EXHIBIT D

CAFETERIA PLAN

CHAPTER 1

1.0 GENERAL PROVISIONS

1.01 Establishment of Plan

1.03.010 The City of Portland (the "City") hereby amends and restates the City of Portland Cafeteria Plan (the "125 Plan") which includes Component Plans of the 125 Plan, effective July 1, 20xx (the "Effective Date"). Capitalized terms used in this 125 Plan that are not otherwise defined shall have the meanings set forth in Chapter 2.

1.03.020 This 125 Plan is designed to permit an Eligible Employee to elect various benefit components, and to pay for those Components with a combination of Employer and Employee contributions. Employee contributions may be paid on a pre-tax Salary Reduction basis or with after-tax deductions, as permitted under the Internal Revenue Code and this 125 Plan for the applicable Component Plan.

1.03.030 This 125 Plan is intended to include a Cafeteria Plan that qualifies under the Internal Revenue Code of 1986, as amended (the "Code"), and regulations issued thereunder and shall be interpreted to accomplish that objective.

1.03.040 The Premium Payment component is intended to qualify as a salary reduction plan under Code Section §125 to permit employees to pay their share of the rates or premiums for their medical, dental and/or vision benefits.

1.03.050 The Medical Expense Reimbursement Plan (""MERP"") Component is intended to qualify as a "self-insured medical reimbursement plan" under the Code, and the expenses reimbursed thereunder are intended to be eligible for exclusion from participating Employee's gross income under Code §105(b).

1.03.060 The Dependent Care Assistance Plan (""DCAP"") component is intended to qualify as a "dependent care assistance plan" under the Code, and the Dependent Care Expenses reimbursed thereunder are intended to be eligible for exclusion from participating Employees' gross income under Code § 129(a).

1.03.070 Although reprinted within this document, the Premium Payment Component, the ""MERP"" Component and the ""DCAP"" Component are separate plans for purposes of administration and all reporting and

nondiscrimination requirements imposed by Code §§§ 105, 125 and 129. The "MERP" Component is also a separate plan for purposes of the provisions of Employee Retirement Income Security Act of 1974 (ERISA) and Comprehensive Omnibus Budget Reconciliation Act of 1985, as amended (COBRA) as applicable to Government Plans by the Public Health Services Act (PHSA).

1.02 Governing Law

Except to the extent that this 125 Plan or any of its Component Plans are governed by federal law, this 125 Plan and all of its Components 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.

1.03 Plan Year

Plan year shall mean the 12 month period beginning July 1 and ending June 30 each year.

1.04 Plan Limitations

Nothing contained in this 125 Plan or any of its Components shall be deemed to give any Participant the right to be retained in the service of the City or to interfere with the right of the City to discharge any Participant at any time regardless of the effect which such discharge shall have upon such Employee as a Participant under this 125 Plan. The City of Portland does not guarantee benefits payable under any insurance policy or other similar contract described or referred to herein, and any benefits thereunder shall be the exclusive responsibility of the insurer or other entity that is required to provide such benefits under such policy or contract.

1.05 Plan Amendments and Termination

The 125 Plan was established with the bona fide intention that it will be continued indefinitely, but the City has no obligation to maintain the 125 Plan or any Component, and reserves the right to amend, change, terminate or cancel the 125 Plan described herein, or any of its Components and provisions, in any manner at any time, subject to the City'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 125 Plan is amended or terminated it will not affect coverage for services provided prior to the effective date of the change.

1.06 Non-Assignability

Except as otherwise provided by law, the benefits provided to Participants hereunder shall not be subject to assignment, anticipation, alienation, attachment, levy or transfer and any attempt to do so shall not be recognized.

1.07 Administrator

The 125 Plan and its Components shall be administered by the Administrator described in Chapter 2.01. The Administrator shall have responsibility for the general operation of the 125 Plan and its Components and shall have the power and duty to decide all questions arising in connection with the administration, interpretation and application of the 125 Plan and its Component Plans and shall take all actions and make all decisions that shall be necessary to carry out the provisions of these Component Plans, including but not limited to:

1.07.01 Determining an employee's eligibility to participate in any Components authorized by the 125 Plan;

1.07.02 Promulgating rules of procedure and keeping records necessary for the proper and efficient administration of the 125 Plan;

1.07.03 Advising the insurers and third party administrators with respect to Participants and with respect to contributions made on behalf of Participants;

1.07.04 Furnishing the City Council, Participants and insurers with information they may require;

1.07.05 Engaging the services of such agents as the Administrator may deem advisable to assist or perform the Administrator's duties;

1.07.06 Consulting with the City Attorney with respect to the meaning or construction of the 125 Plan and its Component Plans and the Administrator's duties thereunder;

1.07.07 Assuming responsibility for all applicable reporting and disclosure requirements and engaging the service of agents to assist with reporting and disclosure requirements, and

1.07.08 The Administrator will be deemed to have properly exercised such discretionary authority unless the Administrator has abused his or her discretion hereunder by acting arbitrarily and capriciously.

1.08 Plan Notification

Reasonable notification of the availability and terms of the 125 Plan and its Components shall be provided to all eligible Employees of the City by the Administrator.

1.09 Tax Effects

Neither the Employer nor the Administrator makes any warranty or other representation as to whether any pre-tax contributions made to or on behalf of any Participant hereunder will be treated as excludable from gross income for local, state, or federal income tax purposes. If for any reason it is determined that any amount paid for the benefits of a Participant or Beneficiary is includible in an Employee's gross income for local, federal, or state income tax purposes, then under no circumstances shall the recipient have any recourse against the Administrator or the Employer with respect to any increased taxes or other losses or damages suffered by the Employees as the result thereof. The 125 Plan and its applicable Components are designed and intended to be operated as a Cafeteria Plan under Code section 125.

1.10 Social Security Impact

Participation in the 125 Plan may reduce the amount of an Employee's taxable compensation. Accordingly, there could be a decrease in the Employee's Social Security benefits.

CHAPTER 2

2.0 DEFINITIONS

2.01 Definitions. As used in the City of Portland Section 125 Plan and any of its Component Plans:

2.01.01 "Administrator" shall mean the Manager, Benefits of the City of Portland.

2.01.02 "Annual Enrollment Period" or "Annual Enrollment" shall mean the period immediately preceding the period of benefit coverage, generally during a portion of May and June of each year, designated by the Administrator during which an Employee may file or amend his or her benefit election form.

2.01.03 "Benefit Election Forms" shall mean the forms, including electronic enrollment forms, promulgated by the Administrator by which an Eligible Employee elects the Components of his or her choice pursuant to this plan.

2.01.04 "Change In Status" means an event that allows a Participant to make changes in his or her benefit elections as defined in Chapter 4. Changes made to coverage and elections must be consistent with and on account of the specific family status changes.

2.01.05 "City" shall mean the City of Portland, Oregon.

2.01.06 "Code" shall mean the Internal Revenue Code of 1986, as amended, and the regulations issued thereunder. References to a Code section shall be deemed to be to that section as it now exists and to any successor provision.

2.01.07 "Component Plan" or "Component" means the Premium Payment Plan, the Medical Expense Reimbursement Plan ("MERP") and the Dependent Care Expense Reimbursement Plan ("DCAP").

2.01.08 "Council" shall mean the members of the City Council of the City of Portland, Oregon.

2.01.09 "Dependent," shall mean for purposes of the premium payment plan and the MERP , as defined below. Proof of a dependent's initial eligibility and continued eligibility may be requested at any time. Enrollees must be able to provide proof of eligibility for continued coverage. Failure to provide proof of dependent status will result in loss of dependent coverage.

A. Legal spouse as recognized by the employee's state of residence. A divorced or legally separated spouse is not eligible for City paid coverage;

B. Domestic partner as defined and declared in the City of Portland's Domestic Partner Affidavit or who is a registered domestic partner as per the Oregon Family Fairness Act of 2007.

C. Child under the age of 26 including the participant's:

1. Natural child,
2. Stepchild, if the employee's spouse is primarily responsible for financial support,
3. Child who is required to be covered by participant or participant's spouse as a result of divorce decree or court order to provide coverage.
4. Adopted child or child placed for adoption, or
5. Other child for whom the employee is the court-appointed legal guardian,
6. Eligible child of an enrolled domestic partner (as declared on the Domestic Partner Affidavit).

D. A newborn child of an Enrolled Dependent for the first 31 days of the newborn's life, but only if the employee is financially responsible for both the newborn and the enrolled dependent. After 31 days, the child of your Enrolled Dependent may be covered only as long as the the child's parent is the Employee's eligible and Enrolled Dependent and both grandchild and birth parent reside in the Employee's home.

E. Incapacitated and dependent children may be covered past the qualifying age of 26 if the incapacitating condition existed prior to the child's first birthday after the qualifying age. An incapacitated child is one who is incapable of self-support because of developmental or physical disability. The disabled child will be covered as long as the child has a Determination of Disability under the Social Security Act, continues to reside with and be primarily supported by the employee.

