **Loss of Spouse or Dependent Eligibility**; For a Change in Status involving a Participant's divorce, annulment or legal separation from a Spouse, the death of a Spouse or a Dependent, or a Dependent's ceasing to satisfy the eligibility requirements for coverage, a Participant may only elect to cancel accident or health coverage for:

(i) The Spouse involved in the divorce, annulment, or legal separation;
(ii) The deceased Spouse or Dependent; or
(iii) The Dependent that ceased to satisfy the eligibility requirements.

Canceling coverage for any other individual under these circumstances fails to correspond with that Change in Status.

(2) **Gain of Coverage Eligibility Under Another Employer's Plan.** For a Change in Status in which a Participant or Spouse or Dependent gains eligibility for coverage under a cafeteria plan or qualified benefit plan of the employer of the Participant's Spouse or Dependent, a Participant may elect to cease or decrease coverage for that individual only if coverage for that individual becomes effective or is increased under the Spouse's or Dependent's employer's plan. The Administrator may rely on a Participant's certification that the Participant has obtained or will obtain coverage under the Spouse's or Dependent's employer's plan, unless the Administrator has reason to believe that the Participant's certification is incorrect.

(3). Coverage changes. If the coverage under a plan is significantly curtailed or ceases during a period of coverage, affected employees may evoke his/her election under the plan and may make a new election on a prospective basis for coverage under another plan option providing similar coverage. Coverage under an accident or health plan is significantly curtailed only if there is an overall reduction in coverage provided to participants under the plan so as to constitute reduced coverage to participants generally. For example, the loss of a participant's primary care physician would not be a significant curtailment because it does not affect participants in general.

(4). Addition (or elimination) of a plan option providing similar coverage. If during a period of coverage the plan adds a new plan option or other coverage option (or eliminates an existing plan option or other coverage option) under the County's Voluntary Payroll Deduction Policy or by order the Employer the affected employees may elect the newly-added option (or elect another option if an option has been eliminated) prospectively and make corresponding election changes with respect to other plan options providing similar coverage.

(e) **HIPAA Special Enrollment Rights** (*Applies to Premium Conversion Plan Benefits only*). If a Participant or Spouse or Dependent is entitled to special enrollment rights under a Group Health Plan, as required by HIPAA under Code §9801, then a Participant may revoke a prior election for Group Health Plan coverage and make a new election, provided that the election change corresponds with a HIPAA special enrollment right. As required by HIPAA, a special enrollment right will arise if a Participant or Spouse or Dependent declined to enroll in group health plan coverage because they had other coverage, and eligibility for such other coverage is subsequently lost due to legal separation, divorce, death, termination of employment, reduction in hours, or exhaustion of the maximum COBRA period, or the other coverage was non-COBRA coverage and employer contributions for such coverage were terminated; or a new Dependent is acquired as a result of marriage, birth, adoption, or placement for adoption. An election to add previously eligible Dependents as a result of the acquisition of a new Spouse or Dependent child shall be considered to be consistent with the special enrollment right. An election change on account of a HIPAA special enrollment attributable to the birth, adoption, or placement for adoption of a new Dependent child may, subject to the provisions of the underlying group health plan be effective retroactively up to thirty (30) days.

(f) **Certain Judgments, Decrees and Orders** *(Applies to Premium Conversion Plan and Health Care Reimbursement Plan).* If a judgment, decree, or order (an "Order") resulting from a divorce, legal separation, annulment or change in legal custody (including a QMCSO) requires accident or health coverage (including an election for Health Care Reimbursement Plan Benefits) for a Participant's Dependent child, a Participant may

(1) Change an election to provide coverage for the Dependent child (provided that the Order requires the Participant to provide coverage); or

(2) Change an election to revoke coverage for the Dependent child if the Order requires that another individual (including the Participant's Spouse or former Spouse) provide coverage under that individual's plan and such coverage is actually provided.

(g) **Medicare and Medicaid** *(Applies to Premium Conversion Plan and Health Care Reimbursement Plan).* If a Participant or Spouse or Dependent who is enrolled in a health or accident plan under this Plan becomes entitled to Medicare or Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act providing for pediatric vaccines), the Participant may prospectively reduce or cancel the health or accident coverage (including Health Care Reimbursement coverage) of the person becoming entitled to Medicare or Medicaid. Further, if a Participant or Spouse or Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, the Participant may prospectively elect to commence or increase the accident or health coverage (including Health Care Reimbursement coverage) of the individual who loses Medicare or Medicaid eligibility.

(h) **Change in Cost** *(Applies to Premium Conversion Plan and Dependent Care Assistance Plan as limited below).* For purposes of this Section, "similar coverage" means coverage for the same category of benefits for the same individuals. A Health Care Reimbursement Plan is not similar coverage with respect to an accident or health plan that is not a Health Care Reimbursement Plan.

A Premium Conversion Plan Benefit is considered to be similar coverage, to coverage by another employer, such as a Spouse's or Dependent's employer.

(1) **Significant Cost Increases.** If the Administrator determines that the cost charged to an Employee for a Benefit significantly increases during a Period of Coverage, the Participant may

(i) Make a corresponding prospective increase to elective contributions (by increasing Salary Reductions) or

(ii) Drop coverage going forward if there is no other Benefit Option available that provides similar coverage. The Administrator, on a uniform and consistent basis, will decide whether a cost increase is significant in accordance with prevailing IRS guidance.

(2). Coverage or cost changes. Changes allowed under this section are not applicable to Health Care Reimbursements Benefits as described in Article VII. Therefore, no changes to an election for Health Care Reimbursement Benefits are allowed due to events described in this section (2).

(3) Cost changes. A participant's plan described under the Premium Conversion Plans will automatically be changed to reflect a change in the cost of coverage. Alternatively, if the premium amount significantly increases a participant may revoke an election and, in lieu thereof, to receive on a prospective basis, coverage under another health plan with similar coverage.

(2) **Insignificant Cost Increases.** Participants are required to increase their elective contributions (by increasing Salary Reductions) to reflect

insignificant increases in their required contribution for the benefits and to decrease their elective contributions to reflect insignificant decreases in the required contribution. The Plan Administrator on a uniform and consistent basis will determine whether an increase or decrease is insignificant based on all the surrounding facts and circumstances, including but not limited to, the dollar amount or percentage of the cost change. The Plan Administrator on a reasonable consistent basis will automatically make this increase or decrease in affected Employees' elective contributions on a prospective basis.

(3) **Limitation on Change in Cost Provisions for Dependent Care Assistance Benefits.** The above Change in Cost provisions apply to Dependent Care Assistance Benefits only if the cost change is imposed by a dependent care provider who is not a relative of the Employee. For this purpose, a relative is an individual who is related as described in Code § 152(a)(1) through (8), incorporating the rules of Code § 152(b)(1) and (2).

(i) **Change in Coverage** *(Applies to Premium Conversion Plan and Dependent Care Assistance Benefits).* The definition of "similar coverage" under Section 9.4(h) applies also to this Section.

(1) **Significant Curtailment.** If coverage is "significantly curtailed" (as defined below), Participants may elect coverage under a benefit package option that provides similar coverage. In addition, if the coverage curtailment results in a "Loss of Coverage" (as defined below), Participants may drop coverage if no similar coverage is offered by the Employer. The Administrator, on a uniform and consistent basis, will decide, in accordance with prevailing IRS guidance, whether a curtailment is "significant," and whether a Loss of Coverage has occurred.

(2) **Significant Curtailment Without Loss of Coverage.** If the Administrator determines that a Participant's coverage under a Benefit Plan (or the Participant's Spouse's or Dependent's coverage under the respective employer's plan) is significantly curtailed without a Loss of Coverage (for example, when there is a significant increase in the deductible, the co-pay, or the out-of-pocket cost-sharing limit under an accident or health plan) during a Period of Coverage, the Participant may revoke an election for the affected coverage and prospectively elect coverage under another Benefit Plan if offered, that provides similar coverage, but not the Health Care Reimbursement Plan,. Coverage under a Plan is deemed to be "significantly curtailed" only if there is an overall reduction in coverage provided under the Plan so as to constitute reduced coverage generally.

(3) **Significant Curtailment With a Loss of Coverage.** If the Administrator determines that a Participant's coverage under this Plan (or the Participant's Spouse's or Dependent's coverage under the respective employer's plan) is significantly curtailed, and such curtailment results in a Loss of Coverage during a Period of Coverage, the Participant may revoke

an election for the affected coverage, and may either prospectively elect coverage under another Benefit Plan that provides similar coverage, but not the Health Care Reimbursement Plan, or drop coverage if no other Benefit Plan providing similar coverage is offered by the Employer.

(4) **Definition of Loss of Coverage.** For purposes of this Section, a "Loss of Coverage" means a complete loss of coverage (including the elimination of the Benefit Plan). In addition, the Administrator, on a uniform and consistent basis, may treat the following as a Loss of Coverage:

(i) A substantial decrease in the medical care providers available under the Benefit Plan (such as a major hospital ceasing to be a member of a preferred provider network or a substantial decrease in the number of physicians participating in the PPO or the HMO);

(ii) A reduction in benefits for a specific type of medical condition or treatment with respect to which the Participant or Spouse or Dependent is currently in a course of treatment; or

(iii) Loss of coverage due to the vendor of the insurance or benefit product losing approval to participate in the County's Voluntary Payroll Dedcution Program or loss of eligibility to participate in the Boone County Cafeteria Plan due to changes in Section 125 of the IRS Code.

