	BOARD POLICY **CAFETERIA PLAN**	**5.10.090-P**

PORTLAND PUBLIC SCHOOLS
CAFETERIA PLAN

Amended and Restated
Effective January 1, 2006

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PORTLAND PUBLIC SCHOOLS

CAFETERIA PLAN

P A R T I E S

THIS AMENDED AND RESTATED PLAN is adopted effective January 1, 2006, by the School District No. 1, Multnomah County, Oregon ("District").

R E C I T A L S

The District established the Portland Public Schools Cafeteria Plan (the "Plan") effective May 1, 1994.

The Plan was last amended effective January 1, 2005.

The District intends that this Plan continue to satisfy the requirements of Section 125 of the Internal Revenue Code of 1986, as amended.

The District desires to amend the Plan to comply with changes in applicable federal law and in certain other respects, and to restate the Plan.

A M E N D M E N T A N D R E S T A T E M E N T

The PORTLAND PUBLIC SCHOOLS CAFETERIA PLAN is hereby amended and restated effective January 1, 2006, as set forth herein.

ARTICLE 1

NAME AND EFFECTIVE DATE

1.1 Name. This Plan shall be known as the Portland Public Schools Cafeteria Plan.

1.2 Effective Date. The effective date of this amended and restated Plan is January 1, 2006. The benefits payable to or on behalf of a Participant in the Plan in accordance with the following provisions shall not be affected by the terms of any amendment to the Plan adopted after the Participant separates from service with the District unless the amendment expressly provides otherwise.

ARTICLE 2

DEFINITIONS

Whenever used herein, unless the context clearly indicates otherwise, masculine, feminine, and neuter words may be used interchangeably, singular shall mean the plural and vice versa, and the following words and phrases shall have the following meanings when used with an initial capital letter:

2.1 "Account" means the separate record or records maintained by the Plan Administrator in the name of a Participant in accordance with this Plan.

2.2 "Benefit Package Option" means a qualified benefit under Code Section 125(f) that is offered under a cafeteria plan, or an option for coverage under an underlying accident or health plan (such as an indemnity option, an HMO option, or a PPO option under an accident or health plan).

2.3 "Code" means the Internal Revenue Code of 1986, as amended, and successor Codes thereto.

2.4 "Compensation" means an Eligible Employee's wages or salary from the District during the Plan Year for personal services rendered, including bonuses, overtime, commissions, and other forms of remuneration includable in gross income.

2.5 "Dental and Vision Care Expense" means an expense incurred by a Participant on behalf of the Participant or the Participant's spouse, Dependent, or child (as defined in Code Section 152(f)(1)) who has not attained age 27 as of the end of the Participant's taxable year, for dental or vision care as defined in Code Section 223(c) which is medical care as defined under Code Section 213(d), but only to the extent such expense is reimbursable under the separate dental and vision care reimbursement account program set forth in Article 10 and not used as a deduction on the Participant's federal income tax return.

2.6 "Dependent Care Expenses" means expenses described in 11.4 that are incurred by a Participant and are considered employment-related expenses as defined in Code Section 21(b)(2), but only to the extent that such amounts are reimbursable under the separate dependent care assistance program set forth in Article 11 and are not used by the Participant to obtain a credit against the Participant's federal income tax for employment-related expenses under Code Section 21.

2.7 "Dependent" means, for purposes of 2.10, 2.18, and 4.3, a person who is a Participant's dependent as defined in Code Section 152, except that, for purposes of accident or health coverage, any child to whom Code Section 152(e) applies is treated as a dependent of both parents, and, for purposes of dependent care assistance provided through a cafeteria plan, a dependent means a qualifying individual (as defined in Code Section 21(b)(1)) with respect to the Participant. For purposes of 2.5, 2.11, Article 9, and Article 10, a Dependent means a person who is a Participant's dependent as defined in Code Section 105(b).

2.8 "District" means School District No. 1, Multnomah County, Oregon.

2.9 "Eligible Employee" means any District employee, other than the following individuals:

(a) An employee who is a member of a collective bargaining unit that has bargained in good faith with the District over the benefits provided under this Plan and the bargaining agreement does not specifically require participation in this Plan;

(b) A student worker;

(c) An employee who is employed on an on-call basis, a limited-term employee, or an employee who does not have regularly scheduled hours of employment, including classified substitutes but excluding substitute teachers;

(d) A person who performs services for the District pursuant to an agreement between the District and an organization that leases employees (including a person who is not an employee, but who is treated as an employee, for purposes of Code Sections 106, 125, and 129, by reason of being a "leased employee" as defined in Code Section 414(n));

(e) A self-employed person as defined in Code Section 401(c);

(f) A person who performs services for the District but who is treated for payroll tax purposes as other than an employee of the District (and regardless whether the person may subsequently be determined by a governmental agency, by the conclusion or settlement of threatened or pending litigation, or otherwise to be or have been an employee of the District); and

(g) An employee who has regularly scheduled hours of employment but is less than half-time.

Notwithstanding the foregoing, substitute teachers are excluded from the definition of "Eligible Employee" for purposes of the Premium Payment Benefit described in 4.1(a) only.

2.10 "Family Member Plan" means a cafeteria plan or Qualified Benefits Plan sponsored by the employer of the Participant's spouse or the Participant's Dependent.

2.11 "Health Care Expense" means an expense incurred by a Participant on behalf of the Participant or the Participant's spouse, Dependent, or child (as defined in Code Section 152(f)(1)) who has not attained age 27 as of the end of the Participant's taxable year, for medical care as defined under Code Section 213(d), but only to the extent such expense is reimbursable under the separate health care reimbursement account program set forth in Article 9 and not used as a deduction on the Participant's federal income tax return.

2.12 "Health Savings Account" means a health savings account ("HSA") as defined by Code Section 223(d). An HSA is an individual trust or custodial account separately established and maintained outside the Plan by a Participant and a qualified trustee or custodian.

2.13 "Participant" means an Eligible Employee who has commenced and continues participation in the Plan as provided in Article 3.

2.14 "Plan" means this Portland Public Schools Cafeteria Plan, as amended from time to time.

2.15 "Plan Administrator" means such person or persons appointed by the District to control and manage the operation and administration of the Plan. In the absence of such an appointment, the District shall be the Plan Administrator.

2.16 "Plan Year" means, with respect to the health care reimbursement account program, dental and vision care reimbursement account program, and the dependent care reimbursement account program, the calendar year (January 1 through December 31). The initial Plan Year of the dental and vision care reimbursement account program shall be a short Plan Year of October 1, 2013, through December 31, 2013.

Notwithstanding the foregoing, with respect only to Eligible Employees whose Premium Payment Benefit's Plan Year is October 1 through September 30, the Plan Year for the health care reimbursement account program and dental and vision care reimbursement account program that begins January 1, 2014, shall be a short Plan Year of January 1, 2014, through September 30, 2014, and, beginning October 1, 2014, the Plan Year shall be October 1 through September 30.

With respect to the Premium Payment Benefit described in 4.1(a), the Plan Year means the plan year of the underlying group health plans. To the extent that the underlying group health plans have differing plan years, there shall be a separate Premium Payment Benefit for each group of group health plans that have the same plan year. The Plan Years for the Premium Payment Benefits are described in Exhibit A, which is attached hereto and incorporated by this reference herein. Exhibit A may be revised from time to time by the Plan Administrator without a formal amendment of this Plan document.

2.17 "Qualified Benefits Plan" means an employee benefit plan governing the provision of one or more benefits that are qualified benefits under Code Section 125(f). A plan does not fail to be a Qualified Benefits Plan merely because it includes a flexible spending arrangement (as defined in Code Section 106(c)(2)), provided that the flexible spending arrangement meets the requirements of Code Section 125 and the regulations thereunder.

2.18 "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 major medical coverage provide Similar Coverage. A health flexible spending arrangement is not Similar Coverage with respect to an accident or health plan that is not a health flexible spending arrangement. Coverage provided by another employer, such as a spouse's or Dependent's employer, may be treated as providing Similar Coverage if it satisfies the requirements of this section.

ARTICLE 3

ELIGIBILITY

3.1 Eligibility for Participation. An Eligible Employee shall be eligible to participate in this Plan on the first day of the calendar month after he or she has completed one full calendar month of employment.

3.2 Termination of Participation. In the event a Participant transfers to an ineligible class of employees or terminates employment with the District, the Participant's participation in this Plan shall cease as of the date of such transfer or termination, except as specifically provided for in this Plan.

3.3 Transfer from Ineligible to Eligible Class. In the event an ineligible employee transfers to the eligible class, he or she shall be eligible to participate in the Plan on the first day of the calendar month following the transfer if he or she is a former Participant or has previously satisfied the requirements of 3.1 and would have previously been eligible to participate if he or she had been in the eligible class.

