EXHIBIT 8

CLEVELAND PUBLIC LIBRARY

Human Resources Committee
January 17, 2012

RESOLUTION APPOINTING NEO ADMINISTRATION COMPANY AS THIRD-PARTY ADMINISTRATOR OF THE CLEVELAND PUBLIC LIBRARY'S FLEXIBLE SPENDING ACCOUNT AND COMMUTER BENEFITS PLAN, RATIFYING CONTRACTS, AND APPROVING AND ADOPTING RESTATED PLAN

WHEREAS, Effective October 1, 2008, the Board of Trustees of the Cleveland Public Library ("Library") adopted a Flexible Spending Plan for employees of the Cleveland Public Library pursuant to Internal Revenue Code Sections 125, 105, and 129, permitting employees to make pre-tax contributions to Health Care Spending Accounts and Dependent Care Spending Accounts for qualified out-of-pocket expenses; and

WHEREAS, The Library also established a Commuter Benefits Plan pursuant to Internal Revenue Code Section 132;

WHEREAS, The Library appointed Automatic Data Processing, Inc. ("ADP") as the third-party administrator of the Flexible Spending Account Plan and Commuter Benefits Plan in 2008; and

WHEREAS, In 2011, the Library decided to terminate its agreement with ADP and solicited proposals from four (4) vendors to provide administration services to replace ADP; and

WHEREAS, The Library determined NEO Administration Company ("NEO") to be the best qualified provider of such services and entered into an Administrative Services Agreement, a Business Associate Agreement, and supporting agreements with NEO, effective January 1, 2012. The total cost of services is not expected to exceed $25,000 for the year 2012; and

WHEREAS, NEO revised the Library's Flexible Spending Account Plan and Plan Summary which have been reviewed and approved by the Library Chief Legal Officer; now therefore be it

RESOLVED, That the restated Flexible Spending Account Plan and Plan Summary dated January 1, 2012 are hereby approved and adopted; and be it further

RESOLVED, That NEO is hereby appointed the third-party administrator of the Flexible Spending Account Plan and Commuter Benefits Plan effective January 1, 2012; and be it further

RESOLVED, That the Administrative Services Agreement, Business Associate Agreement and supporting agreements necessary to administer the Library's Flexible Spending Account and Commuter Benefits Plans are hereby ratified and approved; be it further

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

THE CLEVELAND PUBLIC LIBRARY
FLEXIBLE SPENDING ACCOUNT PLAN

SUMMARY PLAN DESCRIPTION

Restated Effective January 1, 2012

THE CLEVELAND PUBLIC LIBRARY
FLEXIBLE SPENDING ACCOUNT PLAN

INTRODUCTION

We are pleased to announce that we have restated our "flexible spending account plan" for you and other eligible employees effective January 1, 2012. Under this program, you will continue to be able to choose among certain benefits that we make available. The benefits that you may choose are outlined in this summary plan description. We will also tell you about other important information concerning the Plan, such as the rules you must satisfy before you can join and the laws that protect your rights.

One of the most important features of our Plan is that the benefits being offered are generally ones that you are already paying for, but normally with money that has first been subject to income taxes. Under our Plan, these same expenses will be paid with a portion of your pay before federal and state income taxes are withheld. This means that you will pay less tax and have more money to spend and save.

Read this summary plan description carefully so that you understand the provisions of our Plan and the benefits you will receive. We want you to be fully informed before you enroll in the Plan and while you are a participant. You should direct any questions you have to the Administrator. There is a plan document on file which you may review if you desire. In the event there is a conflict between this summary plan description and the plan document, the plan document will control.

TABLE OF CONTENTS

I
ELIGIBILITY

1. When Can I Become a Participant in the Plan?

Before you become a member or a "participant" in the Plan, there are certain rules which you must satisfy. First, you must meet the "eligibility requirements." After that, the next step is to actually join the Plan on the "entry date" that we have established for all employees. You will also be required to complete certain application forms before you can enroll in the Plan.

