Portland Public Schools
Board of Education

2010-2011

Agenda

Regular Meeting

March 14, 2011

BOARD OF EDUCATION	**Board Auditorium**
Portland Public Schools	Blanchard Education Service Center
Regular Meeting	501 North Dixon Street
March 14, 2011	Portland, Oregon 97227

Note: *Those wishing to speak before the School Board should sign the citizen comment sheet prior to the start of the regular meeting. No additional speakers will be accepted after the sign-in sheet is removed, but citizens are welcome to sign up for the next meeting. While the School Board wants to hear from the public, comments must be limited to three minutes. All citizens must abide by the Board's Rules of Conduct for Board meetings.*

Citizen comment related to an action item on the agenda will be heard immediately following staff presentation on that issue. Citizen comment on all other matters will be heard during the "Remaining Citizen Comment" time.

This meeting may be taped and televised by the media.

AGENDA

1.	**STUDENT TESTIMONY**	5:30 pm
2.	**SUPERINTENDENT'S REPORT**	5:45 pm
3.	**LEGISLATIVE UPDATE**	5:50 pm
4.	**EXCELLENCE IN OPERATIONS AND SERVICES**	6:00 pm
	• Policy Amendment: Cafeteria Plan Second Reading *(action item)*	
5.	**EXCELLENCE IN TEACHING AND LEARNING**	
	• Ed Box Presentation *(information item)*	6:15 pm
6.	**COMMITTEE REPORTS**	6:30 pm
7.	**BUSINESS AGENDA**	6:40 pm
8.	**OTHER BUSINESS**	6:45 pm
9.	**CITIZEN COMMENT**	6:55 pm
10.	**ADJOURN**	7:15 pm

The next regular meeting of the Board will be held on **March 28, 2011,** at 5:30 pm at the Blanchard Education Service Center.

NOTE: The Board's agendas are focused on the five strategic operatives of the District as found in the 2005-2010 Strategic Plan: Excellence in Teaching and Learning; Excellence in Operations and Services; Strong Partnerships with Families and Community; Leadership for Results; and Continuous Learning Ethic.

Portland Public Schools Nondiscrimination Statement

Portland Public Schools recognizes the diversity and worth of all individuals and groups and their roles in society. All individuals and groups shall be treated with fairness in all activities, programs and operations, without regard to age, color, creed, disability, marital status, national origin, race, religion, sex, or sexual orientation.
Board of Education Policy 1.80.020-P

PORTLAND PUBLIC SCHOOLS

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STAFF REPORT
SUPERINTENDENT RECOMMENDATION

To: Superintendent Smith

Thru: *Hank Harris, Executive Director Human Resources*

From: *Terri Burton, Director Benefits and Compensation*

Date: *January 19, 2011*

Subject: *Cafeteria Plan Policy 5.10.090-P First Amendment 1/1/2011*

Issue Statement

In response to the 2010 national health care reform legislation and IRS tax code changes it has become necessary to amend the PPS Cafeteria Plan Board (FSA) Policy 5.10.090-P. The Cafeteria Plan Policy governs the administration of the District's Flexible Spending Account Plan. Attached please find a marked copy of the new policy for review. It is requested that FAO approve the new policy to go before the PPS Board of Education on February 7 for a first reading and after public comment final action be taken at the March 14th Board of Education meeting.

Background

The previous Cafeteria Plan Board Policy 5.10.090-P was created January 1, 2006 in response to tax code changes. A letter from Julia A. DeWitt, PC of Miller Nash is attached stating the plan changes that are necessary.

In summary, the plan changes are:

1. Accommodating the health reform addition of dependents under the age of 26
2. Revisions to the definition of a dependent
3. Enrollment rule changes
4. Plan year clarifications to match the underlying group health plans
5. Reducing employee election amounts effective 1/1/2013
6. Including new qualified reservist rules
7. Changing over-the-counter medicine reimbursement rules
8. Tightening of employer coverage rescind rules
9. Clarifying grandfather status of the plan and disclosure rules surrounding that status

Related Policies/Fiscal Impact

In 2013 employees will only be allowed to shelter $2,500, versus $3,000 currently allowed by the IRS.

Board Options

There are no financial implications to the District, other than in 2013 employees will be allowed to shelter $500 less per year in the health savings account. The $500 could be included in District employment tax payments. Currently the plan has approximately 700 participants and many of those do not contribute the maximum.

Staff Recommendation

I recommend the Board approve this policy revision to go forward to the February 7 Board of Education Meeting for a first reading and approval at their March 14th meeting.

Board Committee Review

This policy is slated to go before FAO at their January 19, 2011 meeting.

I have reviewed this staff report and concur with the recommendation to the Board.

Carole Smith

1.19.2011

Carole Smith
Superintendent
Portland Public Schools

Date

ATTACHMENTS

A. Marked copy of revised Cafeteria Plan Board Policy 5.10.090-P First Amendment
B. October 8, 2010 letter from Julie A. DeWitt, P.C. at Miller Nash

F7

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

~~I. NAME~~

ARTICLE 1

NAME AND EFFECTIVE DATE

~~(1)~~ **1.1 Name.** This ~~plan~~**Plan** shall be known as the Portland Public Schools Cafeteria Plan.

