Exhibit A
Voluntary Retirement Incentive Program
January 2017

Background
The Bureau of Human Resources (BHR) is proposing a Voluntary Retirement Incentive Program to run through June 2017. As with previous programs in 2013 and 2016, the City's Voluntary Retirement Incentive Program offers bureaus a tool to mitigate impacts to employees and other bureaus who would otherwise be affected through lay-offs and bumping should City Bureaus be asked to make budget reductions. The VRIP program provides flexibility to achieve the best outcomes citywide, as retirements can reduce the need to lay off employees to meet budget cuts.

This 2017 incentive program would give bureaus the option to offer a City-paid contribution of $15,000 into a Health Reimbursement Account (HRA) for approved retirement-eligible employees who voluntarily separate from City service through retirement. The HRA funds must be used for qualified medical related expenses, which include purchasing healthcare coverage to help bridge the gap to Medicare and for out-of-pockets expenses once participants reach Medicare eligibility.

Goals of the Program:
- Provide an incentive for retirement-eligible employees to retire, thereby reducing the number of potential involuntary lay-offs and/or program reductions
- Reduce unemployment costs should lay-offs be necessary
- Create opportunities to restructure/realign work, thereby resulting in short and long-term savings, and avoiding future layoffs
- Legally compliant – *i.e.*, nondiscriminatory on its face or as applied
- Affordable and provides for measurable cost-savings

General Parameters of the Proposed Program:
Purpose:
In an effort to meet a specifically articulated business need, the incentive program aims to reduce program reductions and/or involuntary layoffs and to make more effective use of human resources. The program will be coordinated by BHR.

Availability:
The incentive program would be available to all PERS, OPSRP or FPDR retirement-eligible individuals who retire on or before June 30, 2017, subject to certain limitations as set forth below.

Overall Rules:
The incentive program is a management tool, not an employee right. No employee shall have a contractual right to a financial incentive offered through this program.

Management will be able to exercise discretion to approve or deny an employee's application under the following guidelines:

- Participation is voluntary and will be made available to all employees, although to be eligible, the employee must meet the eligibility criteria.
- Employees who are not approved for participation in this program may rescind their notification to the City of their intent to retire.
- Individual bureaus will determine the number of incentives they can offer by classification or position, that will meet their bureau requirements and ensure retention of key skills and abilities.
- In the event there are too many applicants, the tie-breaker shall be total years of City service (*i.e.*, those employees with more years of City service will be given preference for approval over those with fewer years).

Eligibility:

To meet the minimum eligibility threshold, an employee must be in regular status with at least 5 years of service with the City of Portland. In addition, an employee must be eligible for retirement under PERS/OPSRP or FPDR criteria.

- The PERS covered employee must submit in writing, no later than May 31, 2017, their intent to retire and must separate from the City and submit retirement paperwork to the appropriate entity (PERS/OPRSP) no later than June 30, 2017. Only those employees not currently receiving a monthly pension benefit from PERS/OPSRP and retire for the first time on or before June 30, 2017 may be considered for this program. Once the letter of intent is submitted and participation in the Voluntary Retirement Incentive Program is approved, it cannot be rescinded. Solely at the discretion of the employee's bureau the qualifying retiree may be allowed to work one additional month, immediately following their retirement date, and extending no later than through July 31, as a returning retiree under Human Resources Administrative Rule 3.06.
- The FPDR covered employee must submit in writing, no later than May 31, 2017, their intent to retire and must separate from the City no later than June 30, 2017. Only those employees not currently receiving a monthly pension benefit from FPDR and retire for the first time on or before June 30, 2017 may be considered for this program. Once the letter of intent is submitted and participation in the Voluntary Retirement Incentive Program is approved, it cannot be rescinded.
- The bureau contribution funding the HRA will be made once retirement has been confirmed and the participant has completed and returned all necessary paperwork for enrollment with the 3rd party administrator. Funds will be made available (retroactively if needed) for qualified medical expenses the day following voluntary retirement and termination of employment with the City of Portland so long as the expense is incurred within the Coverage Period.
- In consideration for resignation and agreement the employee will not seek re-employment with the City in any capacity for two years including as an employee, contractor, or subcontractor; the employee's bureau will contribute a 1 time lump sum payment of $15,000 into an HRA on behalf of the employee. City Council may waive the ban on re-employment by an approved BHR ordinance if rehiring the employee is in the best interest of the City. Employees who participate in this program acknowledge retirement is voluntary and that the City has work available to them at the time of their retirement.

- Employees covered by a collective bargaining agreement must have Union agreement to participate.