2.01.10 "Dependent," for purposes of the Dependent Care Assistance Plan, means any individual who is (a) a dependent of the Participant who is under the age of 13 and with respect to whom the Participant is entitled to an exemption under Code Section 151(c), or (b) a dependent or spouse of the Participant who is physically or mentally incapable of caring for himself or herself; provided, however, that in the case of a divorced Employee, Dependent shall be as defined in Code Section 21(e)(5) (e.g. dependent of the parent with custody). For purposes of the Premium Payment Plan and the "MERP", dependent shall mean a Participant's spouse, children and parents of the Participant of his or her spouse, who qualify as dependents under Code Section 152 (as modified by Section 105(b) and § 152(a)) or dependents of employees no longer qualified as dependent participants under City medical, dental, or vision plans but still qualified as an employee's federal tax dependent for health coverage purposes..

2.01.11 "Dependent Care Account" means the Dependent Care Account established pursuant to Chapter 7.

2.01.12 "Dependent Care Assistance Plan" means the Dependent Care Assistance Plan established pursuant to Chapter 7.

2.01.13 “Dependent Care Expenses” means a Participant’s incurred expenses which (a) are incurred for the care of a Dependent, (b) are paid or payable to a Dependent Care Service Provider and (c) are incurred to enable the Participant to be gainfully employed for any period during which the Participant has one or more Dependents. “Dependent Care Expenses” shall not include (i) amounts paid for services at an overnight camp, or (ii) expenses incurred for services outside the Participant’s household for the care of a Dependent unless such Dependent is described in (a) above (under the definition of Dependent) or regularly spends at least eight (8) hours each day in the Participant’s household.

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

2.01.15 “Effective Date” of this amendment and restatement is July 1, 2011.

2.01.16 "Eligible Employee" means a full-time permanent or temporary employee appointed from an eligible list or appointed to an exempt position in a budgeted full-time position who is regularly scheduled to work at least 72 hours in a biweekly payroll period; a permanent part-time employee appointed from an eligible list or appointed to an exempt position who is regularly scheduled to work at least 40 hours but less than 72 hours in a biweekly payroll period, or a Laborers’ Local 483 seasonal maintenance worker who is paid at least 40 hours in a month excluding any hours paid from a third pay period in a month and otherwise meets the eligibility requirements in Chapter 3 . The term Employee does not include an independent contractor.

2.01.17 “Employee” shall mean an elected official of the City, a non-represented employee of the City of Portland, a City employee in the bargaining unit represented by the City of Portland Professional Employees Association (COPPEA), a member of the Bureau of Police in the bargaining unit represented by the Portland Police Commanding Officers Association (PPCOA), those members of the Bureau of Fire, Rescue and Emergency Services in the bargaining unit represented by the Portland Fire Fighters Association (PFFA), those members of the Bureau of Police in the bargaining unit represented by the Portland Police Association (PPA), those members of the Bureau of Emergency Communications in the bargaining unit represented by AFSCME Council 75 Local 189, those members of the District Council of Trade Unions, those members in the bargaining unit represented by Laborers’ Local 483 Recreation Employees and those members represented by Laborers’ Local 483 Seasonal Maintenance Workers. The term “Employee” does not include an independent contractor.

2.01.18 “Employee Contribution” shall mean the portion of the plan costs paid by the Employee or other eligible participant.

2.01.19 "Employer Contribution" shall mean the portion of the plan costs paid by the City.

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

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

2.01.22 "Initial Enrollment" means the period immediately preceding the date on which the Participant commences participation in the Plan.

2.01.23 "Insurer" shall mean an insurance company duly licensed to do business in Oregon.

2.01.24 "Medical Expenses" means amounts paid for medical care as defined in Code Section 213(d) for the Participant, his or her spouse and/or Dependents.

2.01.25 "Medical Expense Reimbursement Plan" means the Medical Expense Reimbursement Plan established pursuant to Chapter 8.

2.01.26 "Participant" shall mean an Employee who currently meets the eligibility requirements of Chapter 3 of this document and enrolls in the Plan or a Component Plan.

2.01.27 "Part-time Employee" shall mean for purposes of the 125 Plan, an employee in a benefit eligible employee status and job class or equivalent designation and who is regularly scheduled to work the Standard Hours Designation of at least 40 hours but less than 72 hours in a biweekly payroll period.

2.01.28 "Plan" shall mean City of Portland Cafeteria Plan and all of its Component Plans included in this City of Portland Plan document.

2.01.29 "Plan Year" means the 12 month period beginning July 1 and ending June 30 each year.

2.01.30 "Qualified Benefits" means for Eligible Employees of BOEC, COPPEA, DCTU, PFFA, PPCOA, Recreation employees for the Plan Year commencing on July 1, 2011, and subsequent plan years.

A. The Kaiser NW Health Plan of Oregon, group medical and hospital service agreement, including Kaiser optical plan, as amended from time to time.

B. The City of Portland CityCore medical plan and Vision Service Plan as amended from time to time.

C. The Kaiser NW Foundation Health Plan of Oregon group dental services plan, as amended from time to time.

D. Oregon Dental Service Plan, as amended from time to time.

E. Dependent Care Assistance Plan ("DCAP") in Chapter 7.

F. Medical Expense Reimbursement Plan ("MERP") in Chapter 8.

G. Group Term Life Insurance in the amount designated by the appropriate collective bargaining agreement.

H. Long-term disability insurance for BOEC, COPPEA, DCTU, PPCOA and Recreation employees,.

2.01.31 "Qualified Benefits" mean for Eligible non-represented Employees for the Plan Year commencing on July 1, 2011 and subsequent plan years.

A. The Kaiser NW Health Plan of Oregon, group medical and hospital service agreement, including Kaiser optical plan, as amended from time to time.

B. The City of Portland CityCore medical plan and Vision Service Plan as amended from time to time.

D.. The Kaiser NW Foundation Health Plan of Oregon group dental services plan, as amended from time to time.

E.. Oregon Dental Service Plan, as amended from time to time.

F. Dependent Care Assistance Plan ("DCAP") in Chapter 7.

G. Medical Expense Reimbursement Plan ("MERP") in Chapter 8.

H. Group Term Life Insurance at one-time the employee's annual salary to a maximum of $50,000.

I. Long-term Disability Insurance.

2.01.32 "Qualified Benefits" means for Eligible Employees of the PPA for the Plan Year commencing on July 1, 2011 and subsequent plan years.

A. The Kaiser Health Plan of Oregon, group medical and hospital service

agreement, including Kaiser optical plan, as amended from time to time.

B. The City of Portland CityNet medical plan and Vision Service Plan, as amended from time to time.

C. Oregon Dental Service Plan, as amended from time to time..

D. The Kaiser Foundation Health Plan of Oregon group dental services plan, as amended from time to time.

E. Dependent Care Assistance Plan ("DCAP") in Chapter 7.

F. Medical Expense Reimbursement Plan ("MERP") in Chapter 8.

G. Group Term Life Insurance in the amount of $50,000.

2.01.33 "Qualified Benefits" means for Eligible Employees of the Laborers' Local 483 Seasonal Maintenance Workers for the Plan Year commencing on July 1, 2011 and subsequent plan years.

A. The City of Portland Seasonal Maintenance Worker medical plan, as amended from time to time.

2.01.34 "Qualifying Individual" means a dependent of the Participant who is under the age of 13 and for whom the Participant is entitled to a deduction for a personal exemption under Code Section 151(c).

2.01.35 "Salary Reduction Agreement" means a written or electronic agreement or collective bargaining agreement provision by which a Participant elects to reduce his or her compensation or to forego increases in compensation and directs the City to contribute such amounts, on behalf of the Participant, toward the cost of electing, purchasing or funding one or more Component Plans. Such agreement relates to compensation that has not been actually or constructively received by the Participant as of the date of the agreement and, subsequently, does not become currently available.

2.01.36 "Third Party Administrator" a company the City contracts to provide customer service and claims payment or reimbursement for the City's self-insured medical plans and the City's flexible spending account plans i.e. the Medical Reimbursement Plan ("MERP") and the Dependent Care Assistance Plan ("DCAP").

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CHAPTER 3

3.0 ELIGIBILITY AND PARTICIPATION

3.01 General

All Eligible Employees will become Participants during an Annual Enrollment Period or upon initially becoming eligible. If an Eligible Employee does not enroll within thirty-one (31) days of first becoming eligible, the Employee will be assigned default benefits as described in Chapter 6.02.

3.02 Initial Eligibility

3.02.01 Full-time and part-time non-represented, BOEC, COPPEA, DCTU, and Recreation employees shall become eligible to participate in the plan the first day of the month following the date of hire.

3.02.02 Full-time members of the PFFA, PPA and PPCOA shall become eligible to participate in the Plan the first day of the month following 30 days of eligible service.