~~(2)~~ **1.2 Effective Date.** The effective date of this ~~plan~~**amended and restated Plan** is ~~May~~**January** 1, ~~1994.~~ **2006.** The benefits payable to or on behalf of a ~~participant~~**Participant** in the ~~plan~~**Plan** in accordance with the following provisions shall not be affected by the terms of any amendment to the ~~plan~~**Plan** adopted after the ~~participant~~**Participant** separates from service with the ~~district~~**District** unless the amendment expressly provides otherwise.

MARKED COPY
SHADED = ADDITION
~~_____~~ = DELETION
OCT 2 8 2010

~~II. Definitions.~~

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:**

~~(1)~~ 2.1 "**Account**" means the separate record or records maintained by the ~~plan administrator~~**Plan Administrator** in the name of a ~~participant~~**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)~~ 2.3 "**Code**"means the Internal Revenue Code of 1986, as amended, and successor Codes thereto.

~~(3)~~ 2.4 "**Compensation**"means ~~eligible employee~~**an Eligible Employee**'s wages or salary from the District during the ~~plan year~~**Plan Year** for personal services rendered, including bonuses, overtime, commissions, and other forms of remuneration includable in gross income.

~~(4)~~ 2.5 "**Dependent Care Expenses**" means expenses described in ~~Section~~ 10.4 that are incurred by a ~~participant~~**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 10 and are not used by the ~~participant~~**Participant** to obtain a credit against the ~~participant~~**Participant**'s federal income tax for employment-related expenses under Code Section 21.

~~(5)~~ 2.6 "**Dependent**" means**, for purposes of 2.9, 2.16, and 4.3,** a person who is a ~~participant~~**Participant**'s dependent as defined in Code Section ~~152.~~**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 2.10 and Article 9, a Dependent means a person who is a Participant's dependent as defined in Code Section 105(b).**

~~(6)~~ 2.7 "**District**" means ~~school district~~**School District** No. 1, Multnomah County, Oregon.

~~(7)~~ **2.8** "**Eligible Employee**" means any ~~district~~**District** employee, other than the following individuals:

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

(b) ~~Student workers.~~**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, ~~except that~~**excluding** substitute teachers ~~shall be eligible employees.~~**;**

(d) A person who ~~is not a district~~**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)~~ **(e)** A self-employed person as defined in Code Section 401(c)~~.~~**; and**

~~(8)~~ **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).**

Notwithstanding the foregoing, substitute teachers and any employees who have regularly scheduled hours of employment but are less than half-time employees are excluded from the definition of "Eligible Employee" for purposes of the Premium Payment Benefit described in 4.1(a) only.

2.9 "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.

2.10 "**Health Care Expense**" means an expense incurred by a ~~participant on behalf of the participant, the participant's spouse or dependent~~**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 program set forth in Article 9 and not used as a deduction on the ~~participant~~**Participant**'s federal income tax return.

~~(9)~~ "**2.11 "Participant**" means an ~~eligible employee~~**Eligible Employee** who has commenced and continues participation in the ~~plan.~~**Plan as provided in Article 3.**

~~(10)~~ "2.12 "Plan" means this Portland Public Schools Cafeteria Plan, as amended from time to time.

~~(11)~~ "2.13 "Plan Administrator" means such person or persons appointed by the ~~district~~District to control and manage the operation and administration of the ~~plan~~Plan. In the absence of such an appointment, the ~~district~~District shall be the ~~plan administrator~~Plan Administrator.

~~(12) "Plan Year" means the 12-month period beginning each May and ending each April 30. The plan year shall be the year on which the records of the Plan are kept.~~

2.14 "Plan Year" means, with respect to the health care reimbursement account program and the dependent care reimbursement account program, the calendar year (January 1 through December 31).

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 listed 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.

2.15 "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.

2.16 "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.

~~III. Eligibility.~~

ARTICLE 3

ELIGIBILITY

~~(1)~~3.1 **Eligibility for ~~Participant~~. ~~An eligible employee~~Participation. An Eligible Employee** shall be eligible to participate in this ~~plan~~**Plan** on the first day of the calendar month after he or she has completed one full calendar month of employment.

~~(2)~~3.2 **Termination of ~~Participant~~.Participation.** In the event a ~~participant~~**Participant** transfers to an ineligible class of employees or terminates employment with the ~~district~~**District**, the ~~participant~~**Participant**'s participation in this ~~plan~~**Plan** shall cease as of the date of such transfer or termination, except as specifically provided for in this ~~plan~~**Plan**.

~~(3)~~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~~**Plan** on the first day of the calendar month following the transfer if he or she is a former ~~participant~~**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.