Coverage Period:

- The HRA Coverage Period will be administered over a five (5) year period by plan year; the Plan Year will be designated as July 1st to June 30th. The HRA Coverage Period begins July 1, 2017 and ends on June 30, 2022. Should the employee retire prior to June 30th, only eligible expenses incurred on or after July 1, 2017 will be considered for reimbursement.
- All qualifying medical expenses shall be incurred and reimbursed during the Coverage Period. A Participant shall be entitled to benefits under the Voluntary Retirement Incentive Program for expenses incurred in a prior Plan Year, but not prior to the start date of coverage. No reimbursement shall be made with respect to a request for reimbursement submitted more than 90 days following the end of the Plan Year in which expenses are incurred.
- Any unused balances will be carried over to another Coverage Period except for balances held after the five (5) year period will be forfeited after a 90-day grace period for the submission of claims incurred prior to June 30, 2022.

188206

EXHIBIT B

City of Portland

HEALTH EXPENSE REIMBURSEMENT ACCOUNT

PLAN DOCUMENT 2017

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As used in this Plan, the following words and phrases shall have the meanings set forth herein unless a different meaning is clearly required by the context:

ARTICLE I
DEFINITIONS

1.1 "Administrator" means the Benefits and Wellness Manager as appointed by the Employer to carry out the administration of the Plan. In the event the Administrator has not been appointed, or resigns from a prior appointment, the City of Portland's Human Resource Director shall be deemed to be the Administrator.

1.2 "Code" means the Internal Revenue Code of 1986, as amended. References to a Code section shall be deemed to be to that section as it now exists and to any successor provision

1.3 "Coverage Period" means the time period as set forth in the Voluntary Retirement Incentive Program outlined in Exhibit A.

1.4 "Dependent" means any individual who qualifies as a dependent of the Eligible Employee as defined by Code §152(f)(1) and who has not attained age 26, and (b) any tax dependent of a Covered Individual defined in Code §105(b) provided, however, that any child to whom Code §152(e) (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) applies is treated as a dependent of both parents. Notwithstanding the foregoing, the HRA Account will provide Benefits in accordance with the applicable requirements of any QMCSO, even if the child does not meet the definition of "Dependent."

1.5 "Domestic Partner" as defined and declared in the City of Portland's Domestic Partner Affidavit and who qualifies as a "qualifying relative" of the Eligible Employee as defined by IRC Section 152 dependent, as modified by IRC Section 105(b).

1.6 "Effective Date" means the date specified in the Voluntary Retirement Incentive Program outlined in Exhibit A.

1.7 "Eligible Employee" means a Retired City of Portland employee who elects to retire under the provisions of the Voluntary Retirement Incentive Program offered by the Employer

1.8 "Employee" means any person who is employed by the Employer.

1.9 "Employer" means The City of Portland.

1.10 "Employer Contribution" means the amounts contributed to the Plan by the Employer.

1.11 "Participant" means any Eligible Employee, Spouse or Dependent who has satisfied the requirements of Section 2.1 and has not for any reason become ineligible to participate further in the Plan.

1.12 "Plan" means this Basic Plan Document and the Voluntary Retirement Incentive Program outlined in Exhibit A. as adopted by the Employer, including all amendments thereto.

1.13 "Premiums" mean the Participant's cost for any health plan coverage.

1.14 "Spouse" means a legal spouse as recognized by the employee's state of residence.

1.15 "Third-Party Administrator" means a company the Employer contracts to provide customer service and claims payment or reimbursement for the City's HRA Participants.

1.16 "Qualifying Medical Expenses" means any expense eligible for reimbursement under the Health Expense Reimbursement Account which would qualify as a "medical expense" (within the meaning of Code Section 213(d) and as allowed under Code Section 105 and the rulings and Treasury regulations thereunder) of the Participant, the Participant's spouse or a Dependent and not otherwise used by the Participant as a deduction in determining the Participant's tax liability under the Code or reimbursed under any other health coverage, including a health Flexible Spending Account. Qualifying Medical Expenses covered by this Plan are limited as elected in the Voluntary Retirement Incentive Program outlined in Exhibit A. Furthermore, a Participant may not be reimbursed for "qualified long-term care services" as defined in Code Section 7702B(c).

1.17 "Voluntary Retirement Incentive Program" means the program that provides for HRA contributions as described in Exhibit A.

ARTICLE II
PARTICIPATION

2.1 Eligibility

Any Eligible Employee shall be eligible to participate hereunder on the date such Employee satisfies the conditions of the Voluntary Retirement Incentive Program outlined in Exhibit A and as further described in the Summary Plan Description.

2.2 Effective Date of Participation

An Eligible Employee who has satisfied the conditions of eligibility pursuant to Section 2.1 shall become a Participant effective as of the date elected in the Voluntary Retirement Incentive Program outlined in Exhibit A.

If an Employee, who has satisfied the Plan's eligibility requirements and would otherwise have become a Participant, shall go from a classification of a noneligible

Employee to an Eligible Employee, such Employee shall become a Participant on the date such Employee becomes an Eligible Employee or, if later, the date that the Employee would have otherwise entered the Plan had the Employee always been an Eligible Employee.