3.4 Special Rules. Notwithstanding the provisions of 3.1, the following special rules apply.

(a) Eligibility for HSA. To be eligible to elect the Health Savings Account Benefit described in 4.1(e), an Eligible Employee must elect coverage under a District-provided high deductible health plan ("HDHP") option that satisfies Code Section 223(c)(2). An employee is not eligible to elect the Health Savings Account Benefit if he or she elects coverage under the Health Care Expense Reimbursement Benefit described in 4.1(b) or is covered under a general purpose, nonsuspended health reimbursement arrangement provided by the District outside the Plan. An Eligible Employee must also meet additional requirements as described in Article 12 to elect the Health Savings Account Benefit.

(b) Eligibility for Health Care Expense Reimbursement Benefit. An employee is not eligible to elect coverage under the Health Care Expense Reimbursement Benefit described in 4.1(b) if he or she elects coverage under a District-provided HDHP option, the Health Savings Account Benefit described in 4.1(e), or the Dental and Vision Care Expense Reimbursement Benefit described in 4.1(c).

(c) Eligibility for Dental and Vision Care Expense Reimbursement Benefit. An employee is not eligible to elect coverage under the Dental and Vision Care Expense Reimbursement Benefit described in 4.1(c) he or she elects coverage under the Health Care Expense Reimbursement Benefit described in 4.1(b).

ARTICLE 4

PARTICIPATION

4.1 Election to Participate. The participation election form shall be signed by the Eligible Employee, shall designate the benefits in which the Eligible Employee elects to participate, and shall designate the Plan Year (or the remaining portion of the Plan Year) as the time period for which participation will be effective. The election form shall also specify the amounts by which the employee's Compensation shall be reduced or the amount of such reduction shall be determinable from that form. A Participant's Compensation reduction election must satisfy the minimum and maximum elective contribution requirements in 5.3.

An election form filed by a Participant is subject to acceptance, modification, or rejection by the Plan Administrator. The Plan Administrator may modify or reject an election in order to satisfy the terms of this Plan or applicable legal requirements.

Subject to 3.4, an Eligible Employee may elect to receive one or more of the following benefits, all of which (except the cash benefit) shall be paid or reimbursed under this Plan by a Compensation reduction agreement with the employee:

(a) Premium Payment Benefit. This benefit consists of the Participant's share of the cost of the premiums under the District-provided group health plans to the extent that coverage under such plans is excludible from income under Code Section 106. The terms, conditions, and benefits of the various health plans are set forth in separate plan documents which are incorporated herein by this reference.

(b) Health Care Expense Reimbursement Benefit. This benefit consists of Health Care Expenses incurred by the Participant that are reimbursable under the health care reimbursement account program set forth in Article 9.

(c) Dental and Vision Care Expense Reimbursement Benefit. This benefit consists of Dental and Vision Care Expenses incurred by the Participant that are reimbursable under the dental and vision care reimbursement account program set forth in Article 10.

(d) Dependent Care Expense Reimbursement Benefit. This benefit consists of Dependent Care Expenses incurred by the Participant that are reimbursable under the dependent care assistance program set forth in Article 11.

(e) Health Savings Account Benefit. This benefit consists of pre-tax Compensation reduction contributions and District contributions as described in Article 12 to a qualifying HSA established and maintained outside the Plan.

(f) Cash Benefit. This benefit consists of taxable cash compensation payable in substantially equal amounts ratably over the Plan Year or over the portion of the Plan Year during which the Participant's Compensation is generally

paid when the Participant has elected to be compensated on a school year basis. An eligible Participant may elect to receive a portion of the District contribution (other than the District contribution to an HSA) as taxable cash compensation instead of electing coverage under a District-provided group health plan. The eligibility and other requirements for cashing out the District contribution are set forth in Exhibit B, which is attached hereto and incorporated by reference herein. Exhibit B may be revised from time to time by the Plan Administrator without a formal amendment of this Plan document.

4.2 Election Procedures. The following rules shall govern an Eligible Employee's elections under this Plan:

(a) Initial Participation. Except as otherwise provided in 4.3, if the Eligible Employee does not make the participation election before the employee is to begin participation under 3.1, the employee's election may be made only

during the annual open enrollment period and will be effective as of the first day of the Plan Year to which the open enrollment period applies.

(b) Continuation of Participation. A Participant shall make a new election for each Plan Year to continue participation in the Plan. A Participant's election shall be made during the annual open enrollment period chosen by the Plan Administrator, prior to the beginning of the Plan Year to which the election applies. The first day of that Plan Year shall be the effective date of the Participant's participation for that Plan Year.

(c) Eligible Expenses. Expenses eligible for reimbursement under a reimbursement benefit elected by the Participant shall be only the eligible expenses incurred by the Participant after the effective date of the employee's participation and during the Plan Year for which the election is made. Expenses incurred before or after the applicable Plan Year or the period of coverage shall not be reimbursable from amounts contributed by the District on behalf of the Participant during the applicable Plan Year.

(d) Additional Eligibility Requirements. The program and plan documents incorporated by reference into this Plan may have their own eligibility requirements for participation. The eligibility rules of this Plan are in addition to and do not override the eligibility rules of the benefit programs or plans that have been incorporated by reference herein.

4.3 Revocation and Changes. Once made, a Participant's election shall be effective for the entire Plan Year for which made and shall not be revoked or changed except as provided in this section. The reasons for which revocations or changes in elections provided in this section are permitted may be restricted pursuant to nondiscriminatory rules adopted by the Plan Administrator that are consistently applied. Except as provided below, benefit election changes must be made within 31 days after the event that entitles the Participant to make the election change. With respect to a benefit election change made under 4.3(c) on account of losing coverage under Medicaid or a state child health plan ("CHIP") or becoming eligible for a premium assistance subsidy under Medicaid or CHIP, the election change must be made within 60 days after the loss of coverage or the determination of eligibility, as applicable.

Notwithstanding the foregoing, an election to contribute to an HSA can be changed or revoked as provided in 4.3(h).

If any election change is conditioned upon an individual obtaining (or ceasing) coverage under another plan, the Plan Administrator may rely on a Participant's certification that the individual has or will obtain (or does not have or will cease) coverage under the other plan (unless the Plan Administrator has reason to believe that the certification is incorrect).

(a) Significant Cost or Coverage Changes. This 4.3(a) sets forth rules for election changes as a result of changes in cost or coverage. This 4.3(a) does not allow election changes with respect to the Health Care Expense

Reimbursement Benefit described in 4.1(b) or the Dental and Vision Care Expense Reimbursement Benefit described in 4.1(c).

(1) Cost Changes.

(A) Automatic Changes. If the cost of a Qualified Benefits Plan increases or decreases during a Plan Year and, under the terms of the plan, Participants are required to make a corresponding change in their payments, the Plan Administrator may, on a reasonable and consistent basis, automatically make a

prospective increase or decrease, as the case may be, in the affected Participants' Compensation reduction contributions for such plan.

(B) Significant Cost Changes. If the Plan Administrator determines that the cost charged to a Participant for a Benefit Package Option has significantly increased or decreased during a Plan Year, the Participant may make a corresponding change in election under the Plan. Changes that may be made include commencing participation in the Plan for the Benefit Package Option with a decrease in cost, or, in the case of an increase in cost, revoking an election for that coverage and, in lieu thereof, either receiving on a prospective basis coverage under another Benefit Package Option providing Similar Coverage or dropping coverage if no other Benefit Package Option providing Similar Coverage is available.

(C) Application of Cost Changes. For purposes of 4.3(a)(1)(A) and (B), a cost increase or decrease means an increase or decrease in the amount of the Compensation reduction contributions under the Plan, whether that increase or decrease results from an action taken by the Participant or the Employer.

(D) Application to Dependent Care. This 4.3(a)(1) applies in the case of a dependent care assistance plan only if the cost change is imposed by a dependent care provider who is not a relative of the Participant. For this purpose, a relative is an individual who is related as described in Code Sections 152(d)(2)(A) through (G), incorporating the rule of Code Section 152(f)(4).

(2) Coverage Changes.

(A) Significant Curtailment Without Loss of Coverage. If a Participant (or a spouse or Dependent) has a significant curtailment of coverage under a plan during the Plan Year that is not a loss of coverage as described in 4.3(a)(2)(B) (such as a significant increase in the deductible, the copay, or the out-of-pocket cost sharing limit under an accident or health plan), any Participant who had been participating in the plan and receiving that coverage may revoke his or her election for that coverage and, in lieu thereof, elect to receive on a prospective basis coverage under another Benefit Package Option providing Similar Coverage. Coverage under a plan is significantly curtailed only if there is an overall reduction in coverage provided under the plan so as to constitute reduced coverage generally.