~~IV. Participation.~~

ARTICLE 4

PARTICIPATION

~~(1)~~4.1 **Election to Participate.** The participation election form shall be signed by the ~~eligible employee~~**Eligible Employee**, shall designate the benefits in which the ~~eligible employee~~**Eligible Employee** elects to participate, and shall designate the ~~plan year~~**Plan Year** (or the remaining portion of the ~~plan year~~**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~~ **Compensation** shall be reduced or the amount of such reduction shall be determinable from that form. ~~A participant's compensation~~ **A Participant's Compensation** reduction election must satisfy the minimum and maximum elective contribution requirements in ~~V(3).~~5.3.

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

An ~~eligible employee~~**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~~**Plan** by a ~~compensation~~**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 program set forth in ~~IX.~~ **Article 9.**

(c) 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 ~~X.~~ **Article 10.**

(d) 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.

~~(2)~~4.2 **Election Procedures.** The following rules shall govern an ~~eligible employee~~**Eligible Employee**'s elections under this ~~plan~~**Plan**:

(a) Initial Participation. Except as otherwise provided in 4.3, if the ~~eligible employee~~**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~~**Plan Year** to which the open enrollment period applies.

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

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

~~(3)~~ 4.3 **Revocation and Changes.** Once made, a ~~participant~~**Participant**'s election shall be effective for the entire ~~plan year~~**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 ~~non-discriminatory~~**nondiscriminatory** rules adopted by the ~~plan administrator, which~~**Plan Administrator that** are consistently applied. ~~Benefit~~ **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.**

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 ~~(3)~~4.3(a) sets forth rules for election changes as a result of changes in cost or coverage. This ~~(3)~~4.3(a) does not allow election changes with respect to the ~~benefits~~**health care expense reimbursement benefit** described in **4.1(b)**.

(1)~~(a).~~ ~~**(A)**~~ **Cost Changes.**

(~~i~~**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' ~~payments~~**Compensation reduction contributions for such plan**.

~~(b) **Change in Family 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 the revocation portion of the plan year if the revocation and new election are both on account of a change in family status and are consistent with such change in family status. For purposes of this paragraph examples of changes in family status for which a benefit election change is permitted include the marriage or divorce of the participant, the death of the participant's spouse or a dependent, the birth or adoption of a child of the participant, the termination of employment (or the commencement of employment) of the participant's spouse, the switching from part-time to full-time employment status or from full-time to part-time status by the participant or the participant's spouse, and the taking of unpaid leave of absence by the participant or the participant's spouse. Election changes are also permitted where there has been a significant change in the health coverage of the participant or spouse attributable to the spouse's employment. Benefit election changes are consistent with family status changes only if the election changes are necessary or appropriate as a result of the family status changes. Benefit election changes under this subsection (b) must be made within 31 days after the family status change.~~

~~(c) **Termination of Employment** A participant who terminates employment during the plan year may revoke existing benefit elections and terminate the receipt of benefits for the remaining portion of the plan year.~~

~~However, in such a case, if the former participant returns to employment during the same plan year, he or she may not make a new benefit election for the remaining portion of the plan year.~~

(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 ~~V(4)~~**5.4** with respect to eligible Dependent Care Expenses, a benefit will cease to be provided to a ~~participant~~**Participant** if the ~~participant~~**Participant** fails to make the required premium payments with respect to the benefit (e.g., a ~~participant~~**Participant** ceases to make premium payments for health care reimbursement account coverage after a termination of employment). However, in such ~~a~~ case, the former ~~participant~~**Participant** may not again make a new benefit election for the remaining portion of the ~~year~~**Plan Year**.

~~V. Credits and Reimbursement Procedures.~~

ARTICLE 5

CREDITS AND REIMBURSEMENT PROCEDURES

~~(1)~~5.1 **Credits to Plan.** The following rules shall govern the ~~compensation~~**Compensation** reduction credits to this ~~plan~~**Plan** during a ~~plan year~~**Plan Year**:

(a) **Establishment of Accounts.** For each ~~participant~~**Participant**, the ~~plan administrator~~**Plan Administrator** shall establish a separate ~~account~~**Account** for each reimbursement benefit under 4.1 for the ~~plan year~~**Plan Year**.

(b) **Compensation Reduction Credits.** For each ~~participant~~**Participant**, the amount by which the ~~participant~~**Participant** elects to reduce his or her ~~compensation~~**Compensation** for a specific benefit shall be deducted from the ~~participant's compensation~~**Participant's Compensation** during the ~~plan year~~**Plan Year** by payroll deduction and credited to the ~~participant's account~~**Participant's Account** for such benefit or credited against the cost of that benefit as determined by the ~~plan administrator~~**Plan Administrator**.

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

(d) **Allocation of Expense.** An eligible Dependent Care Expense submitted for reimbursement by a ~~participant~~**Participant** shall be paid only from the ~~account~~**Account** established for such ~~participant~~**Participant** for such expense and only to the extent of the amount recorded in the ~~account~~**Account** (after deducting earlier reimbursements made during the ~~plan year~~**Plan Year**). The maximum amount of Health Care Expense reimbursement under Article 9 must be available at all times during the ~~plan year~~**Plan Year** (properly reduced as of any particular time for prior reimbursements for the same ~~plan year~~**Plan Year**). Thus, the maximum amount of Health Care Expense reimbursement at any particular time during the ~~plan year~~**Plan Year** cannot be limited to the amount recorded in the ~~account~~**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).