(iv) Any other similar fundamental loss of coverage.

(j) **Addition or Significant Improvement of a Benefit Plan** *(Applies to Premium Conversion Plan and Dependent Care Assistance Benefits).* If during a Period of Coverage, the Plan adds a new Benefit Plan or significantly improves an existing Benefit Plan, the Administrator may permit the following election changes:

(1) Participants who are enrolled in a Benefit Plan other than the newly-added or significantly improved Benefit Plan that provides similar coverage may change their election on a prospective basis to cancel the current Benefit Plan and instead to elect the newly-added or significantly improved Benefit Plan; and

(2) Employees who are otherwise eligible under the Eligibility and Participation section may elect the newly-added or significantly improved Benefit Plan on a prospective basis, subject to the terms and limitations of the Benefit Plan. The Administrator, on a uniform and consistent basis, will decide whether there has been an addition of, or a significant improvement in, a Benefit Package Option in accordance with prevailing IRS guidance.

(k) **Loss of Coverage Under Other Group Health Coverage** *(Applies to Premium Conversion Plan Benefits).* A Participant may prospectively change his or her election to add group health coverage for the Participant or his or her Spouse or Dependent, if such individual(s) loses coverage under any group health coverage sponsored by a governmental or educational institution, including (but not limited to) the following: a state children's health insurance program (SCHIP) under Title XXI

of the Social Security Act; a medical care program of an Indian Tribal government (as defined in Code § 7701(a)(40)), the Indian Health Service, or a tribal organization; a state health benefits risk pool; or a foreign government group health plan, subject to the terms and limitations of the applicable Benefit Package Option(s).

(l) **Change in Coverage Under Another Employer Plan** *(Applies to Premium Conversion Plan and Dependent Care Assistance Benefits).* A Participant may make a prospective election change that is on account of and corresponds with a change made under an employer plan (including a plan of the Employer or a plan of the Spouse's or Dependent's employer), so long as

(1) The other cafeteria plan or qualified benefits plan permits its participants to make an election change that would be permitted under applicable IRS regulations other than this section 9.4(k)(4)(i); or

(2) The Plan permits Participants to make an election for a Period of Coverage that is different from the Plan year under the other cafeteria plan or qualified benefits plan. For example, if an election is made by the Participant's Spouse during the Spouse's employer's open enrollment to drop coverage, the Participant may add coverage to replace the dropped coverage. The Administrator, on a uniform and consistent basis, will decide whether a requested change is on account of and corresponds with a change made under the other employer plan, in accordance with prevailing IRS guidance.

(m) **Dependent Care Assistance Plan Coverage Changes** *(Dependent Care Assistance Benefits).* A Participant may make a prospective election change that corresponds with a change in the dependent care service provider. For example:

(1) If the Participant terminates one dependent care service provider and hires a new dependent care service provider, the Participant may change coverage to reflect the cost of the new service provider; and

(2) If the Participant terminates a dependent care service provider because a relative or other person becomes available to take care of the child at no charge, the Participant may cancel coverage.

(3) A Participant entitled to change an election as described in this Section must do so in accordance with the procedures described in Section 9.2.

9.5 Election Modifications Required by Administrator

The Administrator may, at any time, require any Participant or class of Participants to amend the amount of their Salary Reductions for a Period of Coverage if the Administrator determines that such action is necessary or advisable in order to

(a) Satisfy any of the Code's nondiscrimination requirements applicable to this Plan or other cafeteria plan;

(b) Prevent any Employee or class of Employees from having to recognize more income for federal income tax purposes from the receipt of benefits hereunder than would otherwise be recognized;

(c) Maintain the qualified status of benefits received under this Plan; or

(d) Satisfy Code nondiscrimination requirements or other limitations applicable to the Employer's qualified Plans. In the event that contributions need to be reduced for a class of Participants, the Administrator will reduce the Salary Reduction amounts for each affected Participant, beginning with the Participant in the class who had elected the highest Salary Reduction amount, continuing with the Participant in the class who had elected the next- highest Salary Reduction amount, and so forth, until the defect is corrected.

ARTICLE X CLAIMS

10.1 CLAIMS UNDER THE PLAN

If a claim for reimbursement under the Health Care Reimbursement Plan or Dependent Care Assistance Plan is wholly or partially denied, or a Participant is denied a benefit under the Plan (such as the ability to pay for premiums on a pre-tax basis) due to an issue particular to the Participant's coverage under the Plan then the claims procedure established by the Administrator and described in the Summary Plan Description for this Plan will apply.

10.2 INSURANCE CLAIMS

Claims and reimbursement for Insurance Benefits shall be administered in accordance with the claims procedures for the applicable Insurance Benefit, as set forth in the Insurance Plan documents and/or summary plan description for the applicable Insurance Plans.

ARTICLE XI GLOSSARY

Administrator means Boone County.

Benefits means the Premium Conversion Plan Benefits, the Health Care Reimbursement Plan Benefits and the Dependent Care Assistance Plan Benefits offered under the Plan.

Benefit Package Option means a qualified benefit under Code §125(f) that is offered under a cafeteria Plan, or an option for coverage under an underlying accident or health Plan.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

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

Compensation means the wages or salary paid to an Employee by the Employer, determined prior to (a) any salary Reduction election under this Plan, (b) any salary reduction election under any other

cafeteria Plan, (c) any compensation reduction under any Code §132(f)(4) Plan, and (d) any salary deferral elections under any Code §§401(k), 408(k) or 457(b) Plan or arrangement.

Dependent means any individual who is a tax dependent of the Participant as defined in Code §152, with the following exceptions: (a) for purposes of accident or health coverage (to the extent funded under the Premium Conversion Plan, and for purposes of the Health Care Reimbursement Plan), 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; and (b) for purposes of the Dependent Care Assistance Plan, 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, the 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. Notwithstanding the foregoing, the Health Care Reimbursement Plan will provide benefits in accordance with the applicable requirements of any QMCSO, even if the child does not meet the definition of "Dependent."

Dependent Care Expenses has the meaning described in Dependent Care Assistance Plan.

Earned Income means all income derived from wages, salaries, tips, self-employment, and other compensation (such as disability or wage continuation benefits), but only if such amounts are includible in gross income for the taxable year. Earned income does not include (a) any amounts received pursuant to any Dependent Care Assistance Plan established under Code §129; or (b) any other amounts excluded from earned income under Code §32(c)(2), such as amounts received under a pension or annuity, or pursuant to workers' compensation.

Effective Date of this Plan has the meaning described in Introduction.

Election Agreement means the form provided by the Administrator or the Internet web site and procedures used for the purpose of allowing an Eligible Employee to participate in this Plan by electing Salary Reductions to pay for any benefits offered under this Plan..

Eligible Employee means an Employee eligible to participate in this Plan, as provided in Eligibility and Participation

Employee Means an individual that Boone County classifies as a common-law employee and who is on Boone County's W-2 payroll. The term "Employee" does include "former Employees" for the limited purpose of allowing continued eligibility for benefits under the Plan for the remainder of the Plan Year in which an Employee ceases to be employed by the Employer.

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

Group Term Life Insurance means the Employee's Group Term Life Insurance Plan coverage for purposes of this Plan.

Medical Insurance Plan means the Plan(s) that the Employer maintains for its Employees (and for their Spouses and Dependents that may be eligible under the terms of such Plan), providing major medical type benefits through a group insurance policy or policies. The Employer may substitute,

add, subtract or revise at any time the menu of such Plans and/or the benefits, terms and conditions of any such Plans. Any such substitution, addition, subtraction or revision will be communicated to Participants and will automatically be incorporated by reference under this Plan.

Boone County Voluntary Payroll Deduction Policy – policy adopted by the County Commission on June 30, 2009 to authorized outside vendors to market products and utilize the County's payroll deduction system for provision of voluntary benefits to county employees.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended.

Medical Care Expenses has the meaning defined in Health Care Reimbursement Plan.

Open Enrollment Period with respect to a Plan Year means a period as described by the Administrator preceding the Plan Year during which Participants may make benefit elections for the Plan Year.

Participant means a person who is an Eligible Employee and who is participating in this Plan in accordance with the provisions of Eligibility and Participation. Participants include (a) those who elect one or more of the Premium Conversion Plan Benefits, Health Care Reimbursement Benefits, or Dependent Care Assistance Benefits, and Salary Reductions to pay for such Benefits; and (b) those who elect instead to receive their full salary in cash and to pay for their share of their premiums under the Premium Conversion Plan (if any) with after-tax dollars outside of this Plan and who have not elected any Health Care Reimbursement or Dependent Care Assistance Benefits.

Period of Coverage means the Plan Year, with the following exceptions: (a) for Employees who first become eligible to participate, it shall mean the portion of the Plan Year following the date participation commences, as described in Eligibility and Participation; and (b) for Employees who terminate participation, it shall mean the portion of the Plan Year prior to the date participation terminates, as described in Eligibility and Participation.

Plan means the Boone County Cafeteria Plan as set forth herein and as amended from time to time.

Plan Year means the twelve-month period between January 1 and December 31 of the same calendar year.