(B) Significant Curtailment With Loss of Coverage. If a Participant (or a spouse or Dependent) has a significant curtailment that is a loss of coverage, that Participant may revoke his or her election under the Plan and, in lieu thereof, elect either to receive on a prospective basis coverage under another Benefit Package Option providing Similar Coverage or to drop coverage if no Benefit Package Option providing Similar Coverage is available. A loss of coverage means a complete loss of coverage under the Benefit Package Option or other coverage option (including the elimination of a Benefit Package Option, an HMO ceasing to be available in the area where the individual resides, or the individual losing all coverage under the option by reason of an overall lifetime or annual limitation). The Plan Administrator may, in its discretion (which may be exercised on a case-by-case basis provided that the exercise of discretion does not discriminate in favor of highly compensated Participants), treat the following as a loss of coverage:

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

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

(iii) Any other similar fundamental loss of coverage.

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

(3) Change in Coverage Under Another Employer Plan. A Participant may make a prospective election change that is on account of and

corresponds with a change made under another employer plan (including a plan of the Employer or of another employer) if:

(A) The other cafeteria plan or Qualified Benefits Plan permits participants to make an election change that would be permitted under paragraphs (b) through (g) of Treasury Regulation Section 1.125-4 (disregarding Treasury Regulation Section 1.125-4(f)(4)); or

(B) The Plan permits Participants to make an election for a Plan Year that is different from the plan year under the other cafeteria plan or Qualified Benefits Plan.

(4) Loss of Coverage Under Other Group Health Coverage. A Participant may make an election on a prospective basis to add coverage under the Plan for the Participant, spouse, or Dependent if the Participant, spouse, or Dependent loses coverage under any group health coverage sponsored by a governmental or educational institution, including the following:

(A) A state's children's health insurance program under Title XXI of the Social Security Act;

(B) A medical care program of an Indian Tribal government, the Indian Health Service, or a tribal organization;

(C) A state health benefits risk pool; or

(D) A foreign government group health plan.

(b) Change in Status. A Participant may revoke an election during a Plan Year and make a new election for the remaining portion of the Plan Year if both (1) and (2) below are satisfied.

(1) One of the following change-in-status events occurs:

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

(B) Number of Dependents. An event that changes a Participant's number of Dependents, including birth, death, adoption, and placement for adoption (as defined in regulations under Code Section 9801).

(C) Employment Status. Any of the following events that change the employment status of the Participant, the Participant's spouse, or the Participant's Dependent: a termination or commencement of employment; a strike or lockout; a

commencement of or return from an unpaid leave of absence; and a change in worksite. In addition, if the eligibility conditions of the cafeteria plan or other employee benefit plan of the employer of the Participant, spouse, or Dependent depend on the employment status of that individual and there is a change in that individual's employment status with the consequence that the individual becomes (or ceases to be) eligible under the plan, then that change constitutes a change in employment under this 4.3(b)(1)(C). If a Participant terminates employment and cancels coverage during the period of unemployment, and resumes employment within 30 days (without any other intervening event that would permit a change in election), the Participant's prior election for the Plan Year is automatically reinstated. If a Participant terminates employment and cancels coverage during the period of unemployment, and resumes employment more than 30 days following termination, the Participant may return to the election in effect prior to termination of employment or make a new election under the Plan.

(D) Dependent Satisfies or Ceases to Satisfy Eligibility Requirements. An event that causes a Participant's Dependent to satisfy or cease to satisfy the eligibility requirements for coverage due to attainment of age, student status, or any similar circumstance.

(E) Residence. A change in the place of residence of the Participant, spouse, or Dependent.

(F) Nondependent Children. A change-in-status event described above that affects a Participant's child who is under age 27 and not a Dependent, including becoming newly eligible for coverage or eligible for coverage beyond the date on which the child otherwise would have lost coverage.

This subsection (F) shall be effective on the first day of the first Plan Year beginning after March 30, 2010.

(2) The election change satisfies the following consistency rules:

(A) An election change satisfies the requirements of this 4.3(b)(2) if the election change is on account of and corresponds with a change in status that affects eligibility for coverage under an employer's plan. A change in status that affects eligibility under an employer's plan includes a change in status that results in an increase or decrease in the number of a Participant's family

members or Dependents who may benefit from coverage under the plan. An election change also satisfies the requirements of this 4.3(b)(2) if the election change is on account of and corresponds with a change in status that affects expenses described in Code Section 129 (including employment-related expenses as defined in Code Section 21(b)(2)) with respect to dependent care assistance.

(B) If the change in status is the Participant's divorce, annulment, or legal separation from a spouse, the death of a spouse or Dependent, or a Dependent ceasing to satisfy the eligibility requirements for coverage, a Participant's election under the Plan

to cancel accident or health insurance coverage for any individual other than the spouse involved in the divorce, annulment, or legal separation, the deceased spouse or Dependent, or the Dependent that ceased to satisfy the eligibility requirements for coverage, respectively, fails to correspond with that change in status. In addition, if a Participant, spouse, or Dependent gains eligibility for coverage under a Family Member Plan as a result of a change in marital status under 4.3(b)(1)(A) or a change in employment status under 4.3(b)(1)(C), a Participant's election under the Plan to cease or decrease coverage for that individual under the Plan corresponds with that change in status only if coverage for that individual becomes applicable or is increased under the Family Member Plan.

(c) Special Enrollment Rights. To the extent that the group health plan benefits described in 4.1 are subject to the special enrollment rules provided in Section 2701(f) of the Public Health Service Act, a Participant who is entitled to special enrollment rights may revoke his or her election with respect to coverage under such group health plan during a Plan Year and make a new election that corresponds with the special enrollment rules.

(d) Judgment, Decree, or Order. The Plan Administrator may change a Participant's election to provide group health plan coverage for the Participant's child (or for a foster child who is a Dependent of the Participant) if a judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in legal custody requires accident or health coverage for the child under the Participant's plan. A Participant may change his or her election to cancel group health plan coverage for the child if such an order requires the spouse, former spouse, or other individual to provide coverage for the child, and that coverage is, in fact, provided.

(e) Entitlement to Medicare or Medicaid. A Participant may prospectively cancel or reduce the Participant's, spouse's, or Dependent's coverage under an accident or health plan if the Participant, spouse, or Dependent becomes entitled to coverage (i.e., becomes enrolled) under Part A or Part B of Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines). In addition, if a Participant, spouse, or Dependent who has been entitled to such coverage under Medicare or Medicaid loses eligibility for such coverage, the Participant may make a prospective election to commence or increase the Participant's, spouse's, or Dependent's coverage under the accident or health plan.

(f) Family and Medical Leave Act. A Participant taking leave under the Family and Medical Leave Act ("FMLA") may revoke an existing election of accident or health plan coverage and make such other election for the remaining portion of the Plan Year as may be provided for under the FMLA.

(g) Cessation of Required Contributions. Except as otherwise provided in 5.4 with respect to eligible Dependent Care Expenses, a benefit will cease to be provided to a Participant if the Participant fails to make the required premium payments with respect to the benefit (e.g., a Participant ceases to make premium payments for health care reimbursement account program coverage after a termination of employment). However, in such case, the former Participant may not again make a new benefit election for the remaining portion of the Plan Year.

(h) HSA Election Changes. A Participant's election to make pre-tax Compensation reduction contributions to an HSA can be prospectively changed on a monthly basis. Only one election change may be made per month. HSA contribution elections can be prospectively revoked if the Participant becomes ineligible to make HSA contributions. If HSA contributions are changed, the contribution amounts must continue to satisfy the HSA contribution limits described in Article 12. Election changes or revocations will be effective beginning with the payroll period during which the election change or revocation is received by the Plan Administrator (provided that the Compensation for that payroll period has not become currently available), unless the Participant elects a later effective date.

(i) Additional Group Health Plan Election Changes. A Participant may prospectively revoke an election of coverage under a group health plan that provides minimum essential coverage (as defined in Code Section 5000A(f)(1)) if either (1) or (2) below is satisfied. This 4.3(i) does not allow election changes with respect to the Health Care Expense Reimbursement Benefit described in 4.1(b) or the Dental and Vision Care Expense Reimbursement Benefit described in 4.1(c).

(1) Reduction in Hours of Service. An election change may be made due to a reduction in hours if both (A) and (B) are satisfied.

(A) The Participant was in an employment status under which he or she was reasonably expected to average at least 30 hours of service a week and the Participant's status is changed so that he or she will reasonably be expected to average less than 30 hours of service a week.

(B) The revocation of the election of coverage under the group health plan corresponds to the intended enrollment of the Participant, and any related individuals who cease coverage due to the revocation, in another plan that provides minimum essential coverage. The new coverage must be effective no later than the first day of the second month following the month in which the original coverage was revoked.

(2) Enrollment in a Qualified Health Plan Through an Exchange. An election change may be made due to enrollment in a qualified health plan if both (A) and (B) are satisfied.

(A) The Participant is eligible for a special enrollment period (as provided in 45 CFR § 155.420(d)) to enroll in a qualified health plan through an exchange established under Section 1311 of the Patient Protection and Affordable Care Act or the Participant seeks to enroll in a qualified health plan through an exchange during the exchange's annual open enrollment period.