(e) **Unused Amounts.** An amount remaining in an ~~account~~**Account** after the ~~participant~~**Participant** has submitted all reimbursable expenses for the ~~plan year~~**Plan Year** of the type for which the ~~account~~**Account** is established,

shall not be carried over to a subsequent ~~plan year~~**Plan Year**, nor shall such amount be paid, directly or indirectly, to the ~~participant~~**Participant** in cash or in the form of any other benefit.

~~(2)~~5.2 **Reimbursement Payment Procedures.** The following rules shall govern the reimbursement of a ~~participant~~**Participant**'s eligible expenses under a reimbursement benefit:

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

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

~~(3)~~5.3 **Amount of Elective Contributions**. The maximum benefits that any Participant may receive from this Plan for a Plan Year shall be 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 $~~8,000.~~ 20,000. The minimum amount of elective contributions that may be elected by any ~~participant~~**Participant** shall be $20 per month.

Notwithstanding the foregoing, effective January 1, 2013, 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 shall equal $2,500 (plus cost-of-living adjustments permitted under applicable law).

~~(4)~~ 5.4 **Expense Reimbursement After Participation Terminates.** If, during a ~~plan year, a participant~~**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~~**Plan Year** to the ~~plan administrator~~**Plan Administrator** for reimbursement under the dependent care reimbursement account program.

If a ~~participant~~**Participant** terminates employment with the ~~district~~**District** or transfers to an ineligible class of employees and revokes his~~/~~ **or** her existing benefit elections, the ~~plan administrator~~**Plan Administrator** shall reimburse the ~~participant~~**Participant** for any amount previously paid for coverage or benefits under the health care reimbursement 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.

(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 health care reimbursement 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) Distribution 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 health care reimbursement 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 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.

~~VI. Claims Procedure.~~

ARTICLE 6

CLAIMS PROCEDURE

~~(1)~~6.1 **Initial Claim.** Any person claiming ~~a~~ **a premium payment** benefit under this ~~plan ("claimant") shall present the claim in writing to the plan administrator.~~**Plan shall present the claim in writing to the Plan Administrator. Any person claiming a dependent care expense reimbursement benefit or a health 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."**

~~(2)~~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~~**Plan Administrator or Claim Reviewer** to the ~~claimant~~**Claimant** within a reasonable period after receipt of the claim by the ~~plan administrator~~**Plan Administrator or Claim Reviewer**.

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

(~~A~~1) The specific reasons for the denial;

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

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

(~~D~~4) An explanation of the ~~plan~~**Plan**'s claim review procedure.

~~(3)~~6.3 **Review of Denied Claim.** If a ~~claimant~~**Claimant** receives a notice of denial, the ~~claimant~~**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~~**Claimant** or his or her authorized representative, to the ~~plan administrator. The claimant~~**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~~**Claimant** shall be deemed to waive his or her right to review. The ~~claimant~~**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.

~~(4)~~**6.4 Decision on Review.** A review shall be made by the ~~plan administrator~~**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~~**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~~**Plan** upon which the decision is based. The decision shall be final and binding upon the ~~claimant and~~**Claimant,** the ~~district~~**District,** and all other persons involved.

6.5 Further Review. 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~~**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~~**Plan Administrator** has discretionary authority to determine eligibility for benefits and to construe the terms of this ~~plan~~**Plan**.

~~VII. Plan Administration.~~

ARTICLE 7

PLAN ADMINISTRATION

~~(1)~~7.1 **Appointment of Plan Administrator.** The ~~district~~**District** shall appoint one or more persons to act as the ~~plan administrator~~**Plan Administrator** and to serve for such terms as the ~~district~~**District** may designate or until a successor has been appointed or until removed by the ~~district~~**District**. Vacancies due to resignation, death, removal or other causes shall be filled by the ~~district~~**District**. The ~~plan administrator~~**Plan Administrator** shall be bonded except as may otherwise be allowed by law. The ~~plan administrator~~**Plan Administrator** may be paid reasonable compensation for its service; however, a ~~plan administrator~~**Plan Administrator** who is a full-time employee of the ~~district~~**District** shall serve without compensation. All reasonable expenses of the ~~plan administrator~~**Plan Administrator** shall be paid by the ~~district~~**District**. If a designation of a ~~plan administrator~~**Plan Administrator** is not made, the ~~district~~**District** shall be the ~~plan administrator~~**Plan Administrator**.