Premium means the amount contributed to pay for the cost of Benefits (including self-funded Benefits) as well as those that are insured, as calculated under the Premium Conversion Plan, the Health Care Reimbursement Plan, and the Dependent Care Assistance Plan.

PHI means protected health information.

Protected health information means information that is created or received by the Boone County Cafeteria 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.

QMCSO means a Qualified Medical Child Support Order, as defined in ERISA §609(a).

Qualifying Dependent Care Services has the meaning described in the Dependent Care Assistance Plan.

Qualifying Individual has the meaning described in the Dependent Care Assistance Plan.

Related Employer means any employer affiliated with Boone County that, under Code §414(b), (c), or (m), is treated as a single employer with Boone County for purposes of Code §125(g)(4).

Salary Reduction means the amount by which the Participant's Compensation is reduced and applied by the Employer under this Plan to pay for one or more of the Benefits.

Spouse means an individual who is legally married to a Participant as determined under applicable state law (and who is treated as a spouse under the Code). Notwithstanding the above, for purposes of the Dependent Care Assistance Plan, the term "Spouse" shall not include (a) an individual legally separated from the Participant under a divorce or separate maintenance decree; or (b) an individual who, although married to the Participant, file a separate federal income tax return, maintains a principal residence separate from the Participant during the last six months of the taxable year, and does not furnish more than half of the cost of maintaining the principal place of abode of the Participant.

Student means an individual who, during each of five or more calendar months during the Plan Year, is a full-time student at any educational organization that normally maintains a regular faculty and curriculum and normally has an enrolled student body in attendance at the location where its educational activities are regularly carried on.

ARTICLE XII RECORD KEEPING AND ADMINISTRATION

12.1 ADMINISTRATOR

The administration of this Plan shall be under the supervision of the Administrator. It is the principal duty of the Administrator to see that this Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in this Plan without discrimination among them.

12.2 POWERS OF THE ADMINISTRATOR

The Administrator shall have such duties and powers as it considers necessary or appropriate to discharge its duties. It shall have the exclusive right to interpret the Plan and to decide all matters there under, and all determinations of the Administrator with respect to any matter hereunder shall be conclusive and binding on all persons. Without limiting the generality of the foregoing, the Administrator shall have the following discretionary authority: (a) to construe and interpret this Plan, including all possible ambiguities, inconsistencies and omissions in the Plan and related documents, and to decide all questions of fact, questions relating to eligibility and participation, and questions of benefits under this Plan (provided that, notwithstanding the first paragraph in this Section 12.2, the Committee shall exercise such exclusive power with respect to an appeal of a claim under Section 12.1); (b) to prescribe procedures to be followed and the forms to be used by

Employees and Participants to make elections pursuant to this Plan; (c) to prepare and distribute information explaining this Plan and the benefits under this Plan in such manner as the Administrator determines to be appropriate; (d) to request and receive from all Employees and Participants such information as the Administrator shall from time to time determine to be necessary for the proper administration of this Plan; (e) to furnish each Employee and Participant with such reports with respect to the administration of this Plan as the Administrator determines to be reasonable and appropriate, including appropriate statements setting forth the amounts by which a Participant's Compensation has been reduced in order to provide benefits under this Plan;(f) to receive, review and keep on file such reports and information concerning the benefits covered by this Plan as the Administrator determines from time to time to be necessary and proper; (g) to appoint and employ such individuals or entities to assist in the administration of this Plan as it determines to be necessary or advisable, including legal counsel and benefit consultants; (h) to sign documents for the purposes of administering this Plan, or to designate an individual or individuals to sign documents for the purposes of administering this Plan;. (i) to secure independent medical or other advice and require such evidence as it deems necessary to decide any claim or appeal; and (j) to maintain the books of accounts, records, and other data in the manner necessary for proper administration of this Plan and to meet any applicable disclosure and reporting requirements.

12.3 Reliance on Participant, Tables, etc.

The Administrator may rely upon the direction, information or election of a Participant as being proper under the Plan and shall not be responsible for any act or failure to act because of a direction or lack of direction by a Participant. The Administrator will also be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions and reports that are furnished by accountants, attorneys, or other experts employed or engaged by the Administrator.

12.4 Provision for Third-Party Plan Service Providers

The Administrator, subject to approval of the Employer, may employ the services of such persons as it may deem necessary or desirable in connection with the operation of the Plan. Unless otherwise provided in the service agreement, obligations under this Plan shall remain the obligations of the Employer and the Administrator.

12.5 Fiduciary Liability

To the extent permitted by law, the Administrator shall not incur any liability for any acts or for failure to act except for their own willful misconduct or willful breach of this Plan.

12.6 Compensation of Plan Administrator

Unless otherwise determined by the Employer and permitted by law, any Administrator who is also an Employee of the Employer shall serve without compensation for services rendered in such capacity, but all reasonable expenses incurred in the performance of their duties shall be paid by the Employer.

12.7 Insurance Contracts

The Employer shall have the right (a) to enter into a contract with one or more insurance companies for the purposes of providing any benefits under the Plan; and (b) to replace any of such insurance companies or contracts. Any dividends, retroactive rate adjustments or other refunds of any type that may become payable under any such insurance contract shall not be assets of the Plan but shall be the property of, and be retained by, the Employer, to the extent that such amounts are less than aggregate Employer contributions toward such insurance.

12.8 Inability to Locate Payee

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

12.9 Effect of Mistake

In the event of a mistake as to the eligibility or participation of an Employee, or 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 it deems administratively possible and otherwise permissible under Code § 125 or the regulations issued there under, 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 the Plan or the Employer from Compensation paid by the Employer.

Article XIII General Provisions

13.1 Expenses

All reasonable expenses incurred in administering the Plan are currently paid by forfeitures to the extent provided in Sections 7.6 and 8.6, and then by the Employer. Any costs associated with participation as in the County's Voluntary Payroll Deduction Policy shall be charged as fees to the vendor unless the County Clerk and Treasurer waive payment of fees when the administrative costs to the County are determined to be covered by the costs savings to the County.

13.2 No Contract of Employment

Nothing herein contained is intended to be or shall be construed as constituting a contract or other arrangement between any Employee and the Employer to the effect that such Employee will be employed for any specific period of time. All Employees are considered to be employed at the will of the Employer.

13.3 Amendment and Termination

This Plan has been established with the intent of being maintained for an indefinite period of time. Nonetheless, the Employer may amend or terminate all or any part of this Plan at any time for any reason by resolution of the Employer's Governing Body or by any person or persons authorized by the Governing Body to take such action, and any such amendment or termination will automatically apply to the Related Employers that are participating in this Plan.

13.4 Governing Law

This Plan shall be construed, administered and enforced according to the laws of the State of Missouri, to the extent not superseded by the Code or any other federal law.

13.5 Code Compliance

It is intended that this Plan meet all applicable requirements of the Code and of all regulations issued there under. This Plan shall be construed, operated and administered accordingly, and in the event of any conflict between any part, clause or provision of this Plan and the Code, the provisions of the Code shall be deemed controlling, and any conflicting part, clause or provision of this Plan shall be deemed superseded to the extent of the conflict.

13.6 No Guarantee of Tax Consequences

Neither the Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Plan will be excludable from the Participant's gross income for federal, state or local income tax purposes. It shall be the obligation of each Participant to determine whether each payment under this Plan is excludable from the Participant's gross income for federal, state and local income tax purposes, and to notify the Administrator if the Participant has any reason to believe that such payment is not so excludable.

13.7 Indemnification of Employer

If any Participant receives one or more payments or reimbursements under this Plan on a pre-tax Salary Reduction basis, and such payments do not qualify for such treatment under the Code, such Participant shall indemnify and reimburse the Employer for any liability it may incur for failure to withhold federal income taxes, Social Security taxes, or other taxes from such payments or reimbursements.

13.8 Non-Assignability of Rights

The right of any Participant to receive any reimbursement under this Plan shall not be alienable by the Participant by assignment or any other method and shall not be subject to claims by the Participant's creditors by any process whatsoever. Any attempt to cause such right to be so subjected will not be recognized, except to such extent as may be required by law.

13.9 HEADINGS

The headings of the various Articles and Sections are inserted for convenience of reference and are not to be regarded as part of this Plan or as indicating or controlling the meaning or construction of any provision.

13.10 PLAN PROVISIONS CONTROLLING

In the event that the terms or provisions of any summary or description of this Plan, or of any other instrument, are in any construction interpreted as being in conflict with the provisions of this Plan as set forth in this document, the provisions of this Plan shall be controlling.

13.11 SEVERABILITY

Should any part of this Plan subsequently be invalidated by a court of competent jurisdiction, the remainder of the Plan shall be given effect to the maximum extent possible.

13.12 COMPLIANCE WITH HIPAA

It is intended that this Plan meet all applicable requirements of the Health Insurance Portability and Accountability Act (HIPAA) and of all regulations issued there under. This Plan shall be construed, operated and administered accordingly, and in the event of any conflict between any part, clause or provision of this Plan and HIPAA, the provisions of HIPAA shall be deemed controlling, and any conflicting part, clause or provision of this Plan shall be deemed superseded to the extent of the conflict.

The Plan will use protected health information (PHI) to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care, and health care operations.