(B) The revocation of the election of coverage under the group health plan corresponds to the intended enrollment of the Participant, and any related individuals who cease coverage due to the revocation, in a qualified health plan through an exchange. The new coverage must be effective no later than the day immediately following the last day of the original coverage that is revoked.

ARTICLE 5

CREDITS AND REIMBURSEMENT PROCEDURES

5.1 Credits to Plan. The following rules shall govern the Compensation reduction credits to this Plan during a Plan Year:

(a) Establishment of Accounts. For each Participant, the Plan Administrator shall establish a separate Account for each reimbursement benefit under 4.1 for the Plan Year.

(b) Compensation Reduction Credits. For each Participant, the amount by which the Participant elects to reduce his or her Compensation for a specific benefit shall be deducted from the Participant's Compensation during the Plan Year by payroll deduction and credited to the Participant's Account for such benefit, credited against the cost of that benefit as determined by the Plan Administrator, or, for HSA contributions, deposited with the HSA trustee/custodian maintaining the Participant's HSA.

(c) District Contributions. Prior to the beginning of each Plan Year, the District shall determine the amount to be credited to each Participant for the purchase of benefits described in 4.1. The amount so established for each Plan Year shall be set forth in Exhibit C, to be attached hereto and incorporated by reference herein. The Plan Administrator may change the District contribution amount set forth in Exhibit C without amending this Plan. District contributions or credits may be made in substantially ratable installments throughout the Plan Year.

(d) Records of Contributions. The Plan Administrator shall maintain appropriate records and shall record the amounts credited for a Participant for a specified benefit under (b) and (c) above in the Participant's Account established for such benefit.

(e) Allocation of Expense. An eligible Dependent Care Expense submitted for reimbursement by a Participant shall be paid only from the Account established for such Participant for such expense and only to the extent of the amount recorded in the Account (after deducting earlier reimbursements made during the Plan Year). The maximum amount of Health Care Expense reimbursement under Article 9 or Dental and Vision Care Expense reimbursement under Article 10 must be available at all times during the Plan Year (properly reduced as of any particular time for prior reimbursements for the same Plan Year). Thus, the maximum amount of Health Care Expense or Dental and Vision Care Expense reimbursements at any particular time during the Plan Year cannot be limited to the amount recorded in the applicable Account at that time. Reimbursement will be deemed to be available at all times if it is paid at least monthly or when the total amount of the claims to be submitted is at least a specified, reasonable minimum amount (e.g. $50).

(f) Unused Amounts. An amount remaining in an Account after the Participant has submitted all reimbursable expenses for the Plan Year of the type for which the Account is established, shall not be carried over to a subsequent Plan Year, nor shall such amount be paid, directly or indirectly, to the Participant in cash or in the form of any other benefit.

5.2 Reimbursement Payment Procedures. The following rules shall govern the reimbursement of a Participant's eligible expenses under the Health Care Expense Reimbursement Benefit, the Dental and Vision Care Expense Reimbursement Benefit, and the Dependent Care Expense Reimbursement Benefit.

(a) Reimbursement Request. The Participant shall submit a written request for reimbursement on the form or forms provided by the Plan Administrator. Requests for reimbursement shall be made at such time or times as specified by the Plan Administrator; however, eligible expenses incurred during a Plan Year must be submitted for reimbursement not later than three months after the close of the Plan Year. Eligible expenses that are not submitted on a timely basis in accordance with this 5.2(a) shall not be reimbursed.

(b) Documentation. A Participant's written request for reimbursement shall establish that the expense was incurred during the applicable time period, and must state that the amount has not been reimbursed and is not reimbursable under any other health plan or dependent care plan, and that the amount will not be used in connection with a deduction or credit on the Participant's federal income tax return. No advance reimbursement may be made of future or projected expenses. The written request must be accompanied with a written statement from an independent third party stating that the expense has been incurred and the amount of such expense.

(c) Payment. A Participant's request for reimbursement, when approved by the Plan Administrator, shall be paid as soon as reasonably practicable following such approval. Payments shall only be made in reimbursement to a Participant and shall not be made directly to a service provider. Except as provided in 5.1(e), reimbursements to a Participant shall not exceed the amount available in the Participant's Account for the type of expense for which reimbursement is requested.

5.3 Amount of Elective and Nonelective Contributions. The maximum amount of nonelective contributions available to any Participant under this Plan for a Plan Year shall equal the District contributions under 5.1(c). The maximum amount of elective contributions available to any Participant under this Plan for a Plan Year shall equal the annual amount of the Participant's share of the cost of the District-provided group health plan premiums for the Premium Payment Benefit, plus $20,000.

The minimum amount of elective contributions that may be elected by any Participant under the health care reimbursement account program, the dental and vision care reimbursement account program, and the dependent care reimbursement account program shall

be $20 per month for each program. The maximum amount for credit to the Participant's HSA is as described in Article 12.

Notwithstanding the foregoing, the maximum amount of salary reduction contributions available to any Participant under this Plan for a Plan Year for the health care reimbursement account program or dental and vision care reimbursement account program shall equal $2,500 (plus cost-of-living adjustments permitted under applicable law) ($2,550 for Plan Years beginning on or after January 1, 2015), prorated for any short Plan Year.

5.4 Expense Reimbursement After Participation Terminates. If, during a Plan Year, a Participant terminates employment, transfers to an ineligible class of employees, or ceases to make required contributions, he or she may nevertheless submit eligible Dependent Care Expenses incurred during the remainder of that Plan Year to the Plan Administrator for reimbursement under the dependent care reimbursement account program.

If a Participant terminates employment with the District or transfers to an ineligible class of employees and revokes his or her existing benefit elections, the Plan Administrator shall reimburse the Participant for any amount previously paid for coverage or benefits under the health care reimbursement account program or dental and vision care reimbursement account program relating to the period after the termination or transfer.

5.5 Qualified Reservist Distributions. Notwithstanding any other Plan provision to the contrary, a Participant may request a qualified reservist distribution from the Participant's health care reimbursement Account or dental and vision care reimbursement Account. The term "Account" as used in this 5.5, refers only to the foregoing two Accounts.

(a) Definition of Qualified Reservist Distribution. A qualified reservist distribution is a distribution to a Participant of all or a portion of the balance in the Participant's Account if: (1) the Participant is a qualified reservist as defined in (b) below, and (2) the request for a distribution is made during the period specified in (e) below.

(b) Definition of Qualified Reservist. A qualified reservist is a Participant who is, by reason of being a member of a reserve component (as defined in 37 U.S.C. § 101), ordered or called to active duty for a period of 180 days or more or for an indefinite period. The Plan Administrator may rely on the order or call to determine the period of active duty. If the order or call specifies that the period is for 180 days or more or is indefinite, the Participant is a qualified reservist, even if the actual period of active duty is less than 180 days or is otherwise changed. If the period of active duty specified in the order or call is less than 180 days, the Participant is not a qualified reservist unless subsequent calls or orders increase the total period of active duty to 180 days or more.

(c) Amount Available. The amount available as a qualified reservist distribution is the amount contributed to the Participant's Account as of the date of the request for distribution minus reimbursements received from the Account as of the date of the request.

(d) Procedures. A Participant must make a written request to the Plan Administrator to receive a qualified reservist distribution. The Plan Administrator must receive a copy of the order or call to active duty before a distribution can be made. Only one qualified reservist distribution is permitted with respect to a Participant during a Plan Year. A Participant may submit requests for reimbursement for medical expenses incurred before the date of the request for a qualified reservist distribution and such reimbursements will be paid in accordance with Article 5 (taking into account the amount of the qualified reservist distribution as a reimbursement). A Participant may not submit requests for reimbursement for medical expenses incurred on or after the date of the request for distribution.

(e) Timing of Requests and Distributions. A request for a qualified reservist distribution must be made on or after the date of the order or call to active duty and before the last day of the Plan Year during which the order or call to active duty occurred. The health care reimbursement account program or dental and vision care reimbursement account program, as applicable, shall pay the qualified reservist distribution to the Participant within a reasonable time, but not more than 60 days after the date of the request for a distribution. A qualified reservist distribution may not be made with respect to a Plan Year ending before the order or call to active duty.

ARTICLE 6

CLAIMS PROCEDURE

6.1 Initial Claim. Any person claiming a premium payment benefit under this Plan shall present the claim in writing to the Plan Administrator. Any person claiming a Dependent Care Expense Reimbursement Benefit, a Health Care Expense Reimbursement Benefit, or a Dental and Vision Care Expense Reimbursement Benefit under this Plan shall present the claim in writing to the entity that administers those benefits ("Claim Reviewer"). For purposes of this article, the person claiming a benefit (or his or her authorized representative) shall be referred to as the "Claimant."

6.2 Decision on Initial Claim.

(a) Time Period for Denial Notice. A decision shall be made on the claim as soon as practicable and shall be communicated in writing by the Plan Administrator or Claim Reviewer to the Claimant within a reasonable period after receipt of the claim by the Plan Administrator or Claim Reviewer.