3.02.03 Part-time members of the PFFA, PPA and PPCOA shall become eligible to participate in the Plan the first day of the month following 174 hours of eligible service.

3.02.04 Full time and part-time members of the Laborers' Local 483 Seasonal Maintenance Workers shall become eligible to participate in the Premium Payment component of the Plan if the employee worked as Seasonal Maintenance Worker during the prior calendar year; satisfies the eligibility waiting period of eighty (80) paid hours in a month after re-employment from the prior year (excluding hours paid in a third pay period in a month) and has been paid at least 80 hours in the next month (excluding hours paid in a third pay period in a month) or as otherwise defined within the collective bargaining agreement effective July 1, 2011.

3.03 Commencement of Participation

For Employees who meet the requirements of Chapter 3.02 on July 1 of a Plan Year, an Employee's eligibility to participate in the Plan will commence on that date.

3.03.01 For Employees who become Eligible Employees subsequent to the commencement of a Plan Year, participation will commence as of the first day of the month following the month in which the employee satisfies the

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applicable eligibility requirements of Chapter 3.02.

3.03.02 Eligible Employees must elect or purchase some or all of the Component Plans. If an Eligible Employee fails to file a Benefit Election Form within the time frame specified by the Administrator the Employee shall automatically be deemed to have purchased the applicable default Components described in Chapter 6.02.

3.04 On-Going Eligibility

3.04.01 City paid benefits will continue for non-represented, BOEC, COPPEA, DCTU, and Recreation employees each month in which they are actively employed in an eligible job class and status and working their regularly scheduled hours, or be in a qualified leave status for the City of Portland, unless otherwise provided by a labor agreement. Employees must make the required premium contribution.

3.04.02 To maintain eligibility, PFFA, PPA and PPCOA Employees must receive pay for a minimum of 80 hours each calendar month, or be in a qualified leave status, or as other wise provided by an applicable labor agreement. Pay includes compensation for hours worked, vacation leave, sick leave and comp time or otherwise provided under the applicable collective bargaining agreement. . Pay does not include lump sum payouts of vacation and/or sick leave.

3.04.03 To maintain eligibility, seasonal maintenance workers must have received at least 80 hours of qualifying pay in the 1st and 2nd pay periods of the prior month and make the required premium contribution. Qualifying pay must consist of regular work hours, holiday pay, or comp time paid for absence from regular work hours. No other type of pay or benefit applies to make up the paid hours required.

3.04.04 Employees who are on non-paid Military Leave or personal leave without pay do not receive City paid benefits.

3.04.05 Participants must enroll their eligible dependents in the Plan at the same time the Participant becomes first eligible for the Plan or during the Annual Enrollment Period except as allowed below:

A. New Spouse/Eligible Stepchildren may be added within 60 days from the date of marriage. Coverage will become effective the first of the month following the date the Participant adds the spouse/eligible stepchildren into the City's online enrollment system or files the required forms with the City's

Wellness and Benefits Office. The Participant is required to provide the Office a completed Affidavit of Benefit Eligible Dependent Status form, a copy of the marriage certificate, and/or a copy of a birth certificate for each child added (as applicable.) If the required documentation is not received within 30 days of the online election or filing of paper forms, coverage for the new spouse/eligible stepchildren will terminate retroactively back to the effective date of coverage and the Participant will be held financially responsible for any claims paid on their behalf.

B. Oregon State's Certificate of Registered Domestic Partnership. Coverage will become effective the first of the month following the date the Employee adds the spouse/eligible stepchildren into the City's online enrollment system or files the required forms with the City's Wellness and Benefits Office. A completed and notarized Affidavit of Benefit Eligible Dependent Status form for the Employee and partner (or a copy of the Oregon state Certificate of Registered Domestic Partnership) and a copy of a birth certificate for each child added (as applicable) must be filed with the City's Wellness and Benefits Office. If the Office does not receive the required documentation within 30 days of the election, coverage for the new partner/eligible stepchildren will terminate retroactively back to the effective date of coverage and the Employee will be held financially responsible for any claims paid on their behalf.

C. Newborn Children will be covered from birth and claims will be paid for the newborn for the first 30 days. The Employee must add the newborn into the City's online enrollment system or file the required forms with the City's Wellness and Benefits Office within 60 days of the birth for continued eligibility. The Employee is required to provide the Benefits & Wellness Office a copy of the hospital or state issued birth certificate. If the Office does not receive the required documentation within 30 days of the online election, coverage for the dependent may terminate retroactively back to the 31st day and the Employee will be held financially responsible for any claims paid on the child's behalf.

D. Adopted Children may be added within 60 days of being physically placed in the Employee's home. Coverage may begin the date the child was placed in the home if the employee is assuming and retaining a legal obligation for financial support of the child. The Employee must add the child into the City's online enrollment system or file the required forms with the City's Wellness and Benefits Office and submit a copy of the adoption or placement papers to the Benefits & Wellness Office. If the Office does not receive the required documentation within 30 days of the online election, coverage for the dependent may terminate retroactively back to the 31st day and the Employee will be held financially responsible for any claims paid on the child's behalf.

E. Newborn child of an Eligible Dependent Child will be covered from birth and claims will be paid for the dependent's newborn for the first 30 days. The Employee must add the child into the City's online enrollment system or file the required forms with the City's Wellness and Benefits Office for continued eligibility. The Employee is required to provide the Benefits & Wellness Office a copy of the hospital or state issued birth certificate. If the Office does not receive the required documentation within 30 days of the election, coverage for the Employee's dependent's child may terminate retroactively back to the 31st day and the Employee will be held financially responsible for any claims paid on the child's behalf.

F. Grandchild or other child may be added within 60 days from the date custody and guardianship are granted so long as the child qualifies as a dependent under the Plan. The employee must add the child into the City's online enrollment system or file the required forms with the City's Wellness and Benefits Office for continued eligibility and provide the Benefits & Wellness Office a copy of the court order granting custody and appointing the guardian and a copy of the letters of guardianship. If the Office does not receive the required documentation within 30 days of the election, coverage for the dependent may terminate retroactively and the Employee will be held financially responsible for any claims paid on the child's behalf.

G. Qualified Medical Child Support Order: If a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody requires health coverage for an employee's child, then the employee may change his or her election to (a) add coverage if the order requires coverage for the child under the employee's plan or (b) drop coverage if the order requires another individual to provide coverage for the child and the coverage is actually provided. If an election is not made by the employee, the Benefits & Wellness Office will add the child to the employee's coverage and will change any required premium share contribution.

H. HIPAA Special enrollment Rights: Mid year changes are allowed if: 1) an individual who was eligible for coverage but who did not enroll because of preexisting coverage under another health plan at the time of initial enrollment and subsequently lost the other coverage (and loss of coverage was due to reasons other than failing to pay premiums on a timely basis) and 2) an individual becomes a dependent through marriage, birth or adoption or placement for adoption after the initial enrollment period. A change in status form must be returned within 60 days.

I. Medicare or Medicaid: Mid year changes are allowed if a person becomes entitled to or loses entitlement to Medicare or Medicaid. A change in status form must be returned to the Wellness and Benefits Office within 60 days of

entitlement or loss of entitlement. Documentation from Medicare or Medicaid must be provided.

3.05 Termination

3.05.01 Participation in the Plan shall terminate when an individual ceases to be an Employee or when it is determined by the Administrator that the Employee no longer meets the eligibility criteria of Section 3.04 and/or fails to make the required premium contribution by the due date established by the Plan Administrator.

3.05.02City paid benefits for non-represented, BOEC, COPPEA, DCTU, and Recreation employees will end on the last day of the month in which an employee terminates employment, enters an unpaid status because of military leave or personal unpaid leave or is unable to meet the minimum work requirements within their job class and/or standard hours designation.

3.05.03Coverage for a non-represented, BOEC, COPPEA, DCTU, and Recreation employee and his/her eligible family members may be reinstated retroactively to the first of the month in which the employee returns to his/her regular work schedule.

3.05.04Coverage for, PFFA, PPA and PPCOA employees will end on the last day of the month in which an employee has been paid at least eighty (80) hours in the prior calendar month unless otherwise provided under an applicable labor agreement. The 80 hours of pay must consist of regular work hours, vacation, sick, holiday, jury duty pay or comp time paid for absence from regular work hours. No other type of pay or benefit applies to make up the hours required. Lump sum vacation or sick leave payments at retirement or termination, time loss payments for workers' compensation paid by Risk Management, disability payments from the Fire and Police Disability, Retirement and Death Benefit Plan or payments made pursuant to a long term disability plan do not count towards the 80 hour requirement.

3.05.05Any required catch-up premium contributions will be deducted from the first paycheck the employee receives upon returning to paid status unless other repayment arrangements have been made.