(a) **Meaning of Payment.** Payment has the meaning specified in The Code of Federal Regulations §164.501, specifically: Payment means

(1) The activities undertaken by:

(i) A health plan to obtain premiums or to determine or fulfill its responsibility for coverage and provision of benefits under the health plan; or

(ii) A health care provider or health plan to obtain or provide reimbursement for the provision of health care; and

(2) The activities in paragraph (1) of this definition relate to the individual to whom health care is provided and include, but are not limited to:

(iii) Determinations of eligibility or coverage (including coordination of benefits or the determination of cost sharing amounts), and adjudication or subrogation of health benefit claims;

(iv) Risk adjusting amounts due based on enrollee health status and demographic characteristics;

(v) Billing, claims management, collection activities, obtaining payment under a contract for reinsurance (including stop-loss insurance and excess of loss insurance), and related health care data processing;

(vi) Review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges;

(vii) Utilization review activities, including pre-certification and preauthorization of services, concurrent and retrospective review of services; and

(viii) Disclosure to consumer reporting agencies of any of the following protected health information relating to collection of premiums or reimbursement: Name and address, Date of birth, Social Security Number, Payment history, Account number, and Name and address of the health care provider and/or health plan.

(b) **Meaning of Health Care Operations.** Health care operations has the meaning as specified in The Code of Federal Regulations §164.501, specifically, health care operations means any of the following activities of the covered entity to the extent that the activities are related to covered functions:

(1) Conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines, provided that the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from such activities; population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting of health care providers and patients with information about treatment alternatives; and related functions that do not include treatment;

(2) Reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, health plan performance, conducting training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers, training of non-health care professionals, accreditation, certification, licensing, or credentialing activities;

(3) Underwriting, premium rating, and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance), provided that the requirements of §164.514(g) are met, if applicable;

(4) Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;

(5) Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies; and

(6) Business management and general administrative activities of the entity, including, but not limited to:

(i) Management activities relating to implementation of and compliance with the requirements of this subchapter;
(ii) Customer service, including the provision of data analyses for policy holders, plan sponsors, or other customers, provided that protected health information is not disclosed to such policy holder, plan sponsor, or customer.
(iii) Resolution of internal grievances;
(iv) The sale, transfer, merger, or consolidation of all or part of the covered entity with another covered entity, or an entity that following such activity will become a covered entity and due diligence related to such activity; and
(v) Consistent with the applicable requirements of §164.514, creating de-identified health information or a limited data set, and fundraising for the benefit of the covered entity.

(c) **As required by law and authorization.** The Plan will use and disclose PHI as required by law and as permitted by authorization of the participant or beneficiary. With an authorization, the Plan will disclose PHI to the Employer's other medical, disability and workers' compensation plans for purposes related to administration of those plans.

(d) **Disclosures to the Employer.** The Plan will disclose PHI to the Employer as sponsor of the Plan provided that the Employer agrees to:

(1) Not use or further disclose PHI other than as permitted or required by this Plan document or as required by law;

(2) Ensure that any agents, including a subcontractor, to whom the Employer provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Employer with respect to such PHI;

(3) Not use or disclose PHI for employment-related actions and decisions unless authorized by the individual;

(4) Not use or disclose PHI in conjunction with any other benefit or employee benefit plan of the Employer unless authorized by the individual;

(5) Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;

(6) Make PHI available to an individual in accordance with HIPAA's access requirements;

(7) Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;

(8) Make available the information required to provide an accounting of disclosures;

(9) Make internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for the purposes of determining the Plan's compliance with HIPAA; and

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

(e) **Employees with access to PHI.** In accordance with HIPAA, only the following employees of the Employer will be given access to PHI solely for the purpose of performing Employer Plan administrations functions.

(1) Any employee responsible for establishing and maintaining employee deduction and reduction records for the Employer,

(2) Any employee with oversight responsibility for management of the Plan or any component of the Plan.

If the above employees do not comply with this Plan document, the Employer shall provide a mechanism for resolving issues of noncompliance including disciplinary sanctions.

IN WITNESS WHEREOF, and as conclusive evidence of the adoption of the foregoing instrument comprising the Boone County Cafeteria Plan, Boone County has caused this Plan to be executed in its name and on its behalf, on this ____ day of _____, 200 _.

Boone County

By: _____
Its the commissioner

Witness
Signature: _____.

Appendix A
Related Employers That Have Adopted This Plan,
With the Approval of Boone County.
No Related Employers have adopted this plan. Boone County is the only employer participating in this Plan.

293 -2009

CERTIFIED COPY OF ORDER

STATE OF MISSOURI } **ea.**
County of Boone

June Session of the April Adjourned **Term. 20** 09

In the County Commission of said county, on the 30th **day of** June **20** 09

the following, among other proceedings, were had, viz:

Now on this day the County Commission of the County of Boone does hereby award bid 29-28APR09 – Automotive Parts and Accessories Term and Supply to New Haven Filter Co., Factory Motor Parts, and O'Reilly Automotive, Inc. It is further ordered the Presiding Commissioner is hereby authorized to sign said contracts.

Done this 30th day of June, 2009.

Kenneth M. Pearson
Presiding Commissioner

ATTEST:

Wendy S. Noren
Clerk of the County Commission

Karen M. Miller
District I Commissioner

Skip Elkin
District II Commissioner

294-2009

CERTIFIED COPY OF ORDER

STATE OF MISSOURI } **ea.**
County of Boone

June Session of the April Adjourned **Term. 20** 09

In the County Commission of said county, on the 30th **day of** June **20** 09

the following, among other proceedings, were had, viz:

Now on this day the County Commission of the County of Boone does hereby award bid 21-13APR09 – Patrol Rifles to Express Police Supply. It is further ordered the Presiding Commissioner is hereby authorized to sign said contract.

Done this 30th day of June, 2009.

Kenneth M. Pearson
Presiding Commissioner

ATTEST:

Wendy S. Noren
Clerk of the County Commission

Karen M. Miller
District I Commissioner

Skip Elkin
District II Commissioner

295 -2009

CERTIFIED COPY OF ORDER

STATE OF MISSOURI } **ea.**
County of Boone

June Session of the April Adjourned **Term. 20** 09

In the County Commission of said county, on the 30th **day of** June **20** 09

the following, among other proceedings, were had, viz:

Now on this day the County Commission of the County of Boone does hereby approve the request from the City of Sturgeon to reallocate 2009 Revenue Sharing funds.

Done this 30th day of June, 2009.

Kenneth M. Pearson
Presiding Commissioner

ATTEST:

Wendy S. Noren
Clerk of the County Commission

Karen M. Miller
District I Commissioner

Skip Elkin
District II Commissioner

295-2009

City of Sturgeon

P.O. Box 387 ~ 303 Station Drive
Sturgeon, Missouri 65284
(573) 687-3321 ~ Fax (573) 687-3474

JUN 17 2009

June 16, 2009

Boone County Public Works
5551 Highway 63 South
Columbia, MO 65201-9711

Dear Mary Schooley,

Our plan for 2009 was to Micro Seal several streets.
$52,500.00 we will have available the $32,500.00 which has already been approved by Boone County Public Works and $20,000.00 of our own money.

Missouri Petroleum has notified our Maintenance Superintendent Gary Lear that they will not be able to do the job this year, because they did not get a contract from Moberly, Missouri , which we tag on to them.

We would like to put in a change request from Micro Seal to 5 or 6 box culverts and a walking bridge at the cost of $50,000.00. The $32,500.00 will be on 4-5 box culverts and the rest will come from city funds.

Thanks for letting us change this project

Please contact myself or Gary Lear if you have any questions.

Sincerely

DeAnna Jacobs

DeAnna Jacobs
City Clerk

296 -2009

CERTIFIED COPY OF ORDER

STATE OF MISSOURI } **ea.**
County of Boone

June Session of the April Adjourned **Term. 20** 09

In the County Commission of said county, on the 30th **day of** June **20** 09

the following, among other proceedings, were had, viz:

Now on this day the County Commission of the County of Boone does hereby approve the following budget amendment for the Domestic Violence Program Grant:

Department	Account	Department Name	Account Name	Decrease	Increase
1243	03451	Judicial Grants	State Grant Reimb.		$6,250.00
1243	71101	Judicial Grants	Professional Services		$6,250.00

Done this 30th day of June, 2009.

Kenneth M. Pearson
Presiding Commissioner

Karen M. Miller
District I Commissioner

Skip Elkin
District II Commissioner

ATTEST:

Wendy S. Noren
Clerk of the County Commission

297 -2009

CERTIFIED COPY OF ORDER

STATE OF MISSOURI } **ea.**
County of Boone

June Session of the April Adjourned **Term. 20** 09

In the County Commission of said county, on the 30th **day of** June **20** 09

the following, among other proceedings, were had, viz:

Now on this day the County Commission of the County of Boone does hereby approve the following budget amendment for the Mid-Missouri Access to Justice Project:

Department	Account	Department Name	Account Name	Decrease	Increase
1243	03451	Judicial Grants	State Grant Reimb.		$12,500.00
1243	71101	Judicial Grants	Professional Services		$12,500.00

Done this 30th day of June, 2009.