If an Employee, who has satisfied the Plan's eligibility requirements and would otherwise become a Participant, shall go from a classification of an Eligible Employee to a noneligible class of Employees, such Employee shall become a Participant in the Plan on the date such Employee again becomes an Eligible Employee, or, if later, the date that the Employee would have otherwise entered the Plan had the Employee always been an Eligible Employee.

2.3 Termination of Participation

This Section shall be applied and administered consistent with any rights a Participant and the Participant's Dependents may be entitled to, or any election within the Voluntary Retirement Incentive Program outlined in Exhibit A and as further described in the Summary Plan Description.

(a) In the case of re-employment with the City in any capacity after more than 2 years of separation, the Participant does not forfeit any remaining balance in the HRA and shall have the right to submit claims for reimbursement, and receive benefits hereunder, for any Eligible Medical Expenses arising during the Coverage Period at any time prior to the expiration of the earlier of (1) exhaustion of the account balance.

(b) In the case of the death of the Participant where there is no surviving Spouse, Domestic Partner and/or eligible Dependent, Eligible Medical Expenses incurred by the Participant prior to his or her death may be submitted within 120 days following the date of death for reimbursement up to the account balance. If there is no Spouse, Domestic Partner or eligible Dependent at the time of the Participant's death, the account balance, if any, is forfeited (reduced to zero).

(c) In the case of the death of the Participants where there is a surviving Spouse Domestic Partner and/or eligible Dependent, the Spouse, Domestic Partner and/or eligible Dependent shall have the right to submit claims for reimbursement, and receive benefits hereunder, for any Eligible Medical Expenses arising during the Coverage Period at any time prior to the expiration of the earlier of (1) exhaustion of the account balance; or (2) the end of the plan year in which the Participant deceased. If there remains an account balance after the expiration of the condition (2), above, then the account balance is forfeited (reduced to zero).

ARTICLE III
BENEFITS

3.1 Establishment of Plan

(d) This Health Expense Reimbursement Account is intended to qualify as a Health Expense Reimbursement Account under Code Section 105 and shall be interpreted in a manner consistent with such Code Section and the Treasury

regulations thereunder.

(e) Participants in this Health Expense Reimbursement Account may submit claims for the reimbursement of Qualifying Medical Expenses as defined under the Plan and the Voluntary Retirement Incentive Program outlined in Exhibit A and as further described in the Summary Plan Description. Unless otherwise elected in the Voluntary Retirement Incentive Program outlined in Exhibit A, this Plan shall reimburse any expenses only after amounts in all other Plans that could reimburse the expense have been exhausted.

(f) The Employer shall make available to each Participant an Employer Contribution as elected in the Voluntary Retirement Incentive Program outlined in Exhibit A. for the reimbursement of Qualifying Medical Expenses. No salary reductions may be made to this Health Expense Reimbursement Account.

(g) This Plan shall not be coordinated or otherwise connected to the Employer's cafeteria plan (as defined in Code Section 125), except as permitted by the Code and the Treasury regulations thereunder, to the extent necessary to maintain this Plan as a Health Expense Reimbursement Account.

3.2 Nondiscrimination Requirements

(a) It is the intent of this Health Expense Reimbursement Account not to discriminate in violation of the Code and the Treasury regulations thereunder.

(b) If the Administrator deems it necessary to avoid discrimination under this Health Expense Reimbursement Account, it may, but shall not be required to reduce benefits provided to "highly compensated individuals" (as defined in Code Section 105(h)) in order to assure compliance with this Section. Any act taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner.

3.3 Health Expense Reimbursement Account Claims

(a) The Third Party Administrator shall direct the reimbursement to each eligible Participant for all Qualifying Medical Expenses. All Qualifying Medical Expenses eligible for reimbursement pursuant to Section 3.1(b) shall be reimbursed during the Coverage Period, even though the submission of such a claim occurs after his participation hereunder ceases; but provided that the Qualifying Medical Expenses were incurred during a Coverage Period. Claims must include receipts or documentation that the expense being incurred is eligible for reimbursement, in order to claim reimbursement. Expenses may be reimbursed in subsequent Coverage Periods. However, a Participant may not submit claims incurred prior to beginning participation in the Plan and/or the Effective Date of the Plan, whichever is earlier.

(b) Notwithstanding the foregoing, if elected in the Voluntary Retirement Incentive Program outlined in Exhibit A. Qualifying Medical Expenses shall not be reimbursable under this Plan if eligible for reimbursement and claimed under the Employer's Health Flexible Spending Account.

(c) Claims for the reimbursement of Qualifying Medical Expenses incurred in any Coverage Period shall be paid as soon after a claim has been filed as is administratively practicable; provided however, that if a Participant fails to submit a claim within the period elected in the Voluntary Retirement Incentive Program outlined in Exhibit A immediately following the end of the Coverage Period, those Medical Expense claims shall not be considered for reimbursement by the Third Party Administrator.