(b) Contents of Notice. If the claim is wholly or partially denied, the notice of denial shall indicate:

(1) The specific reasons for the denial;

(2) The specific references to pertinent Plan provisions on which the denial is based;

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

(4) An explanation of the Plan's claim review procedure.

6.3 Review of Denied Claim. If a Claimant receives a notice of denial, the Claimant may request a review of the claim. The request for review is made by personally delivering or mailing a written request for review, prepared by either the Claimant or his or her authorized representative, to the Plan Administrator. The Claimant's request for review must be made within 60 days after receipt of the notice of denial. If the written request for review is not made on a timely basis, the Claimant shall be deemed to waive his or her right to review. The Claimant or his or her duly authorized representative may, at or after the time of making the request, review all pertinent documents and submit issues and comments in writing.

If a Claimant requests a review of a claim under the health care reimbursement account program, only the employee described in 9.7(b)(3) may review denied claims. Such employee shall act on behalf of the Plan Administrator in reviewing and deciding denied claims.

6.4 Decision on Review. A review shall be made by the Plan Administrator after receipt of a timely filed request for review. A decision on review shall be made and furnished in writing to the Claimant. The decision shall be made within a reasonable period of

time after receipt of the request for review. The written decision shall include the reasons for such decision with reference to the provisions of the Plan upon which the decision is based. The decision shall be final and binding upon the Claimant, the District, and all other persons involved.

6.5 Further Review. The Claimant must follow and exhaust the claims procedure described in this article before he or she can file suit for benefits. In no event may the Claimant file suit for benefits more than one year from the date on which the decision on review under 6.4 is sent to the Claimant.

The scope of any subsequent review of the benefit claim, judicial or otherwise, shall be limited to a determination as to whether the Plan Administrator acted arbitrarily or capriciously in the exercise of its discretion. In no event shall any such further review be on a de novo basis as the Plan Administrator has discretionary authority to determine eligibility for benefits and to construe the terms of this Plan.

ARTICLE 7

PLAN ADMINISTRATION

7.1 Appointment of Plan Administrator. The District shall appoint one or more persons to act as the Plan Administrator and to serve for such terms as the District may designate or until a successor has been appointed or until removed by the District. Vacancies due to resignation, death, removal or other causes shall be filled by the District. The Plan Administrator shall be bonded except as may otherwise be allowed by law. The Plan Administrator may be paid reasonable compensation for its service; however, a Plan Administrator who is a full-time employee of the District shall serve without compensation. All reasonable expenses of the Plan Administrator shall be paid by the District. If a designation of a Plan Administrator is not made, the District shall be the Plan Administrator.

7.2 Rights and Duties. The Plan Administrator shall be the named fiduciary of the Plan. The Plan Administrator, on behalf of the Participants and their beneficiaries, shall have the authority to control and manage the operation and administration of the Plan and shall have all powers necessary to accomplish those purposes. The responsibility and authority of the Plan Administrator shall include, but shall not be limited to, the following:

(a) Determining all questions relating to the eligibility of employees to participate;

(b) Computing and certifying the amount and kind of benefits payable to Participants, spouses, and dependents;

(c) Authorizing all disbursements;

(d) Maintaining all necessary records for the administration of the Plan other than those that the District has specifically agreed to maintain;

(e) Interpreting the provisions of the Plan and publishing such rules for the regulation of the Plan as are deemed necessary and not inconsistent with the terms of the Plan; and

(f) Directing the District to make payments to Participants, former Participants, spouses, and dependents in accordance with the provisions of the Plan.

7.3 Information, Reporting, and Disclosure. To enable the Plan Administrator to perform its functions, the District shall supply full and timely information to the Plan Administrator on all matters relating to the Participants and such other pertinent facts as the Plan Administrator may require. The Plan Administrator shall have the responsibility of complying with the reporting and disclosure requirements of applicable law.

7.4 Independent Qualified Accountant. If required by applicable law or regulation, the Plan Administrator shall engage, on behalf of all Plan Participants, an

independent qualified public accountant who shall conduct such examinations of the financial statements of the Plan and of other books and records of the Plan as the accountant may deem necessary to enable the accountant to form an opinion as to whether the financial statements and schedules required by law to be included in any reports are presented fairly and in conformity with generally accepted accounting principles.

7.5 Allocation and Delegation of Responsibility. The Plan Administrator may allocate fiduciary responsibilities to one or more persons and may delegate to such persons the authority to carry out fiduciary responsibilities under the Plan.

The Plan Administrator, in making the above allocation of fiduciary responsibilities, may provide that a person or group of persons may serve, with respect to the Plan, in more than one fiduciary capacity.

The Plan Administrator or persons to whom fiduciary responsibilities have been delegated by the Plan Administrator may employ one or more persons to render advice with regard to any responsibility such fiduciary has under the Plan.

In the event a fiduciary responsibility is allocated to a person, no other person shall be liable for any act or omission of the person to whom the responsibility is allocated except as may be otherwise required by law. If a fiduciary responsibility is delegated to a person other than the Plan Administrator, the Plan Administrator shall not be responsible or liable for an act or omission of such person in carrying out such responsibility except as may otherwise be required by law.

7.6 Indemnification. The District hereby indemnifies and holds harmless the Plan Administrator and each person to whom a fiduciary responsibility is allocated from any loss, claim, or suit arising out of the performance of obligations imposed hereunder and not arising from the Plan Administrator's or the person's willful neglect, misconduct, or gross negligence.

ARTICLE 8

MISCELLANEOUS

8.1 Right to Amend and Terminate. The District represents that the Plan is intended to be a continuing program for Participants but reserves the right to terminate the Plan at any time. The District may modify, alter, or amend this Plan in whole or in part.

8.2 Unsecured Right to Payment. No employee shall by virtue of this Plan have any interest in any specific asset or assets of the District. An employee has only an unsecured contract right to receive benefits in accordance with the provisions of the Plan.

8.3 No Obligation to Fund. The District shall have no obligation to establish a trust or fund for the payment of benefits or to insure any of the benefits.

8.4 No Interest. The District shall have no obligation to pay interest on any Participant's salary reduction amounts or Accounts used to provide the benefits under this Plan.

8.5 Provision Against Anticipation. No Participant shall have the right or power to alienate, anticipate, commute, pledge, encumber, or assign any of the benefits or proceeds recorded for the Participant under the terms of this Plan, and no such benefits or proceeds shall be subject to seizure by any creditor of the Participant under any writ or proceedings at law or in equity.

8.6 Right to Discharge Employees. Neither the establishment of this Plan, nor any modification thereof, nor the payment of any benefit, shall be construed as giving any Participant or any other person any legal or equitable right against the District unless the same shall be specifically provided for in this Plan, nor as giving any employee or Participant the right to be retained in the District's employ. All employees shall remain subject to discharge by the District to the same extent as if this Plan had never been adopted.

8.7 Construction. This Plan shall be construed in accordance with applicable federal law and regulations issued thereunder and, to the extent applicable, the laws of the state of Oregon.

8.8 Legally Enforceable. The District intends that the Plan terms, including those relating to coverage and benefits, are legally enforceable. The Plan is maintained for the exclusive benefit of employees.

ARTICLE 9

HEALTH CARE REIMBURSEMENT ACCOUNT PROGRAM

9.1 General. This article is intended to qualify as an accident and health plan within the meaning of Code Section 106. It is intended that reimbursements under this program be eligible for exclusion from the gross income of Participants under Code Section 105(b). Accordingly, this program shall be interpreted and construed in accordance with Code Sections 106 and 105(e) and any regulations or other interpretations thereunder. This program represents one benefit that may be elected by Participants under the Portland Public Schools Cafeteria Plan, and a Participant under that Plan who elects the Health Care Expense Reimbursement Benefit thereunder is deemed to be a Participant under this health care reimbursement account program.

9.2 Amount of Coverage. The maximum amount of coverage that may be elected as a salary reduction contribution under this health care reimbursement account program for a Plan Year is limited to $2,500 (plus cost-of-living adjustments permitted under applicable law) ($2,550 for Plan Years beginning on or after January 1, 2015), prorated for any short Plan Year.

9.3 Health Care Expenses. Each Participant under this health care reimbursement account program will be entitled to receive for each Plan Year reimbursements of Health Care Expenses that are incurred during the Plan Year and that are not paid or reimbursed by insurance or otherwise, up to the dollar amount of coverage elected by the Participant for that Plan Year.

There will be no reimbursement for premiums paid by a Participant for health insurance. For example, there will not be any reimbursement for premiums paid for other health plan coverage, including premiums paid for health coverage under a plan maintained by the employer of the Participant's spouse or Dependent.

Health Care Expenses incurred after December 31, 2010, for medicines or drugs may be reimbursed under this health care reimbursement account program only if the medicine or drug (a) requires a prescription, (b) is available without a prescription (i.e., an over-the-counter medicine or drug) and the individual obtains a prescription, or (c) is insulin.