2. What Are the Eligibility Requirements of Our Plan?

You will be eligible to join the plan if you are one of the following employees:

- all District 1199 bargaining unit Employees who are regularly scheduled to work a minimum of 20 hours per week;
- all full-time Teamsters 244 security officer Employees who are regularly scheduled to work a minimum of 37.5 hours per week; and
- all full-time non-bargaining unit staff Employees who are regularly scheduled to work a minimum of 37.5 hours per week.

3. When Is My Entry Date?

You can join the Plan as of the day you satisfy the eligibility requirements.

4. Are There Any Employees Who Are Not Eligible?

Yes, there are certain employees who are not eligible to join the Plan. They are employees who do not meet the eligibility requirements set forth above. Temporary agency staff hired to work on a "casual basis"; substitute staff hired by the Employer; independent contractors; staff hired in the page job classification; members of the Employer's Board of Trustees; contract vendors staff; and non-bargaining unit staff Employees who are regularly scheduled to work less than 37.5 hours per week are not eligible to participate in this Plan.

5. What Must I Do to Enroll in the Plan?

Before you can join the Plan, you must complete an application to participate in the Plan. The application includes your personal choices for each of the benefits which are being offered under the Plan. You must also authorize us to set some of your earnings aside in order to pay for the benefits you have elected.

II
OPERATION

1. How Does This Plan Operate?

Before the start of each Plan Year, you will be able to elect to have some of your upcoming pay contributed to the Plan. These amounts will be placed in special funds or accounts which must be set up for you in order to pay for the benefits you have chosen. The portion of your pay that is paid to the Plan is not subject to income or withholding tax. In other words, this allows you to use tax-free dollars to pay for certain kinds of benefits and expenses which you normally pay with out-of-pocket, taxable dollars. However, if you receive a reimbursement for an expense under the Plan, you cannot claim a federal income tax credit or deduction on your return.

III
CONTRIBUTIONS

1. How Much of My Pay May the Employer Redirect?

Each Plan year, you may elect to have us contribute on your behalf enough of your compensation to pay for the benefits that you elect under the Plan. These amounts will be deducted from your pay each pay period on a pro rata basis over the course of the year. However, you may not have us contribute more than Eight Thousand Dollars ($8,000.00) each Plan Year.

2. How Much Will the Employer Contribute Each Year?

We will contribute no amount at this time.

3. How Is My Compensation Measured Under Our Plan?

Compensation under our Plan means your total pay, including overtime, commissions and bonuses, which you receive during the year.

4. What Happens to Contributions Made to the Plan?

Before each Plan Year begins, you will select the benefits you want and how much of the contributions should go toward each benefit. It is very important that you make these choices carefully based on what you expect to spend on each covered benefit or expense during the Plan Year. Later, they will be used to pay for the expenses as they arise during the Plan Year.

5. When Must I Decide Which Accounts I Want to Use?

You are required by federal law to decide before the Plan Year begins, during the "election period." You must decide two things. First, which benefits you want and, second, how much should go toward each benefit.

6. When Is the "Election Period" for Our Plan?

When you first meet the "eligibility requirements," your election period will start on that date (your "entry date") and continue for 31 days past your "entry date." (You should review Section I on Eligibility to better understand the terms "eligibility requirements" and "entry date.") Then, for each following Plan Year, the election period is the period chosen by the Administrator for elections to be made by all employees. (See the Article entitled "General Information About Our Plan" for the definition of Plan Year.)

7. May I Change My Elections During the Plan Year?

Generally no. You cannot change the elections you have made after the beginning of the Plan Year (and you cannot elect to participate if you decline to participate during open enrollment) except in limited circumstances. Those circumstances are proscribed by the Internal Revenue Service and are called change in status events. Any change you make must be consistent with and on account of one of those change in status events. The following are currently recognized change in status events:

- change in a Participant's legal marital status;
- change in the number of a Participant's Dependents;
- change in employment status (such as commencing employment, a layoff, increase or decrease in hours, change in worksite);
- change in place of residence;
- FMLA leaves;
- Medicare or Medicaid entitlements;
- HIPAA enrollment rights; and
- receipt by the Plan of certain qualified court orders involving Dependents.