(d) Reimbursement payments under this Plan shall be made directly to the Participant.

(e) If the maximum amount available for reimbursement for a Coverage Period is not utilized in its entirety, such remainder shall be carried forward to another Coverage Period or forfeited, as elected in the Voluntary Retirement Incentive Program outlined in Exhibit A.

ARTICLE IV
CLAIM PROCESSING PROVISIONS

4.1 Claim for Benefits

Any claim for Benefits shall be made to the Third Party Administrator. The following timetable for claims and rules below apply:

Notification of whether claim is accepted or denied	30 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information on the Claim:	
Notification of	15 days
Response by Participant	45 days
Review of claim denial	60 days

Third Party Administrator Information:
BenefitHelp Solutions
PO Box 67230
Portland, OR 97268-1230
(888) 398-8057

The Administrator will provide written or electronic notification of any claim denial. The notice will state:

(1) The specific reason or reasons for the denial.

(2) Reference to the specific Plan provisions on which the denial was based.

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

(4) A description of the Plan's review procedures and the time limits applicable to such procedures.

(5) A statement that the claimant is entitled to receive, upon request and free of charge reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

(6) If the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the denial and a copy will be provided free of charge to the claimant upon request.

When the Participant receives a denial, the Participant shall have 180 days following receipt of the notification in which to appeal the decision. The Participant may submit written comments, documents, records, and other information relating to the Claim. If the Participant requests, the Participant shall be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

The period of time within which a denial on review is required to be made will begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information shall be considered relevant to a Claim if it:

(1) was relied upon in making the claim determination;

(2) was submitted, considered, or generated in the course of making the claim determination, without regard to whether it was relied upon in making the claim determination;

(3) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that claim determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or

(4) constituted a statement of policy or guidance with respect to the Plan concerning the denied claim.

The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial claim determination. The review will not afford deference to the initial denial and will be conducted by a fiduciary

of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual. The Participant may request an external review of the claims denial as provided for under the Affordable Care Act (ACA).

4.2 Named Fiduciary

The "named Fiduciaries" of this Plan are (1) the Employer and (2) the Administrator. The named Fiduciaries shall have only those specific powers, duties, responsibilities, and obligations as are specifically given them under the Plan including, but not limited to, any agreement allocating or delegating their responsibilities, the terms of which are incorporated herein by reference. In general, the Employer shall have the sole responsibility for providing benefits under the Plan; and shall have the sole authority to appoint and remove the Administrator; and to amend the elective provisions of the Voluntary Retirement Incentive Program outlined in Exhibit A, or terminate, in whole or in part, the Plan. The Administrator shall have the sole responsibility for the administration of the Plan, which responsibility is specifically described in the Plan. Furthermore, each named Fiduciary may rely upon any such direction, information or action of another named Fiduciary as being proper under the Plan, and is not required under the Plan to inquire into the propriety of any such direction, information or action. It is intended under the Plan that each named Fiduciary shall be responsible for the proper exercise of its own powers, duties, responsibilities and obligations under the Plan. Any person or group may serve in more than one Fiduciary capacity.

4.3 General Fiduciary Responsibilities

The Administrator and any other fiduciary shall discharge their duties with respect to this Plan solely in the interest of the Participants and their beneficiaries and

(a) for the exclusive purpose of providing Benefits to Participants and their beneficiaries and defraying reasonable expenses of administering the Plan;

(b) with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent man acting in like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims; and

(c) in accordance with the documents and instruments governing the Plan.

4.4 Nonassignability of Rights

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

ARTICLE V
ADMINISTRATION

5.1 Plan Administration

The Plan and its Components shall be administered by the Administrator. The Administrator shall have responsibility for the general operation of the Plan and shall

have the power and duty to decide all questions arising in connection with the administration, interpretation and application of the Plan and shall take all actions and make all decisions that shall be necessary to carry out the provisions of the Plan, including but not limited:

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

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

(c) To decide all questions concerning the Plan and the eligibility of any person to participate in the Plan and to receive benefits provided under the Plan;

(d) Promulgating rules of procedure and keeping records necessary for the proper and efficient administration of the Plan;

(e) To limit benefits for certain highly compensated individuals if it deems such to be desirable in order to avoid discrimination under the Plan in violation of applicable provisions of the Code;

(f) To authorize the payment of benefits to a Third Party Administrator;

(g) To appoint such agents, Third Party Administrators, counsel, accountants, consultants, and actuaries as may be required to assist in administering the Plan; and

(h) Furnishing the City Council, Members and insurers with information they may require;

Any procedure, discretionary act, interpretation or construction taken by the Administrator shall be done in a nondiscriminatory manner based upon uniform principles consistently applied and shall be consistent with the intent that the Plan shall continue to comply with the terms of Code Section 105(h) and the Treasury regulations thereunder.