~~(2) Right~~7.2 **Rights and Duties.** The ~~plan administrator~~**Plan Administrator** shall be the named fiduciary of the ~~plan~~**Plan**. The ~~plan administrator~~**Plan Administrator**, on behalf of the ~~participants~~**Participants** and their beneficiaries, shall have the authority to control and manage the operation and administration of the ~~plan~~**Plan** and shall have all powers necessary to accomplish those purposes. The responsibility and authority of the ~~plan administrator~~**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~~**Participants**, spouses, and dependents;

(c) Authorizing all disbursements;

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

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

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

~~(3)~~7.3 **Information, Reporting~~,~~ and Disclosure.** To enable the ~~plan administrator~~**Plan Administrator** to perform its functions, the ~~district~~**District** shall supply full and timely information to the ~~plan administrator~~**Plan Administrator** on all matters

relating to the ~~participants~~**Participants** and such other pertinent facts as the ~~plan administrator~~**Plan Administrator** may require. The ~~plan administrator~~**Plan Administrator** shall have the responsibility of complying with the reporting and disclosure requirements of applicable law.

~~(4)~~**7.4 Independent Qualified Accountant.** If required by applicable law or regulation, the ~~plan administrator~~**Plan Administrator** shall engage, on behalf of all ~~plan participants~~**Plan Participants**, an independent qualified public accountant who shall conduct such examinations of the financial statements of the ~~plan~~**Plan** and of other books and records of the ~~plan~~**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.

~~(5)~~**7.5 Allocation and Delegation of Responsibility.** The ~~plan administrator~~**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~~**Plan**.

The ~~plan administrator~~**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~~**Plan**, in more than one fiduciary capacity.

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

~~(6)~~**7.6 Indemnification.** The ~~district~~**District** hereby indemnifies and holds harmless the ~~plan administrator~~**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~~**Plan Administrator**'s or the person's willful neglect, misconduct, or gross negligence.

~~VIII. Miscellaneous.~~

ARTICLE 8

MISCELLANEOUS

~~(1)~~8.1 **Right to Amend and Terminate.** The ~~district~~**District** represents that the ~~plan~~**Plan** is intended to be a continuing program for ~~participants~~**Participants** but reserves the right to terminate the ~~plan~~**Plan** at any time. The ~~district~~**District** may modify, alter, or amend this ~~plan~~**Plan** in whole or in part.

~~(2)~~8.2 **Unsecured Right to Payment.** No employee shall ~~be~~**by** virtue of this ~~plan~~**Plan** have any interest in any specific asset or assets of the ~~district~~**District**. An employee has only an unsecured contract right to receive benefits in accordance with the provisions of the ~~plan~~**Plan**.

~~(3)~~8.3 **No Obligation to Fund.** The ~~district~~**District** shall have no obligation to establish a trust **or** fund for the payment of benefits or to ~~ensure~~**insure** any of the benefits.

~~(4)~~8.4 **No Interest.** The ~~district~~**District** shall have no obligation to pay interest on any ~~participant~~**Participant**'s salary reduction amounts or ~~accounts~~**Accounts** used to provide the benefits under this ~~plan~~**Plan**.

~~(5)~~8.5 **Provision Against Anticipation.** No ~~participant~~**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~~**Participant** under the terms of this ~~plan~~**Plan**, and no such benefits or proceeds shall be subject to seizure by any creditor of the ~~participant~~**Participant** under any writ or proceedings at law or in equity.

~~(6)~~8.6 **Right to Discharge Employees.** Neither the ~~established~~**establishment** of this ~~plan~~**Plan**, nor any modification thereof, nor the payment of any benefit, shall be construed as giving any ~~participant~~**Participant** or any other person any legal or equitable right against the ~~district~~**District** unless the same shall be specifically provided for in this ~~plan~~**Plan**, nor as giving any employee or ~~participant~~**Participant** the right to be retained in the ~~district~~**District**'s employ. All employees shall remain subject to discharge by the ~~district~~**District** to the same extent as if this ~~plan~~**Plan** had never been adopted.

~~(7)~~8.7 **Construction.** This ~~plan~~**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)~~8.8 **Legally Enforceable.** The ~~district~~**District** intends that the ~~plan~~**Plan** terms, including those relating to coverage and benefits, are legally enforceable. The ~~plan~~**Plan** is maintained for the exclusive benefit of employees.

~~IX. Health Care Reimbursement Account Program.~~

ARTICLE 9

HEALTH CARE REIMBURSEMENT ACCOUNT PROGRAM

~~(1)~~9.1 **General.** This ~~Article~~**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~~**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~~**Participants** under the Portland Public Schools Cafeteria Plan, and a ~~participant~~**Participant** under that ~~plan~~**Plan** who elects the Health Care Expense Reimbursement Benefit thereunder is deemed to be a ~~participant~~**Participant** under this health care reimbursement account program.

~~(2)~~9.2 **Amount of Coverage.** For each ~~plan year, a participant~~**Plan Year, a Participant** may elect any whole dollar amount of coverage under this health care reimbursement account program up to $3,000.

Notwithstanding the foregoing, effective for Plan Years beginning on and after January 1, 2013, 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).