Kenneth M. Pearson
Presiding Commissioner

Karen M. Miller
District I Commissioner

Skip Elkin
District II Commissioner

ATTEST:

Wendy S. Noren
Clerk of the County Commission

298 -2009

CERTIFIED COPY OF ORDER

STATE OF MISSOURI } ea.
County of Boone

June Session of the April Adjourned Term. 20 09

In the County Commission of said county, on the 30th day of June 20 09

the following, among other proceedings, were had, viz:

Now on this day the County Commission of the County of Boone does hereby approve the Agreement for Outside Counsel Services with Rogers, Ehrhardt & Weber, LLC. It is further ordered the Presiding Commissioner is hereby authorized to sign said agreement.

Done this 30th day of June, 2009.

Kenneth M. Pearson
Presiding Commissioner

ATTEST:

Wendy S. Noren
Clerk of the County Commission

Karen M. Miller
District I Commissioner

Skip Elkin
District II Commissioner

298-2007

Policy for Supplemented Neighborhood Improvement District Surface Upgrades for County Maintained Subdivision & No Outlet Roads July 2007

Purpose:

The Boone County Commission through the Public Works Department provides maintenance for an established inventory of graveled or chip and seal roads within subdivisions and no outlet (dead-end) graveled or chip and seal roads. This policy applies only to those roads already in the County's maintenance inventory. The intent of this policy is to provide a means to accelerate paving consideration for roads which have not met traditional criteria to achieve a high ranking on the County's paving priorities. This policy establishes guidelines by which the County can partner with the local residents forming a Neighborhood Improvement District to share in the cost of paving these roads and thus establish a higher priority for a particular project.

Asphalt Paving by Neighborhood Improvement District (NID):

A Neighborhood Improvement District can be formed to design, prepare, and pave roads within the subdivision or on a no outlet road. All rules applicable to the NID process would apply. The NID should include all private property owners along all County maintained roads within the subdivision or the entire length of a no outlet road and any others that are determined by the NID process would receive direct benefit of the project. The pavement should extend to an existing paved surface unless waived by the County Commission. The pavement shall be asphalt or concrete constructed according to current County standards unless a variance is requested and obtained by the Public Works Department through the Road and Bridge Advisory Board or subsequently established process. Variances would be considered by the Department for practical construction concerns such as anticipated traffic volumes, parking considerations, emergency vehicle access, building set-backs, utility conflicts and other obstructions or restrictions.

Supplemental funding by the County would be a budget consideration and must be approved by the County Commission in the normal budgeting process. In order for a project to be considered for a budget year, the costs must be known and the petition established and approved by no later than July 1 of the year prior. Funding and staffing resources are limited and if multiple petitions are received or costs or staffing requirements exceed resources, the County Commission will prioritize the projects and it may be necessary to delay some projects to a future year or phase a single project over multiple years.

The County funding level would include the cost of all design, subgrade preparation, storm water infrastructure upgrades, utility relocation, 50 percent of the paving costs, more or less as determined by the County Commission based on the particular project circumstances, and site restoration. The NID would be responsible for NID administration costs, Right-of-Way acquisition costs, and the remaining percentage of the asphalt paving costs. Acquisition of additional Right-of-Way to widths according to County Policy for the road classification and any needed utility or drainage easements is a condition of approval unless waived by the County Commission. The cost of Right-of-Way would also include payment for items of value such as fencing that would be displaced. The NID process provides for donation of Right-of-Way or for payment according to the preference of the petitioners.

Date: 7/24/07

Kenneth M. Pearson
Presiding Commissioner

Policy for Supplemented Neighborhood Improvement District Surface Upgrades for County Maintained Subdivision & No Outlet Roads July 2007

Purpose:

The Boone County Commission through the Public Works Department provides maintenance for an established inventory of graveled or chip and seal roads within subdivisions and no outlet (dead-end) graveled or chip and seal roads. This policy applies only to those roads already in the County's maintenance inventory. The intent of this policy is to provide a means to accelerate paving consideration for roads which have not met traditional criteria to achieve a high ranking on the County's paving priorities. This policy establishes guidelines by which the County can partner with the local residents forming a Neighborhood Improvement District to share in the cost of paving these roads and thus establish a higher priority for a particular project.

Asphalt Paving by Neighborhood Improvement District (NID):

A Neighborhood Improvement District can be formed to design, prepare, and pave roads within the subdivision or on a no outlet road. All rules applicable to the NID process would apply. The NID should include all private property owners along all County maintained roads within the subdivision or the entire length of a no outlet road and any others that are determined by the NID process would receive direct benefit of the project. The pavement should extend to an existing paved surface unless waived by the County Commission. The pavement shall be asphalt or concrete constructed according to current County standards unless a variance is requested and obtained by the Public Works Department through the Road and Bridge Advisory Board or subsequently established process. Variances would be considered by the Department for practical construction concerns such as anticipated traffic volumes, parking considerations, emergency vehicle access, building set-backs, utility conflicts and other obstructions or restrictions.

Supplemental funding by the County would be a budget consideration and must be approved by the County Commission in the normal budgeting process. In order for a project to be considered for a budget year, the costs must be known and the petition established and approved by no later than July 1 of the year prior. Funding and staffing resources are limited and if multiple petitions are received or costs or staffing requirements exceed resources, the County Commission will prioritize the projects and it may be necessary to delay some projects to a future year or phase a single project over multiple years.

The County funding level would include the cost of all design, subgrade preparation, storm water infrastructure upgrades, utility relocation, 50 percent of the paving costs, more or less as determined by the County Commission based on the particular project circumstances, and site restoration. The NID would be responsible for NID administration costs, Right-of-Way acquisition costs, and the remaining percentage of the asphalt paving costs. Acquisition of additional Right-of-Way to widths according to County Policy for the road classification and any needed utility or drainage easements is a condition of approval unless waived by the County Commission. The cost of Right-of-Way would also include payment for items of value such as fencing that would be displaced. The NID process provides for donation of Right-of-Way or for payment according to the preference of the petitioners.

Kenneth M. Pearson
Presiding Commissioner

Date: 2/24/07

298-2009

AGREEMENT

This agreement is entered into on this 30th day of June, 2009, between The County of Boone, Missouri and Rogers, Ehrhardt & Weber, L.L.C.

The parties agree as follows:

1. Rogers, Ehrhardt & Weber, L.L.C. will represent Boone County / Boone County Sheriff's Department in the matter of William Patrick Cronan v. Trevor Fowler, et al., Case No. 08-4224-CV-C-NKL under the terms and conditions set forth in Exhibit A which is attached to and made a part of this agreement.

2. Notwithstanding any provision of Exhibit A, the County of Boone's obligations for any unpaid or yet to be incurred fees, costs and expenses under this agreement shall not exceed the sum of $10,000.00 unless an addendum to this agreement is executed authorizing additional fees, costs and expenses. This is the third agreement and it intended to authorize up to an additional $10,000.00 in costs ($32,500.00 total costs).

IN WITNESS WHEREOF, the parties have executed this agreement on the day and year first above written.

BOONE COUNTY, MISSOURI
By and through its County Commission

By: _____
Kenneth M. Pearson, Presiding Commissioner

ATTEST:

_____
Wendy S. Noren
Clerk of the County Commission

APPROVED AS TO FORM:

_____
Charles J. Dykhouse, County Counselor

ROGERS, EHRHARDT & WEBER, L.L.C.

By: _____
Glen R. Ehrhardt

ROGERS, EHRHARDT & WEBER, L.L.C.
Attorneys at Law

Glen R. Ehrhardt
Elizabeth H. Weber
Jasen S. Matyas
Megan B. McGuire, Of Counsel
David B. Rogers (1941-2005)
Virna Camacho, Paralegal

Seven Oaks Business Center
302 Campusview Drive, Ste 204
Columbia, Missouri 65201
Phone: (573) 442-0131
Fax: (573) 442-9423
gehrhardt@rewlaw.net

PERSONAL AND CONFIDENTIAL
ATTORNEY/CLIENT PRIVILEGED COMMUNICATION

October 21, 2008

C.J. Dykhouse
Boone County Counselor
601 East Walnut, Room 207
Columbia, MO 65201

RE: William Patrick Cronan v. Trevor Fowler, et al.
Case No. 08-4224-CV-C-NKL

Dear Mr. Dykhouse:

As you are aware, our law firm was previously retained by MARCIT to represent and defend Boone County, Missouri, and Boone County Sheriff Deputies Trevor Fowler and Scott Ewing in the above-referenced cause. It is further our understanding a coverage issue has risen between MARCIT and Boone County, Missouri concerning the applicability of the insurance policy to this matter. As a result, we hereby submit for consideration by the Boone County Commission this Engagement Letter with respect to our continued representation and defense of Boone County and Defendants Fowler and Ewing in the above-referenced litigation. For your reference, I am attaching a Memorandum from Jasen Matyas detailing the current status of this case as well as our future litigation plan to obtain the prompt dismissal of this case.

Please be advised that our hourly billing rates with regard to the continued defense of this litigation will be as follows:

Partners Glen Ehrhardt and Libby Weber -- $125/hr.
Associate Attorney Jasen Matyas -- $110/hr.
Paralegal Virna Camacho -- $85/hr.
Law Clerks -- $60/hr.

In addition to the hourly rates set forth above, we would also expect to be reimbursed for out of town travel expenses for mileage, as well as postage expenses, long distance telephone charges, and copying expenses (10 cents per page).