5.2 Examination of Records

The Administrator shall make available to each Participant, Eligible Employee and any other Employee of the Employer such records as pertain to their interest under the Plan for examination at reasonable times during normal business hours.

5.3 Indemnification of Administrator

The Employer agrees to indemnify and to defend to the fullest extent permitted by law any Employee serving as the Administrator against all liabilities, damages, costs and expenses (including attorney's fees and amounts paid in settlement of any claims approved by the Employer) occasioned by any act or omission to act in connection with the Plan, if such act or omission is in good faith.

5.4 General Plan Information

Plan Name: City of Portland Health Expense Retirement Account
Plan Number: 501
Effective Date: May 1, 2013
Plan Year: July 1st to June 30th.
Type of Plan: Welfare Plan
Your HRA Plan shall be governed by the Laws of the State of Oregon

Employer/Plan Sponsor/ Administrator Information
City of Portland
1120 SW 5th Avenue, Suite 404
Portland, OR 97204
Federal Employer Tax Identification Number (EIN) 93-6002236

ARTICLE VI
AMENDMENT OR TERMINATION OF PLAN

6.1 Amendment

The Employer, at any time or from time to time, may amend any or all of the provisions of the Plan without the consent of any Employee or Participant.

6.2 Termination

The Employer is establishing this Plan with the intent that it will be maintained for enrollees prior to January 2017 until June 30, 2021.

The Employer is establishing this Plan with the intent that it will be maintained for enrollees after January 2017 until June 30, 2022.

This period may be amended, changed or extended. Notwithstanding the foregoing, the Employer has no obligation to maintain the Plan or any component, and reserves the right to amend, change, terminate or cancel the Plan described herein, and provisions, in any manner at any time, subject to the Employer's obligations under the public employees collective bargaining act, provided however, that no amendment, change or termination shall reduce or eliminate benefits retroactively. If the plan is amended or terminated, it will not affect coverage for the services provided prior to the effective date of the change.

ARTICLE VII
MISCELLANEOUS

7.1 Plan Interpretation

All provisions of this Plan shall be interpreted and applied in a uniform, nondiscriminatory manner. This Plan shall be read in its entirety and not severed except as provided in Section 7.11.

7.2 Gender and Number

Wherever any words are used herein in the masculine, feminine or neuter gender, they shall be construed as though they were also used in another gender in all cases where

they would so apply, and whenever any words are used herein in the singular or plural form, they shall be construed as though they were also used in the other form in all cases where they would so apply.

7.3 Written Document

This Plan, in conjunction with any separate written document which may be required by law, is intended to satisfy the written Plan requirement of Code Section 105 and any Treasury regulations thereunder.

7.4 Exclusive Benefit

This Plan shall be maintained for the exclusive benefit of the Employees who participate in the Plan.

7.5 Participant's Rights

This Plan shall not be deemed to constitute an employment contract between the Employer and any Participant or to be a consideration or an inducement for the employment of any Participant or Employee. Nothing contained in this Plan shall be deemed to give any Participant or Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Participant or Employee at any time regardless of the effect which such discharge shall have upon him as a Participant of this Plan.

7.6 Action by the Employer

Whenever the Employer under the terms of the Plan is permitted or required to do or perform any act or matter or thing, it shall be done and performed by a person duly authorized by its legally constituted authority.

7.7 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 the Plan will be excludable from the Participant's gross income for federal or state income tax purposes, or that any other federal or state tax treatment will apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether each payment under the Plan is excludable from the Participant's gross income for federal and state income tax purposes, and to notify the Employer if the Participant has reason to believe that any such payment is not so excludable. Notwithstanding the foregoing, the rights of Participants under this Plan shall be legally enforceable.

7.8 Indemnification of Employer by Participants

If any Participant receives one or more payments or reimbursements under the Plan that are not for a permitted Medical Expense such Participant shall indemnify and reimburse the Employer for any liability it may incur for failure to withhold federal or state income tax or Social Security tax from such payments or reimbursements. However, such indemnification and reimbursement shall not exceed the amount of additional federal and state income tax (plus any penalties) that the Participant would have owed if the payments or reimbursements had been made to the Participant as regular cash compensation, plus the Participant's share of any Social Security tax that would have been paid on such compensation, less any such additional income and Social Security

tax actually paid by the Participant.

7.9 Funding

Unless otherwise required by law, the Employer will maintain a separate account for the benefit of Participants and the plan. 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 other than from the account in which any payment under the Plan may be made.

7.10 Governing Law

Except to the extent that this Plan is governed by federal law, this Health Plan shall be construed, administered, enforced and governed by and in accordance with the applicable laws of the State of Oregon, even if Oregon's choice of laws otherwise would require application of the law of a different jurisdiction

7.11 Severability

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

7.12 Headings

The headings and subheadings of this Plan have been inserted for convenience of reference and are to be ignored in any construction of the provisions hereof.