~~(3)~~9.3 **Health Care Expenses.** Each ~~participant~~**Participant** under this health care reimbursement account program will be entitled to receive for each ~~plan year~~**Plan Year** reimbursements of Health Care Expenses that are incurred during the ~~plan year~~**Plan Year** and that are not paid or reimbursed by insurance or otherwise, up to the dollar amount of coverage elected by the ~~participant~~**Participant** for that ~~plan year~~**Plan Year**.

There will be no reimbursement for premiums paid by a ~~participant~~**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~~**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~~**Plan Year** is available only to reimburse expenses that are incurred during the ~~plan year~~**Plan Year**. An expense shall be treated as having been incurred ~~during~~**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~~**Participant** is formally billed, charged for, or pays for the expense.

~~(4)~~**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.

~~(5)~~**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 ~~there under~~**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. 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 2.10. By submitting an expense for reimbursement, the Participant is making a representation that the expense is a Health Care Expense under 2.10. Whether an expense was incurred by an individual described in 2.10 is a material fact. The coverage of an individual who is not described in 2.10 may be rescinded if the requirements of this section are satisfied.

~~X. Dependent Care Account Program.~~

ARTICLE 10

DEPENDENT CARE REIMBURSEMENT ACCOUNT PROGRAM

~~(1)~~10.1 **Separate Program.** This ~~Article~~article is intended to qualify as a separate written dependent care ~~assistant~~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~~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 ~~there under.~~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~~Participants under the Portland Public Schools Cafeteria Plan, and a ~~participant~~Participant under that ~~plan~~Plan who elects the Dependent Care Reimbursement Benefit ~~there under~~thereunder is deemed to be a ~~participant~~Participant under this dependent care reimbursement account program, provided the ~~participant~~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~~Participant (as defined in Code Section 152(a)(1)) who is under age ~~13 and with respect to whom the participant is entitled to a deduction under Code Section 151(c);~~13, or (b) a dependent (as defined in Code Section 21(b)(1)(B)) or the spouse of the ~~participant~~Participant, if the dependent or spouse is physically or mentally incapable of self-~~care~~-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.

~~(2)~~10.2 **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~~District to ~~non-highly~~nonhighly compensated employees must be at least 55 percent of the average benefits provided to highly compensated employees under all such programs.

~~(3)~~10.3 **Limitations.** The amount of coverage that may be elected under this dependent care reimbursement account program for a ~~plan year~~Plan Year is limited to $5,000 (the limit is $2,500 for a married ~~participant~~Participant who files a separate federal income tax return for the ~~plan year~~Plan Year); provided, however, that the coverage for an unmarried ~~participant~~Participant shall not exceed the ~~participant~~Participant's earned income for the ~~plan year~~Plan Year, and the coverage for a married ~~participant~~Participant shall not exceed the lesser of the ~~participant~~Participant's earned income or the spouse's earned income for the ~~plan year.~~ 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~~**Participant** under this or any other dependent care assistance program. The earned income of a ~~participant~~**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 $~~200~~250 (if the ~~participant~~**Participant** has one qualifying individual for the ~~plan year~~**Plan Year**), or $~~400~~500 (if the ~~participant~~**Participant** has two or more qualifying individuals for the ~~plan year~~**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.

~~(4)~~**10.4** **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~~**Participant** to be employed by the ~~district~~**District** for a period during which the ~~participant~~**Participant** has a qualifying individual. Expenses for services outside the ~~participant~~**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 and with respect to whom the participant is entitled to a personal income tax exemption under Code Section 151(c),~~**13,** or for the care of a qualifying individual who regularly spends at least eight hours each day in the ~~participant~~**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~~**Participant** or the spouse, or expenses for services of a son, stepson, daughter ~~or~~, 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 ~~plan year.~~**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.**

~~(5)~~**10.5** **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.

EXHIBIT A
PORTLAND PUBLIC SCHOOLS
CAFETERIA PLAN

Plan Years
(Referent Section 2.14)

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**

~~History: Adpt. 12/06/93; Emergency Amd. 12/09/02, BA 2512; Final Adpt. 2/10/03, BA 2561~~

EdBox: Learning & Teaching Cooperative

14 March 2011

The EdBox is...
a vision of a digital learning & teaching cooperative

Easy

Efficient

Effective

by Ken Brock

The EdBox is...
an integrated suite of technology systems

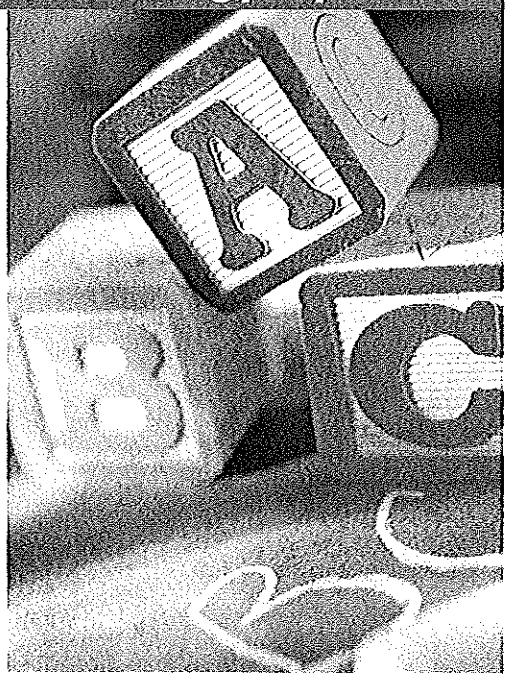
"one stop shopping"

resource center

learning & teaching planner

digital archive

social network



What essential question is driving the EdBox initiative?