3.05.06Notwithstanding any provision to the contrary in the 125 Plan, to the extent required by COBRA, a Participant and his or her spouse and Dependents, whose coverage terminates under the "MERP" benefits because of a COBRA qualifying event, shall be given the opportunity

to continue on a self-pay basis the same coverage that he or she had under the Plan the day before the qualifying event for the periods prescribed by COBRA (subject to all conditions and limitations under COBRA).

3.06 Qualifying Leave Under Family Leave Act (FMLA)

3.06.01 Notwithstanding any provision to the contrary in the Plan, if a Participant goes on a qualifying leave under the Family and Medical Leave Act of 1993 (FMLA), then to the extent required by the FMLA, the Employer will continue to maintain the Participant's group health care plan benefits on the same terms and conditions as if the Participant were still an active Employee. That is, if the Participant elects to continue his or her coverage while on leave, the Employer will continue to pay its contribution share of the premium. If a Participant's coverage ceases while on FMLA leave, the Participant will be permitted to re-enter the Plan upon return from such leave on the same basis the Participant was participating in the Plan prior to the leave, or as otherwise required by the FMLA.

3.06.02 A Participant may elect to continue his or her coverage under the Premium Pay Component of the Plan during the FMLA leave. If the Participant falls into an unpaid status and elects to continue coverage while on leave, the Administrator may terminate medical, dental and vision benefits if the Participant fails to make the required premium contribution. The Administrator may fund coverage during the leave if the participant agrees to payment of "catch-up" amounts either through withholdings or an acceptable repayment schedule upon the Participant's return. During a FMLA leave, a Participant is eligible to participate in the Annual Enrollment Period.

3.06.03 Participant may elect to continue his or her coverage under the "MERP" Component of the 125 Plan during the FMLA leave. If the Participant falls into an unpaid status and elects to continue coverage while on leave, the Administrator may terminate the benefits if the Participant fails to make the required contribution. The Administrator may fund coverage during the leave if the participant agrees to the payment of "catch-up" amounts either through withholdings or an acceptable repayment schedule upon the Participant's return.

CHAPTER 4

4.0 METHOD AND TIMING OF ELECTIONS

4.03.010 A Participant's election of nontaxable benefits shall be via electronic form or in writing and filed with the Administrator on the prescribed Benefit Election Form during the Annual Enrollment Period and prior to the effective date of the election. The Participant shall execute such payroll reduction authorization as the Administrator shall require. When a new benefit is first offered under the Plan, the Participant may file an electronic or written election with respect to that benefit within an initial enrollment period established by the Administrator. Once an election is made under Section 4.0, the Participant may change that election only during a regular Annual Enrollment Period, except on the occurrence of an applicable Change in Status event.

4.03.020 Employees who become Eligible Employees subsequent to the expiration of the Annual Enrollment Period must elect Component Plans prior to the commencement of the payroll period in which their Plan coverage commences. After making an election of one or more Component Plans, a Participant may not revoke that election until the next Annual Enrollment Period after the period of coverage has commenced except if both the revocation and the new election are made on account of and are consistent with a qualifying Change in Status.

4.03.030 A Participant's election to apply his or her salary reduction to the payment of Component Plans will be irrevocable for the balance of the Plan Year, except in certain situations described in this Section 4.01.030. Any of the following election and revocations shall be made pursuant to procedures adopted by the Administrator and shall be effective no sooner than the first day of the payroll period coincident with or immediately following the date the Participant files a new election with the Administrator. An election change can be funded through pre-tax salary reduction only on a prospective basis, except for the retroactive enrollment rights under Code Section 9801(f), which applies in the case of an election made within 30 days of birth, adoption, or placement for adoption. A Participant otherwise entitled to make a new election under this Chapter must do so within sixty (60) days of the event. The circumstances under which a Participant may make a mid-year change of election vary with the type of Component Plan at issue, as follows:

1. Change in Status. A Participant may change an election during the Plan Year for Qualified Benefits under the Plan if a Change in Status has occurred and the requested election change is consistent

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with the Change in Status.

2. "Consistency" with the Change in Status requires that: (i) Change in Status affect coverage eligibility of a Participant, the Participant's spouse, the Participant's domestic partner or the Participant's Dependent under the 125 Plan or another plan offered by the employer of the Participant, spouse, or Dependent, and (ii) the election change be on account of and correspond with the Change in Status. The Administrator, in its sole discretion, shall determine whether an election change meets the consistency requirement based on prevailing IRS guidance.

(a) Loss of Eligibility due to Family Change. If the Change in Status is the Participant's divorce, annulment or legal separation from a spouse, then a Participant's election to cancel Qualified Benefits for any individual other than the spouse would not be consistent with the Change in Status unless they were the children of the former Spouse's or Domestic Partner's and not the children of the Participant. Similarly, if the Change in Status is the death of the Participant's spouse or Dependent, then a Participant's election to cancel Qualified Benefits for an individual other than that deceased spouse or deceased Dependent would not be consistent with the Change in Status. In addition, if one of the Participant's Dependents ceases to satisfy the eligibility requirements for Qualified Benefits coverage under the 125 Plan, the Participant's election to cancel Qualified Benefits for any other Dependent, for the Participant, or for the Participant's spouse would not be consistent with the Change in Status.

(b) Gain of Eligibility under Other Employer's Plan. If a Participant, a Participant's spouse, or a Participant's Dependent gains eligibility for coverage under a premium only plan offered by the employer of the Participant's spouse or Dependent as a result of a Change in Status that is a change in marital or employment status, then a Participant's election to cease or decrease coverage for the Participant, spouse or Dependent under the 125 Plan is consistent with the Change in Status only if coverage for that individual becomes applicable or is increased under the other employer's plan.

(c) COBRA or Continuation Coverage. If the Participant, or his or her spouse or Dependent becomes eligible for continuation coverage for Qualified Benefits, the Participant

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may elect to increase salary reduction contributions hereunder in order to pay for the continuation coverage.

(d) Health Insurance Portability and Accountability Act of 1996 ("HIPAA") Enrollment Rights. A Participant may revoke an election with respect to Qualified Benefits coverage and make a new election that corresponds with the Participant's special enrollment rights granted the Participant under Section 9801(f), whether or not the change in election is otherwise permitted under the Plan.

(e)FMLA Leave. A Participant who takes FMLA leave may revoke an existing election of Qualified Benefits coverage and make such other election for the remaining portion of the Plan Year as may be provided for under the FMLA.

(f)Judgments, Decrees and Orders. If a judgment, decree or order (an "Order") resulting from the divorce, legal separation, annulment, or change in legal custody requires accident or health coverage for a Participant's child or for a foster child who is a Dependent of the Participant, a Participant may change his or her election of Qualified Benefits coverage to: (a) provide coverage for the child (provided that the Order requires the Participant to provide coverage for the child under the Participant's Plan), or (b) cancel coverage for the child if the Order requires the spouse, former spouse, or other individual to provide coverage for the child, and that coverage is, in fact, provided.

(g) Medicare and Medicaid. If a Participant, spouse or Dependent who is enrolled in Qualified Benefits 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 make a prospective election change under the 125 Plan to cancel or reduce coverage for that Participant, spouse or Dependent under the 125 Plan. In addition, if a Participant, spouse, or Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, the Participant may make a prospective election to increase coverage for that Participant, spouse, or Dependent under the 125 Plan.

3. Changes in Cost.

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(a) Automatic Changes. If the cost of a Qualified Benefit increases (or decreases) during the Plan Year, and under the terms of the Component Plan, Participants are required to make a corresponding change in their payments, the Administrator will automatically make a prospective increase (or decrease) in affected Participants pre-tax salary reduction contributions to the 125 Plan.

(b) Significant Cost Changes. If the cost charged to a Participant for a Qualified Benefit significantly increases or significantly decreases during the Plan Year, the Participant may make a corresponding change in election. Changes that may be made include: (a) commencing participation hereunder for a Qualified Benefit with a decreased cost; or (b) revoking an election for the Qualified Benefit with an increased cost and, in lieu thereof, either receiving on a prospective basis coverage under another Qualified Benefit providing Similar Coverage or dropping coverage if no Similar Coverage is available. The Administrator, in its sole discretion, will decide whether an increase or decrease in cost is significant and whether Participants may change their election based on the cost change. "Similar Coverage" is defined in Section 5 (Definitions) below.

(c) If the amount charged to a Participant by a Dependent Care Provider significantly increases or decreases during the Plan Year, or if the Participant changes Dependent Care Providers resulting in a significant increase or decrease in costs, the Participant may revoke an election under the Dependent Care Assistance Plan and make a new election to reflect the increase or decrease in the Dependent Care Provider's cost. This subsection applies to the "DCAP" only if the cost change is imposed by a Dependent Care Provider who is not a relative of the Employee, as described in Code Section 152(a)(1) – (8).