7.13 Continuation of Coverage

Notwithstanding anything in the Plan to the contrary, in the event any benefit under this Plan subject to the continuation coverage requirement of Code Section 4980B becomes unavailable, each qualified beneficiary (as defined in Code Section 4980B) will be entitled to continuation coverage as prescribed in Code Section 4980B.

7.14 Family and Medical Leave Act

Notwithstanding anything in the Plan to the contrary, in the event any benefit under this Plan becomes subject to the requirements of the Family and Medical Leave Act and regulations thereunder, this Plan shall be operated in accordance with Regulation 1.125-3.

7.15 Health Insurance Portability and Accountability Act

Notwithstanding anything in this Plan to the contrary, this Plan shall be operated in accordance with HIPAA and regulations thereunder.

7.16 Uniformed Services Employment and Reemployment Rights Act

Notwithstanding any provision of this Plan to the contrary, contributions, benefits and service credit with respect to qualified military service shall be provided in accordance with USERRA and the regulations thereunder.

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EXHIBIT C

City of Portland
HEALTH EXPENSE REIMBURSEMENT ACCOUNT

SUMMARY PLAN DESCRIPTION

Effective January, 2017

City of Portland
Health Expense Reimbursement Account
Summary Plan Description

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City of Portland
Health Expense Reimbursement Account
Summary Plan Description

Article I
Introduction

The City of Portland (the Employer) is pleased to provide the City of Portland Health Expense Reimbursement Account (the "Plan"), commonly known as the Voluntary Retirement Incentive Program (VRIP) for eligible retirees. Under federal tax law, the HRA Plan is known as a "Health Reimbursement Arrangement" or "HRA Plan".

This Summary Plan Description describes the basic features of the HRA Plan, how it operates, and how you can get the maximum advantage from it. This is only a summary of the key parts of the HRA Plan. If there is a conflict between the official, complete Health Expense Reimbursement Account Plan Document and this summary, the official Plan Document will control. Definitions of terms used in this summary are contained in Article II of the Health Expense Reimbursement Account Plan Document.

ARTICLE II
PARTICIPATION IN YOUR PLAN

What is the purpose of the HRA Plan?
The purpose of the HRA Plan is to reimburse eligible retirees, up to certain limits, for their own and their covered spouse, eligible domestic partner (as defined by the Plan) or dependents medical care expenses. Reimbursements for medical care expenses paid by the HRA Plan generally are excludable from taxable income.

When did the HRA Plan take effect?
The HRA Plan became effective on May 1, 2013, was amended by Council January 13, 2016 and amended by Council again in 2017.

Who can participate in the HRA Plan?
Participation is described in the Voluntary Retirement Incentive Program document, Exhibit A

What Benefits are offered through the HRA Plan?
Once you become a participant, The HRA Plan will maintain an "HRA Account" in your name to keep a record of the amounts available to you for the reimbursement of eligible medical care expenses. Your HRA Account is merely a recordkeeping account; it is not funded (all reimbursements are paid from the general assets of the Employer, and it does not bear interest or accrue earnings of any kind). Benefits must first be reimbursed from any health insurance plan before any benefits are payable from the HRA Plan. Your HRA Account will be credited with the appropriate contributions as outlined in the Voluntary Retirement Incentive Program document, Exhibit A once you become a participant in the HRA Plan. Your HRA Account will be reduced by any amount paid to you, or for your benefit, for eligible medical care expenses. At the end of the plan year, the unused amount (if any) will remain available in the next plan year.

Are there any limitation on benefits available from the HRA Plan?
Only medical care expenses are covered by the HRA Plan. A medical care expense is an expense that is related to the diagnosis, care, mitigation, treatment, or prevention of disease. Some examples of eligible medical care expenses are (a) prescription and over-the counter drugs and medicines; (b) dental expenses; (c) dermatology; (d) physical therapy; and (e) contact lenses or glasses used to correct vision impairment. Medical care expenses include COBRA premiums, co-payments, and deductibles. You may also use your HRA Account to cover Medicare Part B premiums, Medicare Advantage Plan premiums, Medicare Supplement Plan premiums, and the City of Portland Retiree Health Plan premiums.

When must the Medical Care Expenses be incurred for the HRA?
For medical care expenses to be reimbursed to you from your HRA Account, they must be incurred after you become a participant in the HRA Plan. The plan year for the HRA is a 12-month period commencing **July 1st** and ending on **June 30th.** A medical care expense is incurred when the service that causes the expense is provided, not when the

expense was paid. If you have paid for the expense but the services have not yet been rendered, then the expense has not been incurred.