In addition to the above qualifying change in status events, if the cost of your Dependent Care expenses increase or decrease, you may be allowed to change or revoke your prior election. This change in cost exception is not applicable to Health FSAs.

If your dependent care expenses increase, you will be permitted to change or revoke a prior election; provided that, any increase in cost is not imposed by a dependent care provider who is your relative. Please note that no election change is permitted under the Health Care Reimbursement Plan in connection with a change in health care costs or coverage.

If you believe you have a qualifying change in status event, you must complete a new Benefit election form within thirty (30) days of that event.

8. May I Make New Elections in Future Plan Years?

Yes, you may. For each new Plan Year, you may change the elections that you previously made. You may also choose not to participate in the Plan for the upcoming Plan Year. If you do not make new elections during the "election period" before a new Plan Year begins, you will not be considered a participant under the Plan for the upcoming Plan Year.

IV
BENEFITS

1. What Benefits Are Available?

Under our Plan, you can choose to receive your entire compensation in cash or use a portion to pay for the following benefits or expenses during the Plan Year.

A. Health Care Reimbursement Plan:

You may participate in the Health Care Reimbursement Plan which enables you to pay for expenses which are not covered by our insured medical plans and save taxes at the same time. The account allows you to be reimbursed by the Employer for qualifying out-of-pocket medical, dental and vision expenses incurred by you and your dependents which are not eligible for reimbursement by any other source. The expenses which qualify are those permitted by Section 105 of the Internal Revenue Code and must be incurred during the Plan Year and while you were a Participant in the Plan. A list of covered expenses is available from the Administrator. You may not, however, be reimbursed for the cost of other health care coverage maintained outside the Plan.

If you pay for medical expenses with funds from the Health Care Reimbursement Plan, those expenses are not eligible as income tax deductions. Currently, in order to be eligible as income tax deductions, non-covered health care expenses would have to be greater than 7-1/2 percent of your adjusted gross income. You will need to evaluate which alternative would be most advantageous for your personal situation. You may also want to consult a professional tax adviser for a comparison of your federal tax savings under each method.

The most that you can contribute to the Health Care Reimbursement Plan is Three Thousand Dollars ($3,000.00), or the statutory limit, if less than $3,000. In order to be reimbursed for a health care expense, you must submit to the Administrator an itemized bill from the service provider. Amounts reimbursed from the Plan may not be claimed as a deduction on your personal income tax return.

If your coverage under the Health Care Reimbursement Plan is terminated, you may be entitled to continuation coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA).

B. Dependent Care Assistance Account:

The Dependent Care Assistance Account enables you to pay for out-of-pocket, work-related dependent day-care cost with pre-tax dollars. The expenses which qualify are those permitted by Section 129 of the Internal Revenue Code and must be incurred during the Plan Year. There is no Extended Grace Period to incur claims for Dependent Care. If you are married, you can use the account if you and your spouse both work or, in some situations, if your spouse goes to school full-time. Single employees can also use the account.

An eligible dependent is any member of your household for whom you can claim expenses on Federal Income Tax Form 2441 "Credit for Child and Dependent Care Expenses."

Children must be under age 13. Other dependents must be physically or mentally unable to care for themselves. Dependent Care arrangements which qualify include:

- A Dependent (Day) Care Center, provided that care is provided by the facility for more than six individuals and the facility complies with applicable state and local laws.

- An Educational Institution for pre-school children. For older children, only expenses for non-school care are eligible.

- An "Individual" who provides care inside or outside your home. The "Individual" may not be a child of yours under age 19 or anyone you claim as a dependent for federal tax purposes.

You should make sure that the dependent care expenses you are currently paying qualify under our Plan. The law places limits on the amount of money that can be paid to you in a calendar year from your Dependent Care Assistance Account. You may elect a salary reduction of up to $5,000 per Plan Year to be held under your Dependent Care Assistant Account. However, there are two circumstances where the maximum is less than $5,000:

- If you are married and do not file a joint tax return, the maximum you can elect is $2,500 per calendar year.