The coverage elected for a Plan Year is available only to reimburse expenses that are incurred during the Plan Year. An expense shall be treated as having been incurred when the medical, dental, or vision care that gives rise to the expense is provided or at the time the equipment, supplies, or drugs that give rise to the expense are purchased, and not when the Participant is formally billed, charged for, or pays for the expense.

9.4 Administration. The plan administrator of this health care reimbursement account program shall be the same as for the Portland Public Schools Cafeteria Plan. The procedures for making and reviewing claims, plan administration, elections and revocation of elections, and reimbursement requests and payments, shall be as set forth in the Portland Public Schools Cafeteria Plan.

9.5 Continuation Coverage. To the extent that this health care reimbursement account program is a group health plan, it is subject to the continuation coverage requirements under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"), as presently set forth in Sections 2201 through 2208 of the Public Health Service Act. Accordingly, this program shall be construed in accordance with COBRA and the applicable regulations thereunder.

9.6 Military Service.

(a) General. The health care reimbursement account program shall comply with the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"). The USERRA provisions contained in 38 USC Section 4301 et seq are incorporated by reference.

(b) Qualifying Reemployment. If a Participant is absent from employment due to service in the uniformed services as defined in 38 USC Section 4301(13) ('military service"), the Participant is entitled to reemployment rights and benefits if the following conditions are satisfied ("qualifying reemployment"):

(1) The Participant, or an appropriate officer of the uniformed service, must provide advance written or oral notice of the military service to the District. Notice is not required if it is precluded by military necessity or is otherwise impossible or unreasonable as described in 20 CFR Section 1002.86.

(2) The Participant's military absence from the District must be for a cumulative period of less than five years. The Participant may be absent from employment for more than five years if the longer period of time is necessary to complete an initial period of obligated service or a Participant is ordered to or retained on active duty as described in 38 USC Section 4312(c) and 20 CFR Section 1002.103.

(3) The Participant must report to, or apply for reemployment with, the District within a certain number of days after the completion of military service. The period in which to report to the District or apply for reemployment is determined by reference to the period of military service as follows:

(A) If the period of military service is less than 31 days, or if the absence from employment is for the purposes of an examination to determine the Participant's fitness for military service, the Participant must report to the District not later than the first work day following completion of the military service and the expiration of eight hours after a period allowing for safe transportation to the Participant's residence.

(B) If the period of military service is for more than 30 days but less than 181 days, the Participant must submit an application for reemployment (written or oral) not later than 14 days after completion of the military service.

(C) If the period of military service is for more than 180 days, the Participant must submit an application for reemployment (written or oral) not later than 90 days after completion of military service.

(D) If the Participant is hospitalized for, or convalescing from, an illness or injury incurred in, or aggravated during, military service, the Participant shall report to the District or submit an application for reemployment at the end of the recovery period. The recovery period may not exceed two years.

The foregoing periods may be extended pursuant to 38 USC Section 4312(e) and 20 CFR Sections 1002.115-1002.117 if reporting to the District or applying for reemployment is impossible or unreasonable through no fault of the Participant.

(4) The Participant did not receive a type of discharge or separation from service described in 38 USC Section 4304 and 20 CFR Section 1002.135.

(5) If the military service exceeds 30 days, the Participant must provide, upon the District's request, documentation to establish that the requirements of 9.6(b)(2), (3), and (4) above are satisfied. This 9.6(b)(5) shall not apply if such documentation does not exist or is not readily available.

(c) Continuation of Coverage.

(1) Election of Continuation Coverage. If a Participant is absent from employment due to military service, the Participant may elect to continue the Participant's and any Dependent's coverage.

This paragraph shall be effective January 18, 2006. Coverage shall terminate on the date described in 3.2 and shall be retroactively reinstated if the Participant elects to continue coverage and pays all premiums due within the periods described below. To the extent consistent with USERRA, an election to continue coverage must be made in the same manner and time periods applicable to an election of COBRA coverage. Notwithstanding the foregoing, if the Participant does not provide advance notice of the military service because it is precluded by military necessity or is otherwise impossible or unreasonable, the election of USERRA continuation coverage must be made within 60 days after the date it becomes possible and reasonable to make the election or, if later, by the end of the COBRA election period. Notwithstanding the foregoing, if the Participant leaves employment without giving advance notice of the military service (which is not excused as described above), the Participant shall have no right to elect USERRA continuation coverage.

(2) Duration of Continuation Coverage. The maximum period of coverage shall be the lesser of:

(A) The 24-month period (18-month period with respect to elections made before December 10, 2004) beginning on the date on which the Participant's absence begins; or

(B) The period beginning on the date on which the Participant's absence begins and ending on the day after the date on which the Participant fails to report or apply for reemployment as described in 9.6(b)(3).

(3) Premiums. A Participant who elects to continue coverage may be required to pay not more than 102 percent of the full premium, except that a Participant who performs military service for less than 31 days may not be required to pay more than the employee share for the coverage.

This paragraph shall be effective January 18, 2006. To the extent consistent with USERRA, premiums are due on the due dates applicable to premiums for COBRA coverage. Notwithstanding the foregoing, if it is precluded by military necessity or is otherwise impossible or unreasonable for a Participant to pay a premium by the due date, such Participant must pay the premium within 30 days after the date it becomes possible and reasonable for him or her to do so.

(4) Termination of Continuation Coverage. This paragraph shall be effective January 18, 2006. To the extent consistent with USERRA, USERRA continuation coverage shall be terminated if premiums are not paid by the due date described in 9.6(c)(3) or if a Participant receives a type of discharge or separation from service described in 38 USC Section 4304 and 20 CFR Section 1002.135.

(d) Reinstatement of Coverage. If a Participant's or Dependent's coverage terminates due to the Participant's military service, the coverage shall be reinstated upon qualifying reemployment. An exclusion or waiting period shall not be imposed on the Participant or any Dependents in connection with the reinstatement of coverage upon qualifying reemployment if an exclusion or waiting period would not have been imposed had the coverage not been terminated due to military service. The preceding sentence shall not apply to the coverage of any illness or injury determined by the Secretary of Veterans Affairs or his or her representative to have been incurred in, or aggravated during, military service.

9.7 Protected Health Information.

(a) Hybrid Entity. The Plan is a hybrid entity within the meaning of 45 CFR Section 164.103. The health care reimbursement account program is the health care component of the Plan. As provided in 45 CFR Section 164.105(a), the privacy rules under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") apply only to the health care component of the Plan. The health care component shall not disclose protected health information, as defined in 45 CFR Section 164.103 ("PHI") to a non-health care component of the Plan in circumstances in which the HIPAA privacy rules would prohibit such disclosure if the health care component and the other component were separate legal entities.

(b) Disclosure of Protected Health Information to the District.

(1) Permitted and Required Uses and Disclosures of Protected Health Information.

(A) Plan Administration Functions. Subject to the conditions of disclosure described in 9.7(b)(2), (3), and (4), the health care reimbursement account program, or the program's business associate, may disclose PHI to the District for plan administration functions. Plan administration functions means administration functions performed by the District on behalf of the program, such as quality assurance, claims processing, auditing, and monitoring. Plan administration functions are limited to activities that would meet the definition of payment or health care operations, as defined in 45 CFR Section 164.501, but do not include functions to modify, amend, or terminate the program or solicit bids from prospective issuers. Plan administration functions do not include any employment-related functions or functions in connection with any other benefits or benefit plans. These permitted and required uses and disclosures may not be inconsistent with 45 CFR Part 164, Subparts C and E.

(B) Enrollment and Disenrollment Information. The program, or the program's business associate, may disclose to the District information on whether the individual is participating in the program. Such disclosure is not subject to 9.7(b)(2), (3), and (4).

(C) Summary Health Information. The program, or the program's business associate, may disclose summary health information, as defined in 45 CFR Section 164.504(a), to the District, provided the District requests the summary health information for the purpose of modifying, amending, or terminating the program and the disclosure does not violate 45 CFR Section 164.502(9)(5)(i). Such disclosure is not subject to 9.7(b)(2), (3), and (4).

(2) Conditions of Disclosure for Plan Administration Functions. Disclosure of PHI to the District under 9.7(b)(1)(A) is permitted only upon receipt of a certification from the District that the Plan has been amended and the District has agreed to the following conditions regarding the use and disclosure of PHI. The District will:

(A) Not use or further disclose PHI other than as permitted or required by the program or as required by law;

(B) Ensure that any subcontractors or agents to whom the District provides PHI received from the program agree to the

same restrictions and conditions that apply to the District with respect to such information;

(C) Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the District;

(D) Report to the program any use or disclosure of PHI that is inconsistent with the uses and disclosures provided for in the program or under HIPAA, of which it becomes aware;

(E) Make available PHI to comply with HIPAA's right to access in accordance with 45 CFR Section 164.524;

(F) Make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR Section 164.526;

(G) Make available the information required to provide an accounting of disclosures in accordance with 45 CFR Section 164.528;

(H) Make its internal practices, books, and records relating to the use and disclosure of PHI received from the program available to the Secretary of the Department of Health and Human Services ("DHHS"), or any other officer or employee of DHHS to whom such authority has been delegated, for purposes of determining compliance by the program with 45 CFR, Part 164, Subpart E;

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

(J) Ensure that adequate separation between the program and the District, as required in 45 CFR Section 164.504(f)(2)(iii), has been established.