How will the HRA Plan Work?
The HRA Plan will reimburse you for eligible medical care expenses to the extent that you have a positive balance in your HRA Account. The following procedure should be followed:

- You must submit a claim to BenefitHelp Solutions and provide any additional information requested by BenefitHelp Solutions;
- A request for payment must relate to medical care expenses incurred during the time you were a participant under this HRA Plan.

Claims must be submitted in writing. BenefitHelp Solutions may require that participants submit claims on a form provided by BenefitHelp Solutions. The claim must set forth:

- The individual(s) on whose behalf the medical care expenses were incurred;
- The nature and date of the medical care expenses so incurred;
- The amount of the requested reimbursement.

Each claim must be accompanied by bills, invoices, Explanation of Benefits (EOBs) from the Medical Insurance Plan, or other statements from an independent third party (e.g. a hospital, physician, or pharmacy) showing that the medical care expenses have been incurred and showing the amounts of such medical care expenses, along with any additional documentation that BenefitHelp Solutions may request.

How long will the HRA Plan remain in effect?
The Employer is establishing this Plan with the intent that it will be maintained until June 30, 2021. This period may be amended, changed or extended. Notwithstanding the foregoing, the Employer has no obligation to maintain the Plan or any component, and reserves the right to amend, change, terminate or cancel the Plan described herein, and provisions, in any manner at any time, subject to the Employer's obligations under the public employees collective bargaining act, provided however, that no amendment, change or termination shall reduce or eliminate benefits retroactively. If the plan is amended or terminated, it will not affect coverage for the services provided prior to the effective date of the change.

For any new participants beginning calendar year 2017, this Plan will be maintained until June 30, 2022. This period may be amended, changed or extended. All other provisions of this Plan remain as written.

Are my benefits taxable?
The HRA Plan is intended to meet certain requirements of existing federal tax laws, under which the benefits that you receive under the HRA Plan are generally not taxable to you. However, the employer cannot guarantee the tax treatment to any given participant, since individual circumstances may produce differing results. If there is any doubt, you should consult your own tax adviser.

What happens to my HRA Account should I die?
In the case of the death of the Participant where there is no surviving Spouse, eligible Domestic Partner and/or eligible Dependent, Eligible Medical Expenses incurred by the Participant prior to his or her death may be submitted within 120 days following the date of death for reimbursement up to the account balance. If there is no Spouse, eligible Domestic Partner or eligible Dependent at the time of the Participant's death, the account balance, if any, is forfeited (reduced to zero).

In the case of the death of the Participants where there is a surviving Spouse, eligible Domestic Partner and/or eligible Dependent, the Spouse, eligible Domestic Partner and/or eligible Dependent shall have the right to submit claims for reimbursement, and receive benefits hereunder, for any Eligible Medical Expenses arising during the Coverage Period at any time prior to the expiration of the earlier of (1) exhaustion of the account balance; or (2) the end of the plan year in which the Participant deceased. If there remains an account balance after the expiration of the condition (2), above, then the account balance is forfeited (reduced to zero)

What happens if my claim for benefits is denied?
If your claim is denied in whole or in part, you will be notified in writing by BenefitHelp Solutions within 30 days after the date BenefitHelp Solutions received your claim.

Notification of a denied claim will set out:

- A specific reason or reasons for the denial;
- The specific plan provision on which the denial is based;
- A description of any additional material or information necessary for you to validate the claim and an explanation of why such material or information is necessary;
- Appropriate information on the steps to be taken if you wish to appeal BenefitHelp Solutions' decision, including your right to submit written comments and have them considered, your right to review (upon request and at no charge) relevant documents and other information, and your right to file suit with respect to any adverse determination after appeal of your claim.

Appeals
If your claim is denied in whole or part, then you (or your authorized representative) may request review upon written application to the "Appeals Committee". Your appeal must be made in writing within 180 days after your receipt of the notice that the claim was denied. If you do not appeal on time, you will lose the right to appeal the denial and the right to file suit in court. Your written appeal should state the reasons that you feel your claim should not have been denied. It should include any additional facts and/or documents that you feel support your claim. You will have the opportunity to ask additional questions and make written comments, and you may review (upon request and at no charge) documents and other information relevant to your appeal.

Decision on Review
Your appeal will be reviewed and decided by the Committee or other entity designated in the Plan in a reasonable time not later than 60 days after the Committee receives your request for review. The Committee may, in its discretion, hold a hearing on the denied claim. Any medical expert consulted in connection with your appeal will be different from and not subordinate to any expert consulted in connection with the initial claim denial. The identity of a medical expert consulted in connection with your appeal will be provided. If the decision on review affirms the initial denial of your claim, you will be furnished with a notice of adverse benefit determination on review setting forth:

The specific reason(s) for the decision on review;

- The specific plan provision(s) on which the decision is based;
- A statement of your right to review (upon request and at no charge) relevant documents and other information;
- If an "internal rule, guideline, protocol, or other similar criterion" is relied on in making the decision on review, then a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request; and
- A statement of your right to bring suit.