- If you and your spouse both work (or attend school full-time), you cannot elect more than your income or your spouse's income, whichever is lower. A full-time student is considered to have a monthly income of $250 (with one qualifying child; $500 with more than one child) for each month he or she is a full-time student an accredited school.

Also, under federal tax rules, additional limits may apply to "highly compensated employees." You will be notified if such limits apply to you.

Also, in order to have the reimbursements made to you from this account be excludable from your income, you must provide a statement from the service provider including the name, address and, in most cases, the taxpayer identification number of the service provider on your tax form for the year, as well as the amount of such expense as proof that the expense has been incurred. In addition, federal tax laws permit a tax credit for certain dependent care expenses you may be paying even if you are not a participant in this Plan. You may save more money if you take advantage of this tax credit rather than using the Dependent Care Assistant Account under our Plan. Ask your tax adviser which is better for you.

V
BENEFIT PAYMENTS

1. When Will I Receive Payments From My Accounts?

If you elect to receive Health Care Reimbursement Plan benefits, you may submit requests for reimbursement of eligible health care expenses you have incurred during that Plan Year or during

the Extended Grace Period from the end of that Plan Year until March 15 of the next year. If you elect to receive Dependent Care Assistance Plan benefits, you may submit requests for reimbursement of eligible dependent care expenses you have incurred during the course of the Plan Year only. Expenses are considered "incurred" when the service is performed, not necessarily when it is paid for.

Claims for health care expenses can be reimbursed for claims incurred during the Plan Year or during the period from the end of that Plan Year and ending on March 15 of the subsequent plan year. That additional period is known as the Extended Grace Period. In order to take advantage of this Extended Grace Period, you must be either:

- a Participant in the Plan with Health Care Reimbursement Plan coverage that is in effect on the last day of the Plan Year to which the Extended Grace Period relates; or

- a qualified beneficiary who is receiving COBRA coverage under the Health Care Reimbursement Plan on the last day of the Plan Year to which the Extended Grace Period relates.

The following additional rules will apply to Medical Care Expenses that are incurred during an Extended Grace Period or are submitted after the close of the Plan Year in which they were incurred:

- Medical Care Expenses incurred during an Extended Grace Period and approved for reimbursement will be paid first from available amounts that were remaining at the end of the preceding Plan Year and then from any amounts that are available to reimburse expenses incurred during the current Plan Year. For example, assume that $200 remains in your Health FSA Account at the end of the 2012 Plan Year and that you have also elected $2400 of Health FSA coverage for 2013. If you submit a $500 Medical Care Expense that was incurred on January 15, 2013, $200 of your claim will be paid out of the unused amounts remaining in your Health FSA Account from the 2012 Plan Year and the remaining $300 will be paid out of the amounts that are available to reimburse you for Medical Care Expenses incurred in the 2013 Plan Year. Claims will be paid in the order in which they are approved.

- Once paid, a claim can be reprocessed or otherwise recharacterized so as to change the Plan Year from which funds are taken to pay it. For example, using the same facts as in the example in the preceding paragraph, assume that a few days after being reimbursed for the $500 Extended Grace Period expense, you discover $200 of 2012 Medical Care Expenses that have not been submitted for reimbursement. The Plan will reprocess the $500 Extended Grace Period expense so as to pay it entirely from your 2013 Health FSA amounts.

- Expenses incurred during a Plan Year or the applicable Extended Grace Period must be submitted no later than 90 days after the close of the Plan Year or Extended Grace Period in order to be considered for reimbursement from amounts remaining at the end of that Plan Year.

Claims for dependent care expenses must be incurred during the same Plan Year in which you made related pay reductions to the Plan to be eligible for reimbursement under the Plan. The administrator will provide you with acceptable forms for submitting these requests for

reimbursement. If the request qualifies as a benefit or expense that the Plan has agreed to pay for, you will receive a reimbursement payment soon thereafter. Remember, these reimbursements which are made from the Plan are generally not subject to federal and state income tax or withholding, nor are they subject to Social Security taxes. Requests for payment of insured benefits should be made directly to the insurer. The provisions of the insurance policies will control what benefits will be paid and when. You will be reimbursed from the Dependent Care Assistance Account only to the extent that there are sufficient funds in the Account to cover your request. You are eligible to be reimbursed for allowable health care expenses up to your elected pay reductions for Health Care Reimbursement Plan benefits, less any claims previously reimbursed.