What do we want learning & teaching to be like when this year's kindergarten students graduate from high school?

Let's build toward that!

Building a Solid Foundation

- Take advantage of existing technology systems
- Think comprehensively as we acquire and develop new systems and resources
- Standardize courses and clearly define learning targets for each course
- Develop shared grading guidelines and performance scales
- Embed assessment data where teachers and students handle the business processes of teaching and learning
- Secure digital rights to curriculum materials

Addressing Goals

- Save time
- Enhance communication
- Secure vital student information
- Close achievement gaps and positively address milestones outcomes

Gradebook

- Currently being field tested by roughly 280 teachers in 13 high schools
- Facilitates proficiency-based methodologies including alignment of learning targets to courses and assignments
- Enables sound grading/assessing practices
- Integrates with eSIS saving time and promoting data integrity
- Provides student and parent web access to real-time performance information (EdBox Viewer currently activated at Benson, BizTech, Franklin, Lincoln, Madison, Pauling, Renaissance Arts, Wilson)

Curriculum Planner

- Currently being tested by curriculum leaders and piloted by a handful of classroom teachers to determine plans for next year
- Course guide content and adopted curriculum materials are being loaded for teacher and student reference
- Manages hybrid learning experiences (online plus face-to-face) including a robust assessment system integrated with the gradebook
- Will eventually enable students to own and manage their own progress and learning experiences
- Provides collaboration opportunities including a student, teacher, and parent web portal (primary enabler of one stop shopping)

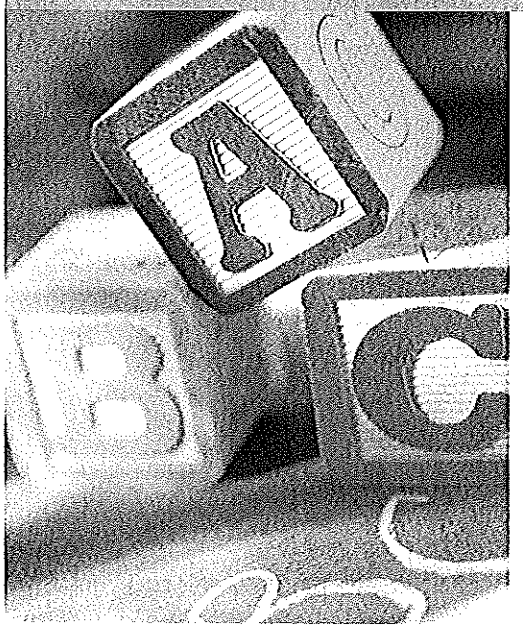
What's in the Works for Next Year?

- All middle schools and high schools will begin using the EdBox Gradebook and some elements of the Curriculum Planner
- We will promote sound grading/assessing practices as part of the implementation
- EdBox Viewers will be activated at all middle schools and high schools
- We hope to move attendance to the gradebook, but we can't commit fully until we've completed system testing
- We are investigating the possible deployment of teacher and student portals as part of curriculum planner

Plan for 2012-2013 and Beyond

- Make the gradebook and curriculum planner available in all schools and programs including K-5 and K-8 schools
- Generate report cards directly from the gradebook including a revised K-5 standards-based report card
- Enable student and parent EdBox Viewers for all schools and programs
- Investigate opportunities to streamline processes via the EdBox
- Plug other education technology systems into the EdBox
- Continue to apply the EdBox philosophy of an integrated suite of systems as we procure additional resources and services

Questions



...and Responses

Thank you!

Gradebook & Curriculum Planner Charter

March 7, 2011

PROBLEM STATEMENT

As Portland Public Schools works toward providing a guaranteed and viable curriculum in support of our milestones framework, we lack the instructional data systems necessary to enable program fidelity and equity of access. In addition, as individual teachers, departments, and schools have taken measures to acquire such data systems on their own, vital student information is not being adequately secured. These problems impact every student, family, teacher, and school.

PROJECT STRATEGY

PPS will acquire and implement an enterprise gradebook and curriculum planner made available to all PPS schools and programs including affiliated Community Based Organizations. The implementation of these systems common to all schools will provide more immediate and finite student performance information which will in turn enable expeditious and relevant responses to interventions.