If you have any additional questions concerning this Engagement Letter, please let us know.

Thank you in advance for your consideration in this matter and for allowing us the opportunity to continue to represent Boone County, Missouri in this litigation.

Respectfully submitted,

Glen R. Ehrhardt

GRE/ljh

299 -2009

CERTIFIED COPY OF ORDER

STATE OF MISSOURI } **ea.**
County of Boone

June Session of the April Adjourned **Term. 20** 09

In the County Commission of said county, on the 30th **day of** June **20** 09

the following, among other proceedings, were had, viz:

Now on this day the County Commission of the County of Boone does hereby approve the Child Support Enforcement Cooperative Agreement with the State of Missouri, Department of Social Services, Family Support Division. It is further ordered the Presiding Commissioner is hereby authorized to sign said agreement.

Done this 30th day of June, 2009.

Kenneth M. Pearson
Presiding Commissioner

ATTEST:

Wendy S. Noren
Clerk of the County Commission

Karen M. Miller
District I Commissioner

Skip Elkin
District II Commissioner

299-2009

LEVEL C

CHILD SUPPORT ENFORCEMENT COOPERATIVE AGREEMENT

State of Missouri

Department of Social Services

Family Support Division

This **AGREEMENT** is entered into between the State of Missouri, Department of Social Services, Family Support Division, hereinafter referred to as **STATE**, and the political subdivision identified below, including the Prosecuting Attorney thereof, the Circuit Clerk thereof, and the County Commissioner thereof, hereinafter referred to as **COUNTY**.

COUNTY: BOONE

WHEREAS, the **STATE** has been delegated the responsibility for the development and administration of a statewide program to establish and enforce child support obligations; and

WHEREAS, the **COUNTY** possesses resources useful in the establishment, enforcement, and collection of child support obligations;

NOW, in consideration of the mutual undertakings and agreements hereinafter set forth, the **STATE** and **COUNTY** agree as follows:

SPECIAL TERMS AND CONDITIONS

A. The **COUNTY** shall:

1. Appropriate to the Office of Prosecuting Attorney a sum of money sufficient for investigation and litigation of cases referred to that office by the **STATE**. Failure to appropriate resources sufficient to allow the Prosecuting Attorney to comply with performance standards established by 13 CSR 30-2.010 shall be deemed a breach of this **AGREEMENT** and cause for its termination.

a. For purposes of this **AGREEMENT**, **COUNTY** is designated as a Level C county. This is defined as a county in which the division has sole responsibility for the entire operation of the IV-D program in that county and the prosecuting attorney performs specific legal functions on referrals sent to him/her by the division.

2. Furnish office space and other administrative requirements mandated by Section 454.405, RSMo, provided that prior approval is obtained from the **STATE** for any office space that must be leased from the private sector. All space obtained from a private source shall be acquired in conformance with Sections 105.454, 50.660, RSMo, and 13 CSR 30-3.010 (5)(A).

3. Hire for the purpose of fulfilling the responsibilities of Section 454.405, RSMo, and this **AGREEMENT**, additional staff, such as assistant prosecuting attorneys, clerical, investigative, or administrative, after first obtaining prior written approval from the **STATE** for additional staff employed by the **COUNTY** in carrying out the responsibilities defined in this **AGREEMENT** and for which federal financial participation is available.

a. For purposes of this **AGREEMENT**, "additional staff" is defined to mean any staff hired and paid by the **COUNTY** over and above the number of staff approved and funded by the **COUNTY's** budget on the effective date of the **AGREEMENT**.

4. Notify the **STATE** within 30 days of all new hires and terminations of staff carrying out the responsibilities defined in this **AGREEMENT** and for which federal financial participation is available.

5. In accordance with the provisions of Section 32.057 and Chapter 143, of the Revised Statutes of Missouri and Regulations promulgated by the Department of Revenue (DOR), the **COUNTY** shall agree and understand that any data being provided by the DOR is confidential. The **COUNTY** must not make such data available to any other person or company in its entirety or in part for any purpose whatsoever.

6. Provide for the **STATE'S** review and approval, ninety (90) days before any proposed implementation date, requests to establish a county-administered (Level A) IV-D investigative office. This request should include a statement of reasons for requesting the establishment of such an office, a proposed organizational statement, a proposed budget, and a comprehensive plan for assuming and processing the **COUNTY'S** IV-D caseload.

7. Maintain, as required by the **STATE**, all fiscal and other records necessary for reporting and accountability under federal regulations and action transmittals, including but not limited to 45 CFR 302.15 and OCSE-AT-77-3, all provisions of 13 CSR 30-2.020; 13 CSR 30-3.010; 13 CSR 30-3.020 and, in addition thereto, records which reflect the direct and indirect costs expended in the performance of this **AGREEMENT**. These records will be available to the **STATE**, State Auditor, Department of Social Services' auditors, and/or federal officials for inspection and audit.

8. Submit monthly billings to the **STATE** for all actual allowable direct and indirect expenditures incurred under this **AGREEMENT** for the preceding month. Allowable expenditures are those eligible for federal financial participation under 45 CFR Part 304 and those eligible under

state regulations. Claims will be documented and submitted in compliance with state regulations and shall be signed by a **COUNTY** official who is a signatory to this **AGREEMENT** or by an individual designated in writing by one of these signatories.

9. If indirect costs are to be claimed, present to the **STATE**, for its review and approval, a cost allocation plan prepared in accordance with applicable state and federal regulations and federal action transmittals pertaining thereto. The **STATE** will review the plan for compliance with federal directives and state regulations, advise the **COUNTY** regarding any area of possible non-compliance, and make reimbursement on the basis of an approved plan. Upon approval, the **STATE** will reimburse the **COUNTY** at the approved rate for the applicable period. Reimbursement in either case will be subject to adjustment upon state or federal audit.

10. Obtain written approval from the **STATE** prior to incurring out-of-state travel expenses as specified in 13 CSR 30-3.010(3)(G*)*. Prior approval for reimbursement is not required for any in-state training provided by the STATE, the federal child support agency, other child support organizations or the Missouri Office of Prosecuting Services (MOPS) bi-annual training conferences provided that attendance is specific to training or discussions related to the child support program. If the subject matter is determined to be sufficiently program related, the director of the Family Support Division (or his/her designee) will approve reimbursement at the current FFP rate. Reimbursement for any travel expense shall be subject to the limitations set by the **STATE** for its own employees.

11. Obtain written approval for participation from the **STATE** prior to purchasing, for use in carrying out this **AGREEMENT**, tangible personal property with an acquisition cost of $2,500.00 or more per unit as specified in 13CSR40.3.010.

12. Ensure that none of the amounts certified for use pursuant to this **AGREEMENT** are federal funds, with the exception of federal revenue-sharing funds, which are matchable.

13. Ensure that should any claimed expenditures for federal financial participation be subsequently disallowed by the Missouri State Auditor, by Department of Social Services' Auditors, or by the United States Department of Health and Human Services (DHHS), the **COUNTY** shall reimburse the **STATE** in the full amount of any such disallowance. The **STATE** may utilize subsequent claims for reimbursement and/or incentives under this or subsequent agreements to offset the disallowance. The repayment period shall not exceed twelve (12) months from the date of notification of the disallowance to the **COUNTY** by the **STATE** unless prior written approval to extend the repayment period is granted by the **STATE**.

14. Establish and implement procedures to ensure that every individual who, as a regular part of his or her employment, receives, disburses, handles, or has access to or control over funds collected pursuant to the **AGREEMENT** is covered by a bond in an amount sufficient to indemnify the **STATE** against loss resulting from employee dishonesty.

15. Establish and implement procedures, consistent with generally accepted accounting principles, to ensure that individuals responsible for handling cash receipts of support payments do not participate in accounting or operating functions that would permit them to conceal in the accounting records the misuse of support payment receipts.

16. Comply with the federal Single Audit Act of 1996 (A-133) by determining, on an annual basis, whether the **COUNTY** is mandated by the Act to fund an independent audit. If it is determined that the **COUNTY** is so mandated, a copy of such audit must be submitted to the **STATE**, specifically to the County Reimbursement Unit, Family Support Division, Department of Social Services, P. O. Box 2320, Jefferson City, MO, 65102-2320, within 30 days of completion.

17. Use the MACSS in performing and maintaining automated IV-D case file and related IV-D information. The **COUNTY** understands that, prior approval notwithstanding, any costs incurred through the use or purchase of services, equipment or automated system equipment is not eligible for federal financial participation if, in the sole opinion of the **STATE**, such equipment duplicates services provided by the MACSS.

18. **COUNTY** certifies that neither it nor its principals are presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal department or agency. The **COUNTY** further agrees that it will not knowingly enter into any lower tier covered transaction with a person who is debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by the Department of Labor. By signing this **AGREEMENT**, **COUNTY** certifies the language in Paragraph K of this document.