4. Changes in Coverage

(a) Loss of Coverage. If a Participant, the Participant's spouse, Participant's domestic partner or the Participant's Dependent has a Loss of Coverage (as defined below) under a Qualified Benefit, the Participant may revoke his or her election under the 125 Plan for that Qualified Benefit, and, in lieu thereof, elect either to receive

coverage under another Qualified Benefit providing Similar Coverage or to drop coverage if no Similar Coverage is available.

If the Participant has a Loss of Coverage under the "DCAP", the Participant may revoke his or her election under the "DCAP" and, in lieu thereof, either make a new election under the "DCAP" to receive coverage through another Dependent Care Provider or drop coverage under the "DCAP".

(b) Significant Curtailment of Coverage. If a Participant, the Participant's spouse, the Participant's domestic partner or the Participant's Dependent has a Significant Curtailment of Coverage (as defined below) under a Qualified Benefit, which is not a Loss of Coverage then that Participant may revoke his or her election for that coverage and, in lieu thereof, receive coverage under another Qualified Benefit providing Similar Coverage.

If a Participant has a Significant Curtailment of Coverage (that is not a Loss of Coverage) under the "DCAP", then that Participant may revoke his or her election for that coverage and, in lieu thereof, make a new election under the "DCAP".

(c) Addition or Improvement of a Benefit Package Option. If, during the Plan Year, a new Qualified Benefit is offered, a new coverage option is added to a Qualified Benefit, or coverage under an existing Qualified Benefit is significantly improved, Eligible Employees and Participants may revoke their elections under the 125 Plan and, in lieu thereof, make new election on a prospective basis for coverage under the new or improved Qualified Benefit.

(d) No part of this Subsection (4) applies to the Medical Expense Reimbursement Plan.

5 Definitions. As used in this Subsection 4.01.030.

(a) "Loss of Coverage" means a complete loss of coverage under a Qualified Benefit or under the Dependent Care Assistance Plan (including elimination of a Qualified Benefit for purposes of the 125 Plan or loss of a Dependent Care Provider for purposes of the "DCAP"). In addition, the Administrator may, in its discretion, treat the following as a Loss of Coverage:

(i) A substantial decrease in the medical care providers available under the Qualified Benefit;

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

(iii) Any similar fundamental loss of coverage.

(b) "Significant Curtailment of Coverage" means an overall reduction in coverage provided under the Qualified Benefits or by a Dependent Care Provider under the "DCAP" so as to constitute reduced coverage generally. The Administrator, in it sole discretion, will determine whether a Significant Curtailment of Coverage has occurred, base on prevailing IRS guidance.

(c)"Similar Coverage" means coverage for the same category of benefits for the same individuals (e.g. family to family or single to single). For example, two plans that provide coverage for major medical care are considered Similar Coverage. Similar Coverage may be offered by a qualified plan of the Participant's spouse, domestic partner or Dependent's employer. The Administrator, in its sole discretion, will determine whether coverage is "similar" based on all the facts and circumstances.

(d) No part of this Subsection (5) applies to the Medical Expense Reimbursement Plan

6 Change in Coverage under Another Employer Plan.

(a) A Participant may make a prospective election change that is on account of and corresponds with a change made under a plan of the Participant's spouse's, domestic partner's or Dependent's employer ("Other Employer Plan"), so long as: (a) the Other Employer Plan permits its participants to make an election change that would be permitted under Code Section 125 and regulations issued thereunder: or (b) the 125 Plan permits Participants to make elections based on a coverage period that is different from the period of coverage under the Other Employer Plan. The Administrator shall determine, based on prevailing IRS guidance, whether a requested change is on account of and corresponds with a change made under the Other Employer Plan.

(b) No part of this Subsection (6) applies to the Medical Expense Reimbursement Plan.

7 Loss of Coverage Under Other Group Health Coverage.

(a) A Participant may elect on a prospective basis to add coverage under the Plan for the Participant or the Participant's spouse, domestic partner or Dependent if the Participant or the Participant's spouse or Dependent loses coverage under any group health coverage sponsored by a governmental or educational institution, including the following: (1) a State's children's health insurance program (SCHIP) under Title XXI of the Social Security Act; (2) a medical care program of an Indian Tribal government (as defined in section 7701(a)(40)), the Indian Health Service, or a tribal organization; (3) a State health benefits risk pool; or (4) a foreign government group health plan.

(b) No part of this subsection (7) applies to the Medical Expense Reimbursement Plan.

8. Duration of Plan Elections

(a) A Participant may not elect a Component Plan benefit for any period of time less than a Plan Year unless the Participant becomes eligible to enroll in the Plan during the Plan Year or makes an election on account of and consistent with a qualifying Change in Status during the Plan Year. Application to revoke and change elections in these circumstances must be made no later than 60 days of the date of the actual event giving rise to the Change in Status. Elections made pursuant to this Chapter shall be effective for the balance of the Plan Year following the change of election unless a subsequent event allows for a further election change, or as provided in Section 4.01.030, 2b for HIPAA special enrollment rights in the event of a 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 first day of the calendar month following the date that the election change was filed.) A Participant may also change elections each year during the Annual Enrollment Period by filing a new Benefit Election Form with the Administrator within the Annual Enrollment Period.

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CHAPTER 5

5.0 BENEFITS OFFERED AND FUNDING

5.01 Benefits Offered

When first eligible or during the Annual Enrollment Period as described in Chapter 3, Participants will be given the opportunity to elect one or more of the following Component Plans unless otherwise provided under a collective bargaining agreement:

(1) Premium Payment Benefits described in Chapter 6;

(2) Dependent Care Assistance Plan described in Chapter 7;

(3) Medical Expense Reimbursement Plan described in Chapter 8.

5.02 Funding

The Cafeteria Plan will be funded through Employer contributions by the City and/or salary reduction agreements between the Eligible Employee and the City.

5.02.010 Employer Contributions: The Employer may, but is not required to, make available contributions on behalf of Participants. The amount of the contributions shall be set forth in the annual enrollment materials. Contributions may either be limited to purchase of a particular Qualified Benefit, or they may be unrestricted, as described in the enrollment materials. The amount of the Contribution for each Participant shall be based on the Employee's standard hours designation as of May 1 of each year or as otherwise provided in the applicable collective bargaining agreement.

5.02.020 Employee Contributions: The Employer shall withhold from the Eligible Employees compensation on a pre-tax basis or with after-tax deductions an amount equal to the contributions required by the Eligible Employee for the Qualified Benefits elected less any applicable employer contribution allocable to such benefits. One twenty-fourth of the annual Employee required contribution to fund each Component Plan elected by the Employee shall be credited to the Employee's plan accounts the first and second pay period of each month. In the event of a shortage of reducible compensation, an amount deemed appropriate by the Administrator not to exceed the actual cost of the Employee election in a Plan Year shall be withheld from current and future compensation.

5.02.030 Opt-Out dollars. Opt-Out dollars are a residual benefit determined at initial election and enrollment and annually thereafter at the time of the Annual

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Enrollment Period and election. Opt-Out dollars are generated under the 125 Plan solely as a result of the Eligible Employees affirmative choice not to elect coverage for medical and vision plans under Chapter 6 for the Plan Year. Opt-Out dollars elected by an Employee shall be a fully taxable benefit unless used as contributions to the "MERP" or "DCAP".

CHAPTER 6

PREMIUM PAYMENT BENEFIT COMPONENT

6.0 BENEFITS

The medical, dental and vision benefits that are offered under the Premium Payment Component are the benefits under the Medical/Vision Plans (PPO and HMO options) and Dental Plans (PPO and HMO options) of the City of Portland Health Plan. Notwithstanding any other provision in the 125 Plan, the Medical and Dental Benefits are subject to the terms and conditions of those plans as provided in the City of Portland Health Plan and no changes can be made with respect to such Benefits (such as mid-year changes in elections) if such changes are not permitted under the City of Portland Health Plan.

Medical/Vision and Dental Benefits will be provided by the Medical/Vision and Dental Plans as provided in the City of Portland Health Plan, not this 125 Plan. The specific benefits, amounts of benefits, the participation requirements, and the other terms and conditions of coverage are set forth in the City of Portland Health Plan. All claims to receive benefits under the City of Portland Health Plan shall be subject to and governed by the terms and conditions of the City of Portland Health Plan and the rules, regulations, polices and procedures adopted in accordance therewith as may be amended from time to time.

6.01 FUNDING

The annual Contribution for a Participant's Premium Payment Benefits is equal to the amount as authorized by the City.