2. What Happens If I Don't Spend All Plan Contributions?

Any monies left at the end of the Plan Year will be forfeited. Obviously, qualifying expenses that you incur late in the Plan Year for which you seek reimbursement after the end of such Plan Year will be paid first before any amount is forfeited. However, you must make your requests for reimbursement no later than ninety (90) days after the end of the Plan Year or any monies remaining in your accounts will be forfeited. Because it is possible that you might forfeit amounts in the Plan if you do not fully use the contributions that have been made, it is important that you decide how much to place in each account carefully and conservatively. Remember, you must decide which benefits you want to contribute to and how much to place in each account before the Plan Year begins. You want to be as certain as you can that the amount you decide to place in each account will be used up entirely.

3. What Happens If I Terminate Employment?

If you leave our employ during the Plan Year, your right to benefits will be determined in the following manner:

- You will still be able to request reimbursement for qualifying dependent care expenses for the remainder of the Plan Year from the balance remaining in your dependent account at the time of termination of employment. However, no further salary redirection contributions will be made on your behalf after you terminate.

- Your participation in the Health Care Reimbursement Plan will cease, and no further salary redirection contributions will be contributed on your behalf. You will not be able to request reimbursement for health care expenses incurred after your termination of employment.

Under Federal law, you, your spouse, and your dependents may be entitled to continuation of health care coverage. Please see Section IV(1)(A) of this Summary for more information about your health care continuation rights.

4. What Happens If My Employer Is A Covered Employer Under The Family And Medical Leave Act And I Take Leave Under That Federal Law?

If you take leave under the FMLA, your Employer will continue, at your option, your participation in the Health Care Reimbursement Plan Benefit. Of course, you and your Employer will need to work out the payment arrangements for that continued participation during that leave.

VI
HIGHLY COMPENSATED AND KEY EMPLOYEES

1. Do Limitations Apply to Highly Compensated Employees?

Under the Internal Revenue Code, "highly compensated employees" and "key employees" generally are Participants who are officers, shareholders or highly paid. You will be notified by the Administrator each Plan Year whether you are a "highly compensated employee" or a "key employee".

If you are within these categories, the amount of contributions and benefits for you may be limited so that the Plan as a whole does not unfairly favor those who are highly compensated or key employees, their spouses or their dependents. Federal tax laws state that a plan will be considered to unfairly favor the key employees if they as a group receive more than 25% of all of the nontaxable benefits provided for under our Plan.

Plan experience will dictate whether contribution limitations on "highly compensated employees" or "key employees" will apply. You will be notified of these limitations if you are affected.

VII
PLAN ACCOUNTING

1. Periodic Statements

The Administrator will provide you with a statement of your account periodically during the Plan Year that shows your account balance. It is important to read these statements carefully so you understand the balance remaining to pay for a benefit. Remember, you want to spend all the money you have designated for a particular benefit by the end of the Plan Year or your remaining monies will be forfeited.

VIII
GENERAL INFORMATION ABOUT OUR PLAN

This Section contains certain general information which you may need to know about the Plan.

1. General Plan Information

The Cleveland Public Library Flexible Spending Account Plan is the name of the Plan.

Your Employer has assigned Plan Number 502 to your Plan.

The provisions of your Plan as restated are effective January 1, 2012.

Your Plan's records are maintained on a twelve-month period of time. This is known as the Plan Year. The Plan Year begins on January 1 and ends on December 31.