What are my HIPAA Privacy Rights?
Except for certain permitted uses and disclosures, the Privacy Rule issued by the federal government prohibits the HRA Plan from using or disclosing certain health information about you that is created or received by the HRA Plan without your written authorization. If you wish to authorize the HRA Plan to use or disclose your Personal Health Information (PHI) in a manner that is not otherwise permitted, you must submit a signed and completed authorization form to the HRA Plan. You may request a copy of the authorization form from Human Resources.

The HRA Plan is permitted under the Privacy Rule to use or disclose your PHI without your authorization only for purposes related to:

- Health care treatment;
- Payment for health care;
- Health care operations; and
- Other specifically permitted exceptions, such as disclosures to assist disaster relief, disclosures to lessen serious health or safety threats, or disclosures to business associates.

After the Employer has certified to the HRA Plan that it is in compliance with the Privacy Rule, the HRA Plan may disclose PHI to the Employer without your authorization to the extent that the PHI is necessary for the Employer to perform HRA Plan administration functions. The HRA Plan may not disclose any more PHI to the Employer than is necessary for the Employer to fulfill its administration functions, and the HRA Plan may

not disclose PHI to the Employer for purposes of any employment-related actions or in connection with any other employee benefit provided by the Employer.

To the extent that your PHI is disclosed to the Employer, the Employer will:

- Not use or further disclose PHI other than as permitted or required by the official HRA Plan document or as required by law;
- Ensure that any agents to whom the Employer provides PHI (or certain Electronic Protected Health Information (EPHI)) received from the HRA Plan agree to the same restrictions and conditions that apply to the Employer with respect to PHI:
  - Not use or disclose PHI for employment-related actions and decisions unless authorized by you;
  - Not use or disclose PHI in connection with any other benefit provided by the Employer unless authorized by you;
  - Report to the HRA Plan's Privacy Officer any misuse or improper disclosure of PHI;
  - Make PHI available to you in accordance with the requirements of the Privacy Rule;
  - Make PHI available to you for amendment and incorporate any amendments to PHI in accordance with the requirements of the Privacy Rule;
  - Make available to you the information required to provide an accounting of disclosures in accordance with the requirements of the Privacy Rule;
  - Make internal practices, books, and records relating to the Employer's use and disclosure of PHI available to the Secretary of Health and Human Services for the purposes of determining the HRA Plan's compliance with HIPAA; and
  - If feasible, return or destroy all PHI received from the HRA Plan that the Employer still maintains in any form, and retain no copies of the PHI, when the PHI is no longer needed for the purpose for which the 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)

The Employer may only disclose your PHI to the following employees and may only do so to the extent that the employees perform HRA Plan administration functions:

- Employees in the Employer's Human Resources Department; and
- Employees in the Employer's Office of General Counsel.

If an employee does not comply with the requirements of the Privacy Rule, then the Employer may apply appropriate sanctions to the employee in order to ensure compliance with the Privacy Rule. If you become aware of any inappropriate use or improper disclosure of PHI, contact the Employer immediately.

ARTICLE III
GENERAL INFORMATION

General Plan Information

- Plan Name: **City of Portland Retirement HRA Plan**
- Plan Number: 501

- Effective Date: **May 1, 2013**
- Plan Year: **July 1st** to **June 30th.** Your HRA Plan's records are maintained on this **12-month** period of time.
- Type of Plan: Welfare Plan
- Your HRA Plan shall be governed by the Laws of the **State of Oregon**

Employer/Plan Sponsor/Administrator Information
Name and Address:
City of Portland
1120 SW 5th Avenue, Suite 404
Portland, OR 97204

Federal Employer Tax Identification Number (EIN): **93-6002236**

Third Party Administrator Information
Name, address, and business telephone number:
BenefitHelp Solutions
PO Box 67230
Portland, OR 97268-1230
(888) 398-8057

The Plan Administrator appoints the BenefitHelp Solutions to keep the records for the HRA Plan and to be responsible for the administration of the HRA Plan. However, the Appeals Committee acts on behalf of the Plan Administrator with respect to appeals. The BenefitHelp Solutions will answer any questions that you may have about the HRA Plan. You may contact the BenefitHelp Solutions at the above address for any further information about the plan.

Funding and Type of Plan Administration
The HRA is a group health plan and is self-funded by the Employer. This is a contract administration plan. A third-party administrator processes claims for the HRA Plan. All of the amounts payable under this plan may be paid from the general assets of the Employer. Nothing herein will be construed to require the Employer or the Plan 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,

Named Fiduciary
The named fiduciary for the HRA Plan is:
City of Portland

Agent for Service of Legal Process
City of Portland
1120 SW 5th Avenue, Suite 404
Portland, OR 97204