6.02 ELECTIONS

Eligible Employees can (a) elect benefits under the Premium Payment Component by electing to pay their share of the contributions to the applicable Medical/Vision and Dental Plans under the City of Portland Health Plan on a pre-tax Salary Reduction basis (Premium Payment Benefits) or (b) elect no benefits under the Premium Payment Component and to pay their share of the Contributions, if any for the Medical/Vision and Dental Benefits with after tax dollars outside of this 125 Plan. Unless an exception applies as described in Chapter 4, elections are irrevocable for the duration of the Period of Coverage to which it relates. All Qualified Benefits are optional Employee elections except as follows:

6.03.010 All Full-Time Participants except seasonal maintenance workers must elect a medical and vision plan from the menu unless the Employee provides evidence of enrollment in another Employer's group medical coverage. If the Participant elects Medical/Vision coverage, then the Participant must elect a Dental Plan. The determination to allow the Employee to opt-out of the City's medical coverage is made at the discretion of the Administrator after review of documentation that the Employee has coverage through another employer group medical plan. It shall be the responsibility of the Participant

to immediately notify the Administrator upon cessation of any such other group medical coverage as described in the initial or annual enrollment form or online enrollment system.

6.03.020 All Full-time and Part-time Eligible Employees except seasonal maintenance workers must elect a group term life benefit plan from the menu irrespective of other life insurance coverage or financial resources of the Employee.

6.03.030 All Full-time and Part-time Eligible Employees except PFFA, PPA and seasonal maintenance workers must elect a group Long Term Disability benefit plan from the menu irrespective of other Long Term Disability benefit coverage or financial resources of the Employee.

6.03.040 All eligible full-time and part-time seasonal maintenance worker employees are deemed to have elected single party seasonal maintenance worker medical plan coverage as provided in their collective bargaining agreement unless the Employee provides evidence of enrollment in another medical plan. The determination to allow the Employee to opt-out of the City's medical coverage is made at the discretion of the Administrator after review of documentation that the Employee has medical coverage through another plan. It shall be the responsibility of the Participant to immediately notify the Administrator upon cessation of any such other group medical coverage as described in the initial or annual enrollment form.

6.03.050 Notwithstanding any other language in this Chapter, Participants who elect the long term disability insurance plan shall, for all purposes under the Code, be treated as having received cash equal to the amount required to purchase such plan(s) and then purchasing such plan(s) with after-tax dollars.

6.03.060 Notwithstanding any other language in this Chapter, Participants who purchase any medical, dental or vision or plan and elect coverage for someone other than a spouse or Dependent of the Participant, as permitted by the medical, dental or vision plan purchased, shall, for all purposes under the Code, be treated as having received cash equal to the amount required to purchase such coverage and then purchasing such coverage with after-tax dollars.

6.03 DEFAULT BENEFITS

6.03.070 With respect to the Plan Year commencing on July 1, 2011 and for any subsequent Plan Year, any participant who fails to make a proper election for such Plan Year, on or before the specified due date, in conformance with the procedures prescribed by the Administrator, shall be deemed automatically to

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have elected the following default benefits:

1. For any Plan Year in which any one or all of the medical, dental, vision, life and long term disability benefit options have not been substantially changed as determined by the Administrator, any Eligible Employee who fails to make a proper election for such Plan Year, on or before the specified due date, in conformance with the procedures prescribed by the Administrator, shall be deemed automatically to have elected:

   (a) The same benefit coverages, if any, as were in effect for the Participant just prior to the end of the preceding Plan Year, and

   (b) An agreement to a reduction in the Participant's compensation for such Plan Year equal to the Participant's share of the cost during such Plan Year of such benefit coverage.

2. For any Plan Year in which any one or all of the medical, dental, vision, life and long term disability benefit options have been substantially changed as determined by the Administrator or for which no prior election was made by a Participant, any Eligible Employee who fails to make a proper election for such Plan Year, on or before the specified due date, in conformance with the procedures prescribed by the Administrator, shall be deemed automatically to have elected:

   (a) For Initial Enrollment, the non-represented, BOEC, COPPEA, DCTU, PFFA, PPCOA and recreation eligible employees will be enrolled in Eligible Employee only coverage under the CityCore self-insured medical plan option, the vision plan offered with the self-insured medical plan, the dental plan option with the lowest total premium cost other than Kaiser Dental, the Employer funded group term life insurance and, excluding PFFA, the Employer funded group long term disability plan.

   (b) For Initial Enrollment, the PPA employees will be enrolled in Eligible Employee only coverage under the CityNet insured medical plan option, the vision plan offered with the CityNet medical plan, the dental plan option with the lowest total premium cost other than Kaiser Dental, and the Employer funded group term life insurance plan.

   (c) For Initial Enrollment, the SMW employees will be enrolled in Eligible Employee only coverage under the SMW self-insured medical plan.

(b) For Annual Enrollment, eligible employees will be enrolled in the medical, vision and dental options most similar to their prior plan year election, at the same tier (i.e. Single, two-party or family) as elected the prior Plan Year; the Employer funded group term life insurance, the employer funded group long term disability plan, if applicable, and if previously enrolled, the Employee funded group long term disability plan buy-up and the Employee funded term supplemental life insurance.

6.03 Claims Procedure

All claims for reimbursement for Dependent Care and Medical Expenses shall be made as provided in Chapters 7 and 8 respectively. All other claims shall be made directly to the Third Party Administrator or insurer providing claims payment or coverage.

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CHAPTER 7

7.0 DEPENDENT CARE ASSISTANCE PLAN

7.01 Purpose

This Chapter is to be known as the City of Portland Dependent Care Assistance Plan (““DCAP””). The purpose of this Chapter is to reimburse City Employees for the costs associated with Dependent Care Expenses incurred by such Employees. This Chapter is intended to qualify as a plan providing dependent care assistance within the meaning of Section 129(d)(1) of the Code, as amended, and it is intended that the amounts reimbursed pursuant to this Chapter be eligible for exclusion from the income of a Participant under Section 129(a) of the Code.

7.02 Eligibility and Enrollment

7.02.010 Each Employee, except a seasonal maintenance worker, who is a Participant in the Plan described in Chapter 3 may become a Participant in this ““DCAP”” by completing and filing an electronic or paper Benefit Election Form with the Administrator indicating the Employee's application to participate in the ““DCAP”” or by funding the ““DCAP”” with salary reductions.

7.02.020 An election to participate in the Dependent Care Assistance Plan shall be irrevocable after the period of coverage has commenced unless the Participant experiences a qualifying Change in Status or as allowed in Chapter 4. A Participant may revoke his or her election to participate in the "DCAP" after the period of coverage has commenced and may make a new election with respect to the remainder of the period of coverage if both the revocation and the new election are made on account of and are consistent with a qualifying Change in Status.

7.02.030 Participation in the "DCAP" shall terminate when an individual ceases to be an Employee or when it is determined by the Administrator that the Employee no longer meets the Plan eligibility criteria in Chapter 3. Participation in the "DCAP" may thereafter be renewed upon the satisfaction of the eligibility requirements described in Chapter 3.

7.02.040 A Participant who terminates participation prior to the end of a Plan Year shall have the right to submit claims for reimbursement for Dependent Care Expenses incurred during the remainder of the Plan Year at any time until ninety (90) days following the end of the Plan Year. No reimbursement shall exceed the balance in the Participant's Dependent Care Account for the Plan Year in which the expenses were incurred.

7.03 Establishing an Account; Payment of Expenses

The Administrator will establish and maintain a Dependent Care Account for each Participant hereunder. From amounts credited to a Participant's Dependent Care Account during the Plan Year, there shall be paid from time to time reimbursement of Dependent Care Expenses incurred by the Participant during the Plan Year.

7.04 Benefits.

7.04.010 Upon becoming eligible, each Participant may elect in electronically or in writing on a Benefit Election Form to reduce his or her salary or wages the first two pay checks of each month and to have the amount of the reduction contributed to a Dependent Care Account on such Participant's behalf. The Benefit Election Form shall be filed with the Administrator prior to the date the Participant is enrolled in the Plan. Such election may not reduce the Participant's salary or wages by more than $5,000 per Plan Year or $2,500 in the case of married individuals filing separately. The maximum amount a Participant may receive for any Plan Year for reimbursement for expenses incurred for Dependent Care Expenses shall be the lesser of:

1. The amount credited to his or her Dependent Care Account during the Plan Year; or

2. In the case of a Participant who is not married at the close of such taxable year the earned income of such Participant for such taxable year; or

3. In the case of a Participant who is married at the close of such taxable year, the lesser of:

   (a) The earned income of such Participant for such taxable year, or

   (b) The earned income of the spouse of such Participant for such taxable year. In determining the earned income of a spouse who is actively seeking employment, a student or incapable of self care, it shall be deemed for each month during which such spouse is a student at an Educational Institution or is incapable of self care that such spouse has an earned income not less than:

      (i) $250 if there is one qualifying individual with respect to the Participant, or
      (ii) $500, if there are two or more qualifying individuals with respect to the Participant;

(iii) $5,000 (or $2,500 in the case of a separate return by a married Participant).

7.04.020 Reimbursement will not be paid to a Participant for Dependent Care Expenses provided by an individual for whom a deduction is allowable under Code Section 151(c) (relating to personal exemptions for dependents) to a Participant or the Participant's spouse.