(3) Adequate Separation Between the Program and the District. The District's Benefits Manager will have access to PHI under 9.7(b)(1)(A). The Benefits Manager shall only have access to and use of PHI to the extent necessary to perform the plan administration functions that the District performs for the program.

In the event that the Benefits Manager uses or discloses PHI in a way prohibited by the program or HIPAA, the District shall impose sanctions to ensure

that no further non-compliance occurs. Such sanctions may include an oral warning, a written warning, time off without pay, or termination of employment. The District shall determine the appropriate sanction based on the severity of the violation.

(4) Conditions of Disclosure of Electronic Protected Health Information. The provisions of this 9.7(b)(4) shall be effective April 20, 2006. Disclosure of electronic PHI, as defined in 45 CFR Section 160.103, to the District under 9.7(b)(1)(A) is permitted if the following rules are satisfied. The District will reasonably and appropriately safeguard electronic PHI created, received, maintained, or transmitted to or by the District on behalf of the program. The District will:

(A) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the program;

(B) Ensure that any agent, including a subcontractor, to whom it provides such electronic PHI agrees to implement reasonable and appropriate security measures to protect the information;

(C) Ensure that the adequate separation required by 45 CFR Section 164.504(f)(2)(iii) and 9.7(b)(3) is supported by reasonable and appropriate security measures; and

(D) Report to the program any security incident of which it becomes aware.

9.8 Rescissions. This health care reimbursement account program will not rescind an individual's coverage under the program unless the individual (or a person seeking coverage on his or her behalf) performs an act, practice, or omission that constitutes fraud or makes an intentional misrepresentation of material fact, both of which are prohibited by the program. A rescission is as defined in 45 CFR § 147.128 or subsequent guidance. To the extent consistent with such guidance, a rescission is a cancellation or discontinuance of coverage that has retroactive effect (other than one due to a failure to timely pay required contributions). The program must provide at least 30 days advance written notice to each affected individual before coverage may be rescinded.

A Participant is prohibited from submitting for reimbursement an expense incurred by an individual other than the individuals described in 2.11. By submitting an expense for reimbursement, the Participant is making a representation that the expense is a Health Care Expense under 2.11. Whether an expense was incurred by an individual described in 2.11 is a material fact. The coverage of an individual who is not described in 2.11 may be rescinded if the requirements of this section are satisfied.

9.9 Mandatory Conversion of Account. The health care reimbursement Account of an Eligible Employee who is a Participant in this health care reimbursement account program immediately prior to October 1, 2013, and elects the Health Savings Account Benefit under 4.1(e) effective October 1, 2013, shall be converted, on a mandatory basis, to a dental and vision care reimbursement Account for the period of October 1, 2013, through December 31, 2013.

ARTICLE 10

DENTAL AND VISION CARE REIMBURSEMENT ACCOUNT PROGRAM

10.1 General. This article is intended to qualify as an accident and health plan within the meaning of Code Section 106. It is intended that reimbursements under this program be eligible for exclusion from the gross income of Participants under Code Section 105(b). Reimbursements under this program are limited to expenses that qualify as dental or vision care under Code Section 223(c). Accordingly, this program shall be interpreted and construed in accordance with Code Sections 106, 105(e), and 223 and any regulations or other interpretations thereunder. This program represents one benefit that may be elected by Participants under the Portland Public Schools Cafeteria Plan, and a Participant under that Plan who elects the Dental and Vision Care Expense Reimbursement Benefit thereunder is deemed to be a Participant under this dental and vision care reimbursement account program.

10.2 Limitations. The maximum amount of coverage that may be elected as a salary reduction contribution under this dental and vision care reimbursement account program for a Plan Year shall equal $2,500 (plus cost-of-living adjustments permitted under applicable law) ($2,550 for Plan Years beginning on or after January 1, 2015), prorated for any short Plan Year.

10.3 Dental and Vision Care Expenses. Each Participant under this dental and vision care reimbursement account program will be entitled to receive for each Plan Year reimbursements of Dental and Vision Care Expenses that are incurred during the Plan Year and that are not paid or reimbursed by insurance or otherwise, up to the dollar amount of coverage elected by the Participant for that Plan Year.

There will be no reimbursement for premiums paid by a Participant for any kind of health insurance. For example, there will not be any reimbursement for premiums paid for other dental plan coverage, including premiums paid for dental coverage under a plan maintained by the employer of the employee's spouse or Dependent.

Dental and Vision Care Expenses incurred for medicines or drugs may be reimbursed under this dental and vision care reimbursement account program only if the medicine or drug (a) requires a prescription, (b) is available without a prescription (i.e., an over-the-counter medicine or drug) and the individual obtains a prescription, or (c) is insulin.

The coverage elected for a Plan Year is available only to reimburse expenses that are incurred during the Plan Year. An expense shall be treated as having been incurred when the dental or vision care that gives rise to the expense is provided or at the time the equipment, supplies, or drugs that give rise to the expense are purchased, and not when the Participant is formally billed, charged for, or pays for the expense.

10.4 Other Provisions. The provisions contained in 9.4 through 9.7 apply to this dental and vision care reimbursement account program and are hereby incorporated by reference into this Article 10.

ARTICLE 11

DEPENDENT CARE REIMBURSEMENT ACCOUNT PROGRAM

11.1 Separate Program. This article is intended to qualify as a separate written dependent care assistance program within the meaning of Code Section 129. It is intended that reimbursements under this program be eligible for exclusion from the gross income of Participants under Code Section 129(a). Accordingly, this program shall be interpreted and construed in accordance with Code Section 129 and any regulations or other interpretations thereunder. To the extent that the requirements for such exclusion change under applicable federal law, the limitations and other rules set forth in this article shall automatically change to be consistent with such law.

This program represents one benefit that may be elected by Participants under the Portland Public Schools Cafeteria Plan, and a Participant under that Plan who elects the Dependent Care Reimbursement Benefit thereunder is deemed to be a Participant under this dependent care reimbursement account program, provided the Participant has one or more qualifying individuals at the time an election is permitted under the Portland Public Schools Cafeteria Plan. A "qualifying individual" means (a) a dependent of the Participant (as defined in Code Section 152(a)(1)) who is under age 13, or (b) a dependent (as defined in Code Section 21(b)(1)(B)) or the spouse of the Participant, if the dependent or spouse is physically or mentally incapable of self-care and has the same principal place of abode as the Participant for more than one-half of the taxable year. An individual shall not be treated as having the same principal place of abode as the Participant if at any time during the taxable year the relationship between the individual and the Participant is in violation of local law.

11.2 Nondiscrimination Requirements. The contributions and benefits provided under this program shall not discriminate in favor of highly compensated employees (as defined in Code Section 414(q)) or their dependents. The average benefits provided under all dependent care assistance programs of the District to nonhighly compensated employees must be at least 55 percent of the average benefits provided to highly compensated employees under all such programs.

11.3 Limitations. The amount of coverage that may be elected under this dependent care reimbursement account program for a Plan Year is limited to $5,000 (the limit is $2,500 for a married Participant who files a separate federal income tax return for the Plan Year); provided, however, that the coverage for an unmarried Participant shall not exceed the Participant's earned income for the Plan Year, and the coverage for a married Participant shall not exceed the lesser of the Participant's earned income or the spouse's earned income for the Plan Year. "Earned income" means wages, salaries, tips, and other employee compensation, but only if such amounts are includible in gross income for the taxable year, plus the amount of net earnings from self-employment for the taxable year. Earned income shall be computed without regard to any community property laws. Amounts received from pensions and annuities are not included. Amounts to which Code Section 871(a) applies are not included. Earned income shall not include any amounts paid or incurred by any employer for the Participant under this or any other dependent care assistance program. The earned income of a Participant's spouse for any month during which the spouse is a full-time student at an educational institution described in

Code Section 170(b)(1)(A)(ii) or is physically or mentally incapable of self-care shall be deemed to be not less than $250 (if the Participant has one qualifying individual for the Plan Year), or $500 (if the Participant has two or more qualifying individuals for the Plan Year). A full-time student is an individual who is enrolled at and attends the educational institution during each of five calendar months of the individual's taxable year for the number of course hours that is considered to be a full-time course of study. The enrollment for five calendar months need not be consecutive. School attendance exclusively at night does not constitute a full-time course of study. However, a full-time course of study may include some attendance at night.