2. Employer Information

Your Employer's name, address and employer identification number are:

Cleveland Public Library
325 Superior Avenue
Cleveland, Ohio 44114
ID No.: 34-6000711

3. Plan Administrator Information

The name, address and business telephone number of your Plan's Administrator are:

Cleveland Public Library
325 Superior Avenue
Cleveland, Ohio 44114
(216) 623-2944

The Administrator keeps the records for the Plan and is responsible for the administration of the Plan. The Administrator will also answer any questions you may have about our Plan. You may contact the Administrator for any further information about the Plan.

4. Service of Legal Process

The name and address of the Plan's agent for service of legal process is:

Cleveland Public Library
325 Superior Avenue
Cleveland, Ohio 44114

5. Type of Administration

The type of Administration is Employer Administration.

IX
ADDITIONAL PLAN INFORMATION

1. Your Rights

Plan participants are entitled to:

(a) examine, without charge, at the Administrator's office, all Plan documents; and

(b) obtain copies of all Plan documents and other Plan information upon request to the Administrator. The Administrator may make a reasonable charge for the copies.

The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the best interest of you and other Plan participants.

No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights.

If your claim for a benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have your claim reviewed and reconsidered.

2. Claims Process

You should submit reimbursement claims during the Plan Year, but in no event later than ninety (90) days after the end of a Plan Year. Any claims submitted after that time will not be considered. If a noninsured claim under the Plan is denied in whole or in part, you or your beneficiary will receive written notification. If the Claims Administrator denies a claim, the Claims Administrator will provide notice in writing, within 30 days after the claim is filed unless special circumstances require an extension of time for processing the claim. If the Claims Administrator does not notify you of the denial of the claim within the 30 day period specified above, then the claim shall be deemed denied. The notice of a denial of a claim shall be written in a manner calculated to be understood by the claimant and shall set forth specific references to the pertinent Plan provisions on which the denial is based; a description of any additional material or information necessary to perfect the claim and an explanation as to why such information is necessary; and an explanation of the Plan's claim procedure.

Within 180 days after receipt of the above material, you shall have a reasonable opportunity to appeal the claim denial to the Claims Administrator for a full and fair review. You or your duly authorized representative may request a review upon written notice to the Claims Administrator; review pertinent documents; and submit issues and comments in writing.

A decision on the review by the Claims Administrator will be made not later than 30 days after receipt of a request for review, unless special circumstances require an extension of time for processing (such as the need to hold a hearing), in which event a decision should be rendered as

soon as possible, but in no event later than 60 days after such receipt. The decision of the Claims Administrator shall be written and shall include specific reasons for the decision, written in a manner calculated to be understood by the claimant, with specific references to the pertinent Plan provisions on which the decision is based.

A claim may be suspended for payment upon receipt of additional information if the original claim was submitted without the appropriate documentation or claim form. If a claim is unpaid pending additional information, the Claims Administrator will provide the Participant a Request for More Information (RMI) notice, in writing, within 30 days after the claim is filed. The Participant may submit the additional information to perfect the claim any time within the Plan Year and claim run-out period. However, requests for substantiation of debit card transactions shall be governed by separate card use terms, and failure to submit requested information within the time requested may result in suspension of debit card use.

The Plan Administrator has the exclusive right to interpret the provisions of the Plan. Decisions of the Plan Administrator are final, conclusive and binding. The Plan Administrator has final claims adjudication authority under the Plan.

3. Protection of Health Information

The Plan has committed to complying with the Health Insurance Portability and Accountability Act of 1996 with respect to your health information. This means that there are limited uses and disclosures which will be made of the protected health information that your Employer (and the claims administrator) receive in conjunction with this Plan to be utilized in processing your claims. The Plan will only disclose protected health information as permitted by law, or as may be authorized by you, and will limit access of that protected health information to persons at the Employer who have been designated in the Plan document.

The Plan has also committed to the notice and disclosure requirements of HITECH.

X
SUMMARY

The money you earn is important to you and your family. You need it to pay your bills, enjoy recreational activities and save for the future. Our flexible benefit plan will help you keep more of the money you earn by lowering the amount of taxes you pay. The Plan is the result of our continuing efforts to find ways to help you get the most for your earnings.

If you have any questions, please contact the Administrator.