19. The **COUNTY** has ownership of all computer hardware, including, but not limited to PC's, printers, desktops, monitors, hubs, servers, uninterruptible power supplies, and tape drives. The **COUNTY** shall be responsible for providing maintenance, repair and/or replacement of the above mentioned hardware. Any replacement equipment shall meet the minimum Department of Social Services' requirements. The **STATE** strongly recommends the **COUNTY** leases or purchases computer equipment from a vendor utilized by the Department of Social Services, so that adequate support to the **COUNTY** can be provided by the **STATE**. If the **COUNTY** chooses not to utilize said vendor, the **COUNTY** recognizes the support of this equipment may be limited. In order to be eligible for reimbursement by the **STATE**, the **COUNTY** shall request approval from the **STATE** in accordance with paragraph A.8. and A.11. of this **AGREEMENT**.

20. Safeguard and hold confidential information found in MACSS per the policies of the **STATE**. Ensure that the appropriate employees have access to MACSS, and upon termination of employment, said access is terminated. It is not permissible for circuit clerk and prosecuting attorney staff to share assigned passwords with anyone. It is not permissible for circuit clerk or prosecuting attorney staff to sign on with his or her own ID and password with the intent to allow another person access to the system. Violation of the confidentiality policy by an employee must result in appropriate disciplinary action.

21. Failure to comply with the terms of this agreement will result in the following action by the **STATE**: 1) The **STATE** will request a corrective action plan from the county within 30 days of notice by the **STATE**, which shall include the reasons for the deficiency and the plans for achieving compliance, 2) If the **COUNTY** fails to satisfactorily meet the corrective action plan and remains out of compliance with the terms of this agreement after two years of corrective action, continued non-compliance may result in the termination of the cooperative agreement.

B. <u>The **COUNTY**, through the OFFICE OF THE PROSECUTING ATTORNEY shall:</u>

1. Establish, modify and enforce obligations, including medical support obligations, and establish paternity on all cases referred to the **COUNTY** by the **STATE**, using civil or criminal proceedings as deemed necessary by the Prosecuting Attorney. The office of the Prosecuting Attorney shall have authority to forgive or reduce Unreimbursed Assistance paid by the **STATE**

prior to the entry of an order for child support to the same extent as **STATE** personnel. The office of the Prosecuting Attorney shall not have the authority to forgive or reduce any arrearages, which have been assigned to the **STATE**.

2. Take all appropriate action pursuant to Chapters 210, 452 and 454 RSMo, on each case referred by the **STATE**, within the times specified in 13 CSR 30-2.010. In the event that federal law or regulations require the **STATE** to meet stricter time requirements than those specified in 13 CSR 30-2.010 for any case action or outcome, this **AGREEMENT** shall require the Prosecuting Attorney to also meet the stricter federal requirements for the same case action or outcome upon notification of the change(s) in federal requirements by the **STATE**

3. Such appropriate action shall include but not be limited to: filing co-respondent petitions when the custodial parent fails to cooperate in paternity actions where appropriate; pursue arrears due the state in all cases, with or without the custodial parent's cooperation; and pursue all enforcement referrals either criminally or civilly, whichever is appropriate.

4. If a referral is active, the Prosecuting Attorney will be responsible for all direct communication with the custodial parent, the non-custodial parent or his/her attorney, if ethically appropriate, and for providing any and all information requested by the **STATE** to respond to inquiries by other parties. At the request of the **STATE**, the Prosecuting Attorney shall provide all necessary information to the **STATE** in order to respond to case inquiries within five days of request. At the request of the **STATE**, the Prosecuting Attorney shall provide written response to constituent, legislative or other inquires, and provide a copy to the **STATE** within five days of request. For clarification purposes, the five (5) days of request timeframe is intended to address only situations where the **STATE** has received an inquiry from a legislator, the department or

other external entities where the **STATE** is required to provide a formal response. The **STATE** will advise when requesting the information that it is in relation to such a request.

5. Use MACSS equipment to accept referrals from the **STATE,** record all child support activities deemed necessary by the **STATE**, and use said equipment to the extent necessary for the **STATE** to be able to determine whether or not the Prosecuting Attorney has complied with requirements of 13 CSR 30-2.010 solely by auditing MACSS case records. Only return referrals to the **STATE** to the office which currently has the case per the MACSS. Referrals will be returned to the **STATE** due to a lack of jurisdiction, a conflict of interest, through mutual agreement with the **STATE** or if no reasonable legal remedy is presently available. In addition, the **COUNTY** may reject a referral if the referral packet is incomplete and the **STATE** fails to provide the necessary information requested by the **COUNTY** within fourteen (14) days. If the **COUNTY** returns or rejects a referral for any reason, that reason must be clearly documented in the MACSS diary. Referrals must be returned if requested by the **STATE**.

6. The Prosecuting Attorney agrees that (s)he will not represent any interested party other than the Family Support Division in any matter referred to the Prosecuting Attorney's office.

7. Referrals made by the **STATE** and accepted by the **COUNTY** for enforcement of existing orders must be retained and monitored by the Prosecuting Attorney for a period of not less than 6 months after initial judicial action is completed to ensure compliance with the court's order or any agreement entered into between the Prosecuting Attorney and obligor. In the event that the obligor has complied with the court's order for a period of 3 consecutive months, within the 6 month period, the **COUNTY** can, at the prosecuting attorney's discretion, end and return the referral. In the event that the obligor is not complying with the court's order it is the prosecutor's obligation to take subsequent action to enforce the order within the 6 month period. In situations where it is

known that the obligor cannot make payments as ordered, due to circumstances beyond the obligor's control such as incarceration, disability, or the case is dismissed by the court, the **COUNTY** may end and return the referral. In other extenuating circumstances, the **COUNTY** in mutual agreement with the **STATE**, may end and return the referral. In all situations, where the **COUNTY** ends and returns the referral, the prosecutor must document the reason and appropriate information on the Case Diary in MACSS prior to closing and returning the referral.

8. Maintain individual (hard copy and electronic) case records adequate to permit evaluation of the progress of each case. Such records shall be maintained in strict compliance with 45 CFR 302.15 and 303.2 and shall include, at a minimum, the following:

a. original referral documents;

b. record of all contacts with parties to the action; and

c. record of all legal actions.

Such records will be made available to federal or state personnel for the purpose of conducting audits and reviews. At the discretion of the **STATE**, provide whatever documentation and/or information as is necessary to monitor performance.

9. Attend necessary and required training when the **COUNTY** is found to be out of compliance with program performance standards, and when, in the sole opinion of the **STATE**, such training should be a component of the **COUNTY's** corrective action plan.

10. Report to the **STATE** on a quarterly basis the number of felony charges filed and the number of misdemeanor charges filed under Section 568.040, RSMo, as well as the number of felony and misdemeanor convictions obtained. The **COUNTY** will submit the report in a format and manner specified by the **STATE.**

11. Have access to all necessary information, which the **STATE** can provide. This information shall be subject to all relevant federal and state laws and regulations providing for safeguarding of information. The information received in the execution of the child support enforcement program shall be used only for the purposes enumerated in Section 454.440.9 RSMo.

13. **COUNTY** understands and agrees that because their Prosecuting Attorney employees are not employees of the **STATE**, they are not covered under the State Legal Expense Fund, Section 105.711. RSMo (Supp. 2003). **COUNTY** further understands and agrees that the **STATE** cannot save and hold harmless or indemnify any Prosecuting Attorney employees against any liability arising under this **AGREEMENT**. Any liability insurance that the **COUNTY** deems necessary must be procured at their own expense as part of the cost of providing services under this **AGREEMENT**.

C. The **COUNTY**, through The OFFICE OF THE CIRCUIT COURT CLERK/ ADMINISTRATOR shall:

1. To the extent required by Chapters 452 and 454, use MACSS on all child support and/or spousal support cases. The Circuit Clerk/Administrator shall enter such information as is required for the state case registry.

2. Provide the Bureau of Vital Records of the Missouri Department of Health with certified copies of all orders establishing paternity with accompanying instructions to enter the name of the father in the birth records pursuant to Section 454.485 RSMo.

3. Comply with 45 CFR Section 304.50 in such a manner that the **STATE** meets its state plan requirements.

4. Respond to requests from FSD for copies, certified copies, and authenticated copies of orders within fourteen (14) days of receipt.

D. The **STATE** shall:

1. Refer appropriate IV-D cases to the Prosecuting Attorney for establishment, enforcement or modification.

2. Respond to appropriate information inquiries from the Prosecuting Attorney within fourteen (14) days of receipt thereof.

3. Provide federal and state parent locator services to the **COUNTY**, pursuant to Section 454.440, RSMo.

4. Reimburse the **COUNTY** pursuant to federal and state law and regulations, specifically 45 CFR 304.21, and 13 CSR 30-3.010, from funds received from the federal government and appropriated by the General Assembly at the current applicable rate for the actual allowable direct and indirect expenditures incurred in providing the services specified in this **AGREEMENT** and submitted to the **STATE** in compliance with instructions issued by the **STATE**. Such

reimbursement to the **COUNTY** for IV-D personnel costs including fringe benefits shall not exceed the hourly rate (or computed equivalent) paid by the **COUNTY** for non-IV-D public work (legal, clerical, administrative, or investigative) of equal responsibility. These reimbursements will in all cases be subject to adjustment at audit.

5. Distribute incentive payments to the **COUNTY** pursuant to federal and state law and regulations, specifically Sections 454.405, RSMo; 45 CFR 303.52; 45CFR 304.12 and 13 CSR 30-9.010. The **COUNTY** may terminate this **AGREEMENT** upon sixty days written notice.