11.4 Dependent Care Expenses. Dependent Care Expenses mean expenses for household services and expenses for the care of a qualifying individual, but only if the expenses are incurred to enable the Participant to be employed by the District for a period during which the Participant has a qualifying individual. Expenses for services outside the Participant's household will qualify only if the expenses are for the care of a dependent (as defined in Code Section 152(a)(1)) who is under age 13, or for the care of a qualifying individual who regularly spends at least eight hours each day in the Participant's household. If the outside services are provided by a dependent care center as defined in Code Section 21(b)(2)(D), the expense will qualify only if the dependent care center complies with all applicable laws and regulations of the applicable state or unit of local government. Dependent Care Expenses do not include expenses for services performed by an individual for whom a personal income tax exemption is allowable either to the Participant or the spouse, or expenses for services of a son, stepson, daughter, stepdaughter, or eligible foster child (as defined in Code Section 152(f)(1)(C)) of the Participant who has not attained age 19 at the close of the taxable year. For purposes of the preceding sentence, a Participant's child shall include a Participant's legally adopted child and a child placed with the Participant for adoption.

11.5 Administration. The plan administrator of this dependent care reimbursement account program shall be the same as for the Portland Public Schools Cafeteria Plan. The procedures for making and reviewing claims, plan administration, elections and revocation of elections, and reimbursement requests and payments shall be as set forth in the Portland Public Schools Cafeteria Plan.

ARTICLE 12

HEALTH SAVINGS ACCOUNT

12.1 General. An Eligible Employee may elect to make pre-tax Compensation reduction contributions to an HSA under 4.1(e) subject to the terms of Article 3 and this article. To make such contributions, the Eligible Employee must (a) be an "eligible individual" within the meaning of Code Section 223(c), (b) be covered by an HDHP coverage option provided by the District, and (c) have established an HSA account with an HSA trustee/custodian satisfactory to the Plan Administrator. If an Eligible Employee elects the Health Savings Account Benefit, the District will contribute to the Eligible Employee's HSA, subject to the Eligible Employee's continuing eligibility to contribute to an HSA, an amount as determined by the District and listed on Exhibit C. In no event will an Eligible Employee be allowed to receive such District contribution as a Cash Benefit.

12.2 Maximum Amount of Contributions. In no event shall the annual amount of the Participant's pre-tax Compensation reduction contributions and the District Contributions to the Participant's HSA exceed the annual limit described in Code Section 223(b). The limit is the annual statutory maximum under Code Section 223(b), as adjusted for cost-of-living increases ($3,350 for single HDHP coverage and $6,650 for family HDHP coverage in 2015), plus additional catch-up contribution amounts for Participants who are age 55 or older as described in Code Section 223(b)(3) ($1,000 for 2015).

Subject to the following, if the Participant is not eligible to contribute to an HSA for the entire Plan Year under this Article 12, the maximum annual contribution will be prorated for the number of months in which the Participant is eligible to contribute to an HSA. If a Participant is eligible to make HSA contributions during the last month of a Plan Year, however, the Participant's maximum annual HSA contribution for the Plan Year is the greater of the following:

(a) The prorated amount described in the preceding sentence; or

(b) The maximum annual HSA contribution under Code Section 223(b)(2)(A) or 223(b)(2)(B) based on the Participant's HDHP coverage (self-only or family) December 1 of that Plan Year, plus catch-up contributions under Code Section 223(b)(3), if applicable.

12.3 Forwarding of Contributions. The District will forward contributions to the Participant's HSA that the Participant has established with an HSA custodian or trustee. The Plan Administrator may limit the number of HSA providers to whom it will forward HSA contributions.

12.4 Status of HSA. The HSA Benefit under this Plan consists solely of the Participant's ability to make pre-tax Compensation reduction contributions to the HSA and the District contributions that are made to the HSA. The terms and conditions of each Participant's HSA are described in the HSA trust or custodial agreement provided by the applicable trustee or custodian and are not a part of this Plan.

The HSA is not an employer-sponsored employee benefit plan. It is a savings account that is established and maintained by an HSA trustee or custodian outside this Plan to be used primarily for reimbursement of "qualified medical expenses" as set forth in Code Section 223(d)(2). The District has no authority or control over the Participant's use of the amounts contributed to the HSA, the investment or distribution of such amounts, or any other aspect of the HSA's administration. The District's sole duty is to forward the District contributions and Compensation reduction amounts elected by the Participant to the HSA custodian or trustee. Even though this Plan allows pre-tax Compensation reduction contributions to an HSA, the HSA is not intended to be a benefit plan sponsored or maintained by the District.

The District has caused this amended and restated Plan to be executed by its duly authorized representative as of the date set forth below.

SCHOOL DISTRICT NO. 1,
MULTNOMAH COUNTY, OREGON

By: _____

Date: _____

EXHIBIT A
PORTLAND PUBLIC SCHOOLS
CAFETERIA PLAN

Plan Years
(Referent Section 2.16)

The Plan Years of the separate premium payment benefits are as follows:

FEBRUARY 1 – JANUARY 31 PLAN YEAR

ATU/DCU/PFTCE

Full-Time and Part-Time Option 1 Employees:

- Kaiser
- Providence Personal Option Plan
- Providence Point of Service
- Trust Dental Plan
- Providence Vision
- Kaiser Vision
- VSP Vision
- Walgreens Prescription Mail Service
- Postal Prescriptions Mail Service
- Wellpartners Prescription Mail Service
- Providence Pharmacy Plan
- Kaiser Mail Service Pharmacy
- Caremark Mail Service Pharmacy
- Caremark Pharmacy Plan

Part-Time Option 2 Employees:

- Kaiser
- Providence Open Option Plan
- Providence Personal Option Plan
- Walgreens Prescription Mail Service
- Postal Prescriptions Mail Service
- Wellpartners Prescription Mail Service
- Providence Pharmacy Plan
- Kaiser Mail Service Pharmacy
- Caremark Mail Service Pharmacy
- Caremark Pharmacy Plan

PAT

Full-Time and Part-Time Option 1 Employees:

- Kaiser
- Trust Preferred Provider Plan
- Providence Personal Option Plan
- Trust Dental Plan
- Kaiser Pharmacy Plan
- Providence Pharmacy Plan
- Caremark Pharmacy Plan
- Caremark Mail Service Pharmacy
- Kaiser Mail Service Pharmacy
- Providence Mail Service Pharmacy
- Trust Vision Plan
- Kaiser Vision Plan
- Trust Vision Plan

Part-Time Option 2 Employees:

- Kaiser
- Trust Indemnity Plan
- Providence Personal Option Plan
- Caremark Prescription Plan
- Caremark Mail Service Pharmacy
- Kaiser Pharmacy Plan
- Kaiser Mail Service Pharmacy

OCTOBER 1 – SEPTEMBER 30 PLAN YEAR

NON REPRESENTED AND SEIU EMPLOYEES

Full-Time and Part-Time Employees:

- OEBB – ODS Medical Plan 6 PPO
- OEBB – ODS Medical Plan 7 PPO
- OEBB – ODS Medical Plan 9 – High Deductible Plan
- OEBB – Kaiser Medical Plan 1A
- OEBB – ODS Dental Plan 4
- OEBB – Kaiser Dental Plan 8
- OEBB – ODS Vision Plan 2
- OEBB – Kaiser Vision Plan 5
- OEBB – Kaiser Pharmacy Plan A
- OEBB – ODS Pharmacy Plan A
- OEBB – ODS Integrated Pharmacy Plan
- OEBB – Kaiser Orthodontia Plan A
- OEBB – ODS Orthodontia Plan

DCU TEAMSTERS

Full-Time and Part-Time Employees:

- Teamsters Trust Medical Plan A
- Teamsters Kaiser Permanente Plan A
- Providence Health Plan PPO Plan A
- Teamsters Trust Kroger Pharmacy Plan A
- Teamsters Trust Dental Plan A
- Teamsters Trust VSP Vision Plan

EXHIBIT B
PORTLAND PUBLIC SCHOOLS
CAFETERIA PLAN

Cash Out of District Contribution
(Referent Section 4.1(d))

A Participant for whom the Plan Year under Exhibit A would be October 1 through September 30 shall be entitled to $275 in taxable cash compensation in each month in which he or she elects not to receive (and does not receive) coverage under the District's medical, dental, and vision plans, provided the Participant demonstrates to the Plan Administrator's satisfaction that he or she has coverage under another group medical plan, including a government provided basic medical plan.

EXHIBIT C
PORTLAND PUBLIC SCHOOLS
CAFETERIA PLAN

District Contribution
(Referent Section 5.1(c))

The amount of the District monthly contribution for each Plan Year for each Participant shall be the District's share of the premium for coverage under the District-provided group health plans.

The District will contribute the following additional amount for each Eligible Employee who elects the Health Savings Account Benefit described in 4.1(e): (1) $150 per month for an Eligible Employee enrolled in self-only coverage under a District-provided HDHP option, or (2) $275 per month for an Eligible Employee enrolled in family coverage under a District-provided HDHP option.