7.04.030 Reimbursement will not be paid to a Participant for Dependent Care Expenses provided by a child of the Participant within the meaning of Code Section 151(c)(3) under the age of 19.

7.04.040 Notwithstanding the previous subsection, a Participant will not receive reimbursement for the cost of Dependent Care Expenses provided by a Dependent Care Services Provider, unless the Dependent Care Service Provider complies with all applicable laws and regulations of the state or unit of local government where such center is located, (e.g., requirements for licensing, if applicable, and building and fire code regulations).

7.05 Forfeiture

7.05.010 Participants are ineligible to receive any benefits under this Chapter except as reimbursement for eligible Dependent Care Expenses and shall not receive any funds which may remain in their accounts after reimbursement for all eligible expenses has been made. Any unused funds remaining in said accounts at the end of a Plan Year may not be carried over to a subsequent Plan Year, shall not be available to the Participant in any other form or manner and the Participant shall forfeit all rights with respect to the unused funds.

7.05.020 Reimbursement under this "DCAP" shall be made only in the event, and to the extent, that reimbursement for amounts expended or payment, for dependent care assistance is not provided for under any other dependent care assistance plan or under any federal or state law. If there is such a policy, plan or law in effect providing for such reimbursement or payment in whole or in part, then to the extent of the coverage under such policy, plan or law no reimbursement shall be made hereunder.

7.06 Funding

Funding for participation in the Dependent Care Assistance Plan is as described in Chapter 5.

7.07 Claims Procedure

7.07.010 In order to obtain reimbursement for Dependent Care Expenses, a Participant

shall submit an application in electronic form or in writing to the Administrator or designated third party administrator , in such form as the Administrator or designated third party administrator may prescribe, setting forth:

1. The amount, date and nature of the expense with respect to which payment is requested;

2. The name of the person, organization or entity to which the expense was or is to be paid, and taxpayer identification number (Social Security Number if an individual);

3. Such other information as the Administrator or designated third party administrator may from time to time require.

4. The relationship, if any, of the person performing the services to the Participant;

5. If the dependent care services are being performed by a child of the Participant, the age of the child;

6. A statement as to where the dependent care services will be performed;

7. If any of the dependent care services are to be performed outside the Participant's household, a statement as to whether the Dependent for whom such services are being performed spends at least 8 hours a day in the Participant's household, and

8. If the services are being performed in a dependent care center, a statement that:

    (a). The dependent care center complies with all applicable laws, regulations and ordinances of the state, county and city where it is located;

    (b). The dependent care center provides care for more than six individuals (other than individuals residing at the center), and

    (c) The amount of the fee paid to the dependent care center;

7.07.020 Such applications shall be accompanied by bills, invoices, receipts, canceled checks or other statements showing the amounts of such expenses. The Participant must provide a written statement from an independent third party verifying the Dependent Care Expenses incurred and the amount of such

expenses, and must verify in writing that the expenses have not been reimbursed under any other dependent care assistance plan.

7.07.030 Requests for reimbursement should normally be processed within 30 days of the receipt of the claim. Where additional information is required to process the claim or where no benefit is payable, a written notice/explanation shall be sent to the claimant within 30 days of claim filing. The eligibility of all claims shall be determined within 60 days of the receipt of proper documentation. The decision of the Administrator or designated third party administrator regarding claim eligibility shall be final.

7.07.040 If approved Dependent Care Expenses exceed the amount credited to a Participant's Dependent Care Account, the Administrator or designated third party administrator shall reimburse claims up to the account balance and hold the remainder of the claims until sufficient funds are credited to the account in the year in which the claims were incurred.

7.07.050 On or before January 31 of each year, the Administrator or designee shall furnish to Participants in the Dependent Care Assistance Plan, a written statement showing the amounts paid by the City in providing dependent care assistance to such Participants during the preceding calendar year.

CHAPTER 8

8.0 MEDICAL EXPENSE REIMBURSEMENT PLAN

8.01 Purpose

This Chapter is to be known as the City of Portland Medical Expense Reimbursement Plan (""MERP""). The purpose of this Chapter is to reimburse Participants for the cost of certain Medical Expenses enumerated herein. It is the intention of the City that this Chapter qualify as an accident and health plan within the meaning of Section 105 and Section 106 of the Code, and that the benefits payable under this Chapter be eligible for exclusion from the Participant's income.

8.02 Eligibility and Enrollment

8.02.010 Each Employee who is a Participant in the Cafeteria Plan described in Chapter 3 of the 125 Plan document may become a Participant in this "MERP" by completing and filing a Benefit Election Form with the Administrator indicating the Employee's desire to participate in the "MERP".

8.02.020 An election to receive reimbursement under the "MERP" shall be irrevocable after the period of coverage has commenced unless the Participant experiences a qualifying Change in Status. A Participant may revoke his or her election to participate in the Plan after the period of coverage has commenced and may make a new election with respect to the remainder of the period of coverage if both the revocation and the new election are made on account of and consistent with a qualifying Change in Status. Examples of Changes in Status for which a benefit election change may be permitted are described in Chapter 4, Section 4.01.030.

8.02.030 Participation in the "MERP" shall terminate when an individual ceases to be an Employee or when it is determined by the Administrator that the Employee no longer meets the eligibility criteria for the Cafeteria Plan described in Chapter 3. Participation in the "MERP" may thereafter be renewed upon the satisfaction of the requirements of Chapter 3 and this Chapter.

8.02.040 To the extent required by law (COBRA) (see e.g., Internal Revenue Code Section 4980B, and regulations promulgated thereunder), a Participant, and the Participant's spouse and Dependents, whose coverage terminates under the "MERP" on account of a COBRA qualifying event, shall be given the opportunity to continue coverage under this "MERP" on an after-tax basis for the period prescribed by COBRA (subject to all conditions and limitations under COBRA). However, if the following two conditions are satisfied, a

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special COBRA rule will apply, as discussed below, that limits the extent to which COBRA must be offered under the medical expense reimbursement plan. The two conditions which must be satisfied are:

1. "MERP" is Exempt From HIPAA. The "MERP" is exempt from HIPAA (i.e., a major medical plan is available to all Employees who are eligible for the "MERP" and the same eligibility and same entry rules apply to both, and the "MERP" benefit does not exceed two times the salary reduction or, if greater, the salary reduction plus $500); and

2. The COBRA Premium Equals or Exceeds the "MERP" benefit. If for the Plan Year in which the COBRA qualifying event occurs, the maximum amount the qualified beneficiary could be required to pay for a full year of "MERP" coverage equals or exceeds the maximum benefit available to the qualified beneficiary for the Plan Year.

8.02.050 Individuals will be eligible for COBRA continuation coverage only if they have a positive "MERP" balance at the time of a COBRA qualifying event (taking into account all claims submitted before the date of the qualifying event). Such individuals will be notified if eligible for COBRA continuation coverage. If COBRA is elected, it will be available only for the year in which the qualifying event occurs; such COBRA coverage for the medical expense reimbursement plan will cease at the end of the Plan Year and cannot be continued for the next Plan Year.

8.03 Establishing an Account - Payment of Expenses

The Administrator will establish and maintain a Health Care Spending Account for each Participant hereunder. From amounts credited to a Participant's Health Care Spending Account during a Plan Year, there shall be paid from time to time reimbursement of Medical Expenses incurred by the Participant, his or her spouse, and/or Dependents during the Plan Year.

8.04 Participation

Upon becoming eligible, a Participant may elect via an electronic enrollment form or in writing on a Benefit Election Form to reduce his or her salary or wages each pay day and to have the amount of the reduction contributed to a Health Care Spending Account on such Participant's behalf. The Benefit Election Form shall be filed with the Administrator prior to the date the Participant is enrolled in the Plan. Such election may not reduce the Participant's salary or wages by more than $3,999.84 during a Plan Year. If a Participant elects not to establish a Health Care Spending Account, he or she may later elect to establish such an account during the Annual Enrollment Period, effective as of the following July 1 or on account of a qualifying change in family status.

8.05 Benefits.

8.05.010 Payments shall be made to the Participant in cash as reimbursement for eligible Medical Expenses (as defined in Code Section 213(d) and Revenue Ruling 2003-102 and as modified by the 2010 Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010) incurred by the Participant or his or her Dependents while he or she is an Eligible Employee, during the Plan Year for which the Participant's election is effective. A Participant may receive payments or reimbursements for Medical Expenses as defined in Code Section 213 (d), but only to the extent that the Participant is not reimbursed (or entitled to reimbursement) for the expense through any insurance or otherwise. Reimbursement or payment for such Medical Expenses incurred in any Plan Year may be received up to the annual dollar amount specified by the Participant in his or her enrollment application, but not exceeding $3,999.84.

If, as of the end of the Plan Year, it is determined that a Participant has received payments under this "MERP" that exceed the amount of eligible reimbursement expenses that have been substantiated by the Participant during the Plan Year, the Administrator shall give the Participant prompt written notice of any such excess amount, and the Participant shall repay the amount of such excess to the employer within sixty (60) days of receipt of such notification.