6. Pay the costs incurred by the sheriff for serving Notice and Findings of Financial Responsibility required in administrative process actions under Chapter 454 RSMo. Service of process costs will be reimbursed in accordance with 45 CFR Section 304.21.

7. Upon filing with the Secretary of State any proposed rule or regulation, notify each county signatory to this **AGREEMENT**, pursuant to Section 454.400, RSMo.

8. Make accessible to the Prosecuting Attorney all necessary information that the agency can provide. This information shall be subject to all relevant federal and state law and regulations providing for safeguarding of information. The information received in the execution of the Child Support Enforcement Program shall be used only for the purposes enumerated in subsection 454.440.9, RSMo.

9. Provide MACSS and program training for county Prosecuting Attorney child support staff.

10. The **STATE** through the DSS Information Systems and Technology Division (ISTD) shall provide services the **COUNTY** as follows: installation and problem resolution assistance for Personal Communications software; problem resolution assistance for MACSS related printing problems; problem resolution assistance for Outlook e-mail as it relates to communication with the

STATE on child support activities; and Microsoft Office Application assistance related to child support business.

11. The **STATE** through the DSS information Systems and Technology Division (ISTD) shall provider USER IDs and passwords to prosecuting attorney staff needing access to State applications within 5 working days of receipt of the request for such access submitted via the *On-Line Security Access Request* (DDP-137).

12. The **STATE** will provide the Prosecuting Attorney or their designee the following information, in the same fashion and at the same time, as it is prepared and distributed to FSD personnel: FSD key personnel changes, statewide statistical data, annual federal audit compliance reports, MACSS changes, policy issued, all program related information distributed to the staff supervisors or managers of FSD.

13. The **STATE** will measure performance of the **COUNTY** based on pre-determined performance indicators. These indicators will be measured separately from the audit criteria.

GENERAL TERMS AND CONDITIONS

E. Nondiscrimination in Employment and Services:

The **COUNTY** agrees to comply with the 1964 Civil Rights Act, as amended; Section 504 of the Rehabilitation Act of 1973; the Age Discrimination Act of 1975; the Omnibus Reconciliation Act of 1981 and the Americans with Disabilities Act of 1990 and all other applicable federal and state laws that prohibit discrimination in the delivery of services on the basis of race, color, national

origin, age, sex, handicap, disability or religious beliefs. The **COUNTY** likewise agrees to comply with Title VII of the Civil Rights Act of 1964 which prohibits discrimination in employment on the basis of race, color, national origin, age, sex, handicap, disability and religious beliefs. The **COUNTY** further agrees to comply with Public Law 100-690, the Omnibus Drug Initiative Act of 1988.

F. Duration and Modification of **AGREEMENT**:

1. This **AGREEMENT** shall be in effect from **July 1, 2009 through June 30, 2010**.

2. References to federal and state statutes and regulations incorporate such statutes and regulations herein, subject to amendment after the effective date of this **AGREEMENT**. This **AGREEMENT** may be modified at any time in writing by the mutual consent of the parties. The **STATE** may terminate this **AGREEMENT** at any time in accordance with the provisions of Section 454.405, RSMo.

3. The parties to this **AGREEMENT** understand and agree that the Federal and State laws and regulations cited in this **AGREEMENT** are subject to change as a result of the enactment of Public Law 104-193. Further, the parties agree that any changes in Missouri law required by P.L. 104-193 will be binding on the parties.

G. Funding Limitation:

The funds available for use in this program are limited to monies received from the United States Department of Health and Human Services (DHHS) for operation of the Missouri State Plan

for Child Support Enforcement under Title IV-D of the Social Security Act and are further limited by appropriation of the Missouri General Assembly. It is clearly understood by the parties to this **AGREEMENT**, therefore, that this **AGREEMENT** shall automatically terminate without penalty if funds for the Child Support Enforcement Program are not appropriated by the Missouri General Assembly or if the program is not funded by DHHS.

H. Prosecutorial Discretion:

No provision of this **AGREEMENT** shall be construed to alter the statutory, constitutional, or common law powers and duties of the Prosecuting Attorney, including, but not limited to, the power to use his/her discretion in determining the course of action to be taken in a case.

I. Treatment of Assets:

Title to any equipment furnished by the **STATE** pursuant to this **AGREEMENT** shall remain in the **STATE**. Title to any equipment purchased by the **COUNTY** pursuant to this **AGREEMENT** shall vest in the **COUNTY**, subject to applicable federal regulations pertaining to usage and disposition.

J. Budget Estimates:

Total **COUNTY** expenditures during the period covered by this **AGREEMENT** are estimated at: $536,000.00. This estimate is made to comply with 45 CFR 303.107 (d). The parties understand that this estimate shall neither authorize nor limit any particular expenditure nor level of expenditures. The **COUNTY** shall also comply with 13 CSR 30-9.010(4), which require counties to submit an annual budget before the 1st day of July for the upcoming calendar year.

K. Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion From Lower Tier Covered Transactions:

1. **COUNTY** understands this certification is required by the regulations implementing Executive Order 12549, Debarment and Suspension, 29 CFR Part 98 Section 98.510, Participants' Responsibilities.

2. **COUNTY** certifies, by signing and submitting this **AGREEMENT**, that neither it nor its principals are presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department or agency.

3. Where **COUNTY** is unable to certify to any of the statements listed in K.2. above, it shall attach an explanation to this **AGREEMENT**.

IN WITNESS WHEREOF, THE COUNTY AND THE STATE EXECUTE THIS AGREEMENT:

FOR THE COUNTY OF BOONE:

KENNETH M. PEARSON, Presiding Commissioner

DATED: 6/30/09

ATTEST:

WENDY NOREN, Clerk of the County Commission

DANIEL K. KNIGHT, Boone County Prosecutor

DATED: 6-18-09

CHRISTY BLAKEMORE, Clerk of the Circuit Court

DATED: 6·18·09

APPROVED AS TO LEGAL FORM:

C.J. DYKHOUSE, County Counselor

AUDITOR CERTIFICATION

I hereby certify that this contract is within the purpose of the appropriation to which it is to be charged and there exists a sufficient unencumbered appropriation balance.

JUNE E. PITCHFORD, Auditor by cg — Date 6/25/09

FOR THE FAMILY SUPPORT DIVISION:

Director

DATED: 7-8-09

300 -2009

CERTIFIED COPY OF ORDER

STATE OF MISSOURI } **ea.**
County of Boone

June Session of the April Adjourned **Term. 20** 09

In the County Commission of said county, on the 30th **day of** June **20** 09

the following, among other proceedings, were had, viz:

Now on this day the County Commission of the County of Boone does hereby approve the following budget amendment for Phase I of the Government Center Remodel Project:

Department	Account	Department Name	Account Name	Decrease	Increase
4010	71211	Admin Bldg Const.	A/E Fees		$42,500.00
4010	71212	Admin Bldg Const.	A/E Reimbursables		$650.00

Done this 30th day of June, 2009.

Kenneth M. Pearson
Presiding Commissioner

Karen M. Miller
District I Commissioner

Skip Elkin
District II Commissioner

ATTEST:

Wendy S. Noren
Clerk of the County Commission

301 -2009

CERTIFIED COPY OF ORDER

STATE OF MISSOURI } **ea.**
County of Boone

June Session of the April Adjourned **Term. 20** 09

In the County Commission of said county, on the 30th **day of** June **20** 09

the following, among other proceedings, were had, viz:

Now on this day the County Commission of the County of Boone does hereby appoint Richard Shanker to the Building Code Commission for a term beginning July 1, 2009, and ending June 30, 2011.

Done this 30th day of June, 2009.

Kenneth M. Pearson
Presiding Commissioner

Karen M. Miller
District I Commissioner

Skip Elkin
District II Commissioner

ATTEST:

Wendy S. Noren
Clerk of the County Commission

Ken Pearson, Presiding Commissioner
Karen M. Miller, District I Commissioner
Skip Elkin District II Commissioner

RECEIVED JUN 2 2009

301-2009

Boone County Government Center
801 E. Walnut, Room 245
Columbia, MO 65201
573-886-4305 • FAX 573-886-4311
E-mail: commission@boonecountymo.org

effective: 6/30/09
xpi: 6/30/2011
~~please~~ re

Boone County Commission

BOONE COUNTY BOARD OR COMMISSION APPLICATION FORM

Board or Commission: Building Code Commission Term: _____

Current Township: _____ Today's Date: _____

Name: Richard Shanker

Home Address: 1829 Cliff Dr Town Columbia Zip Code: 65201

Business Address: _____ Town _____ Zip Code: _____

Home Phone: _____ Work Phone: _____
Fax: 875-2035 E-mail: _____

Qualifications: City of Columbia → Electrical Board, Electrical Board
Master Electrician in Columbia ~30 years
Boone County - IDA
City of Columbia - Building Codes Commission

Past Community Service: Columbia airport advisory

References: Pearson, Miller, Elkin, John Sudduth Jim Pancek

I have no objections to the information in this application being made public. To the best of my knowledge at this time I can serve a full term if appointed. I do hereby certify that the above information is true and accurate.

Richard Shanker
Applicant Signature

Return To: **Application**

Boone County Commission Office
Boone County Government Center
801 East Walnut, Room 245
Columbia, MO 65201
Fax: 573-886-4311