8.05.020 A Participant shall be entitled to benefits under this "MERP" for expenses incurred in a prior Plan Year, but 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. Participants in this "MERP" are ineligible to receive any benefits under this Chapter except as reimbursement for eligible Medical Expenses and shall not receive any funds which may be designated for healthcare expenses after reimbursement for all eligible healthcare expenses has been made. Any unused benefits which may have been designated for Medical Expenses may not be carried over to a subsequent Plan Year, shall not be available to the Participant in any other form or manner and the Participant shall forfeit all rights with respect to the unused funds.

8.06 Claims Procedure

8.06.010 In order to obtain reimbursement for Medical Expenses, a Participant shall submit an application in writing or as otherwise allowed by the Administrator or designated third party administrator in such form and in such detail as the Administrator or designated third party administrator may prescribe with the

following information:

1. The amount, date and nature of the expense.
2. The name of the person, organization or entity to which the expense was or is to be paid.
3. Such other information as the Administrator or designated third party administrator may from time to time require.
4. The name of the person for whom Medical Expenses were incurred and, if such person is not the Participant requesting reimbursement, the relationship of such person to the Participant and that such person is a Dependent of such Participant.

8.06.020 Such applications shall be accompanied by bills, invoices, receipts, cancelled checks or other statements showing the amount of such expenses. The Participant must provide a written statement from an independent third party verifying the Medical Expense incurred and the amount of such expenses, and must verify in writing that the expenses have not been reimbursed and are not reimbursable under any other health plan.

8.06.030 The Participant shall be reimbursed from the Participant's Health Care Spending Account for Medical Expenses incurred during the Plan Year for which the Participant submits documentation in accordance with this Chapter. Medical Expenses will be treated as having been incurred when the care is provided, and not when the Participant is formally billed, charged for, or pays for the expenses. Expenses that were incurred before the Effective Date or before the date the Participant was enrolled in the Plan will not be reimbursed. The Administrator, or third party administrator may, at its option, pay an Medical Expense directly to the medical care provider in lieu of reimbursing the Participant.

8.06.040 Requests for reimbursement should normally be processed within 30 days of receipt of the claim. Where additional information is required to process the claim or where no benefit is payable, a written notice/explanation shall be sent to the claimant within 30 days of claim filing. The eligibility of all claims shall be determined within 60 days of the receipt of proper documentation. The decision of the Administrator or third party administrator regarding claim eligibility shall be final.

8.06.050 On or before January 31 of each year, the Administrator or designated third party administrator shall furnish to Participants in the Medical Expense Reimbursement Plan, a written statement showing the amounts paid by the

City in medical expense reimbursement to such Participants during the preceding calendar year.

8.07 Funding

The total amount which may be set aside by any Participant in a health care spending account shall not exceed $3,999.84 per Plan Year. It is intended that the health care spending accounts authorized under this Chapter be funded by funds made available pursuant to a salary reduction agreement affirmed by the Participant. However, if, at the time reimbursement is payable to a Participant, the eligible expenses exceed the amount of funds available in the Participant's account from such sources, the City of Portland will fund the account in an amount necessary to make up the difference between such available funds and the amount required to reimburse the Participant for his or her eligible expenses. The maximum funding to be provided by the City of Portland under this subsection in any Plan Year shall be $3,999.84 minus the sum of any funds available in the account and the amount of any reimbursement previously received by the Participant for expenses incurred during the Plan Year.

8.08 Termination of Participation

8.08.010 A Participant's participation in the "MERP" will end on the day on which he or she terminates employment, ceases to be an Eligible Employee, or ceases to make required contributions, whichever occurs first. Such Participant shall be entitled to reimbursement of Medical Expenses from his or her Health Care Spending Account for expenses incurred through the day on which the Participant terminates employment or ceases to be an Eligible Employee. A Participant has until September 30 following the end of the Plan Year to obtain reimbursement for Medical Expenses incurred during the eligibility period of the preceding Plan Year. Any amounts still credited to the Participant's account after September 30 shall be forfeited and applied to the costs of maintaining the "MERP". In the event that a Participant ceases to make required contributions, the Participant will not be permitted to again contribute to the Health Care Spending Account for the remaining portion of the coverage period during which the cessation of contributions occurred.

CHAPTER 9

9.0 HIPAA PROVISIONS FOR THE "MERP" AND PREMIUM PAYMENT PLAN

9.01 Health Insurance Portability and Accountability Act

The City of Portland (the "Plan Sponsor") sponsors this 125 Plan with the Medical Expense Reimbursement Plan and the Premium Payment Component Plans as well as the City of Portland Health Plan (the "Plans"). Employees of the Benefit Office have access to the individually identifiable health information of Plan Participants for administrative functions of the Plans. When this health information is provided from the Plans to the Plan Sponsor, it is Protected Health Information (PHI). The Health Insurance Portability and Accountability Act of 1996 (HIPAA) restricts the Plans and Plan Sponsor's ability to use and disclose PHI.

9.01.010 The following HIPAA definition of PHI applies to the 125 plan:

(1) Protected Health Information. Protected health information means information that is created or received by the Plan and relates to the past, present, or future physical or mental health or condition of participant; the provisions 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.

(2) The Plan Sponsor shall have access to PHI from the Plans only as permitted under this Chapter or as otherwise required or permitted by HIPAA.

9.02 Permitted Disclosure of Enrollment/Disenrollment Information

The Plans shall disclose to the plan sponsor information on whether the individual is participating in the Plan.

9.03 Permitted Uses and Disclosure of Summary Health Information

9.03.010 Summary Health Information. Summary Health Information is information that (a) summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a health plan. The summary will only identify the general geographical location of the Participant, and will not include any information by which a particular Participant can be identified.

9.03.020 The Plans may disclose Summary Health Information to the Plan Sponsor, provided the Plan Sponsor requests the Summary Health Information for the purpose of (a) obtaining premium bids from health plans for providing health

insurance coverage under the Plan; or (b) modifying, amending, or terminating the Plan.

9.04 Permitted and Required Uses and Disclosure of Protected Health Information for Plan Administrative Purposes

Unless otherwise permitted by law, and subject to the conditions of disclosure described in paragraph IV and obtaining written certification pursuant to paragraph VI, the Plan may disclose PHI to the Plan Sponsor, provided the Plan Sponsor uses or discloses such PHI only for Plan administration purposes. "Plan administration purposes" means administration functions performed by the Plan Sponsor on behalf of the Plans, such as quality assurance, claims processing, auditing and monitoring. Plan administration functions do not include functions performed by the Plan Sponsor in connection with any other benefit of the Plan Sponsor and they do not include any employment-related functions. In no event shall the Plan Sponsor be permitted to use or disclose PHI in a manner that is inconsistent with 45 CFR §164.504(f).

9.05 Conditions of Disclosure for Plan Administration Purposes

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

1. Not use or further disclose the PHI other than as permitted or required by the Plans or as required by law.
2. Ensure that any agent, including a subcontractor, to whom it provides PHI received from the Plans, agrees to the same restrictions and conditions that apply to the Plan Sponsor with respect to PHI.
3. Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.
4. Make available PHI to comply with HIPAA's right to access in accordance with 45 CFR §164.524.
5. Make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR §164.526
6. Make available the information required to provide and accounting of disclosure in accordance with 45 CFR §164.528.
7. Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plans available to the Secretary of

Health and Human Services for purposes of determining compliance by the Plan with HIPAA's privacy requirements.

8. Return or destroy all PHI received from the Plans that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made.

9. Ensure that the adequate separation between Plans and Plan Sponsor (i.e., the "firewall"), required in 45 CFR §504(f)(2)(iii), is satisfied.

9.06 Adequate Separation Between Plans and Plan Sponsor

The City as Plan Sponsor shall allow the following City employees access to PHI: Benefit Office employees, Payroll employees, and the Bureau of Technical Services employees that provide technical support for the Plan Participant database, the City Attorney's Office for the provision of legal advice and representation as to any matter or issue regarding the Plan or Plan Participant, and City Council as may be required by law or administrative rule to administer, authorize and approve issues related to the Plan. No other persons shall have access to PHI. These specified classes of employees shall only have access to and use PHI to the extent necessary to perform the plan administration functions that the Plan Sponsor performs for the Plan. In the event that any of these specified classes of employees do not comply with the provisions of this Chapter, that employee shall be subject to disciplinary action up to and including discharge by the Plan Sponsor for non-compliance.

9.07 Certification of Plan Sponsor

The Plans shall disclose PHI to the Plan Sponsor only upon the receipt of a certification by the Plan Sponsor that the Plan has been amended to incorporate the provisions of 45 CFR § 164.504(f)(2)(ii), and that the Plan Sponsor agrees to the conditions of disclosure set forth in 9.05 of this Chapter.