IDENTIFIED OUTCOMES

- All PPS schools and programs will actively use the gradebook and curriculum planner by September 2012.
- Stronger correlations will be present between student performance as reflected by benchmark assessments and curriculum embedded measurements such as course grades.
- Evidence of student performance will reflect a more consistent interpretation of proficiency levels.
- Students and parents will demonstrate an increased awareness of student performance by course objectives and learning targets.
- A greater number of teachers will effectively apply proficiency-based tools and strategies.
- Teachers will more consistently and effectively employ district adopted instructional materials.

OUT-OF-SCOPE WORK

The project scope is limited to the functionality available through GlobalScholar's Pinnacle Grade and Pinnacle Instruction modules (referenced in PPS as the EdBox Gradebook & Curriculum Planner) and affiliated data integrations and business process changes.

PROJECT SCHEDULE

#	**Phase One Deliverables** (through first semester 2010-11)	**Critical Success Factors**	**Constraints & Risks**
1	Install hardware and software and make the gradebook optionally available in 17 high schools for the start of the 2010-11 school year.	• Secure schools and teachers willing to participate	• Short implementation window
2	Establish eSIS integration, which allows efficient transfer of demographic data (including eSIS alerts) from eSIS to the gradebook and transfer of marks data from the gradebook to eSIS for production of progress and report cards and long term record keeping.	• GlobalScholar's expertise to make this happen	• No other district has used the eSIS API to handle some of these data transfers
3	Enable Internet Viewer for students and parents as optional service with participation determined by school leaders.	• Teachers enter enough information to make it useful • Simple authentication processes	• Only partial information will be available until all teachers use the gradebook
4	Establish gradebook change request process with approved requests being processed as appropriate.	• Student & Academic Services ownership of this process	• Keeping the degree of variations within a manageable scope
5	Refine grading scales to simplify use and support standardized naming conventions.	• Effective communication and change notifications	• Making too many changes could make things unnecessarily confusing
6	Load standards for those courses with identified priority standards and/or learning targets and additional standards by teacher request and as recommended by Student & Academic Services.	• Prioritization of this work within Student & Academic Services	• Uncertainty around how to handle standards as the state adopts national standards
7	Put in place the necessary support resources and short-term professional development plan for stakeholder groups.	• Taking the time to develop and implement a well thought out PD plan	• Getting access to job embedded time when there are so many competing priorities
8	Load course guide content for 9th grade courses in the curriculum planner.	• Content is not just loaded but used to promote curriculum	• Keeping content up to date as changes are made • The module is not intuitive enough to meet our needs

#	**Phase Two Deliverables** (through end of 2010-11 academic year)	**Critical Success Factors**	**Constraints & Risks**
1	Provide necessary support for teachers joining the field test at second semester and create a plan for full high school adoption in 2011-12.	• Learn from phase one implementation	• Getting access to job embedded time when there are so many competing priorities
2	Load course guide content for 10th grade courses in the curriculum planner.	• Momentum is maintained within Student & Academic Services to continue the work	• The guides continue to be differentiated in their organization and terminologies
3	Develop gradebook reports as requested by users and deemed necessary by the project team.	• Adequately engage stakeholders to determine needs	• Not losing this in the long list of activities to be completed
4	Expand demographics to include all eSIS alerts, program participation, and assessment scores in gradebook demographics view.	• They are easy to locate	• API limitations
5	Prepare for teachers to take period and daily attendance in the gradebook for 2011-12 if deemed part of phase three deliverables.	• Make sure we build a robust change management process	• We don't yet have an API and will likely be constrained by eSIS
6	Plan for generating progress and report cards and proficiency reports from the gradebook for 2011-12.	• Make sure we build a robust change management process	• We go to all this effort and wind up with a new set of problems
7	Pilot Instruction module including current materials adoptions to inform future pilots as applicable.	• Transparent and concrete scope, goals, and evaluation methods	• Keeping the depth and breadth of pilots within a manageable scope
8	Develop a new data transfer process from the gradebook to the PPS data warehouse.	• Make sure we identify all relevant data fields prior to rollover	• Data captured in ways that can be referenced by an analytics system
9	Create a version 8.x upgrade plan based on evaluation of functionality and readiness.	• Adequately prepare users for changes they will experience	• Delays in determining what is included in 8.2
10	Develop a plan for MS/ES expansion during 2011-12 including possible spring 2011 pilots.	• Apply lessons learned from 2010-11 field test	• We stretch ourselves too thinly to adequately support all levels
11	Develop a robust professional development plan in support of 2011-12 users.	• Getting Student and Academic Services to help own this	• Being too distracted with the work at hand

#	**Phase Three Deliverables** (2011-12 academic year)	**Critical Success Factors**	**Constraints & Risks**
1	Make the gradebook available to all high schools and high school teachers.	• Build upon what was learned during the 2010-11 field test	• The change in scale could require more support than we're prepared to handle
2	Move high school period attendance to the gradebook if early explorations into this deliverable leads us to believe it will be unnecessarily distracting to other deliverables.	• Working through this quickly enough to pilot before broad application	• This will involve significant business process changes for users
3	Generate high school progress reports and report cards from the gradebook.	• Make sure we build a robust change management process	• We may not be able to include all information traditionally included on these reports
4	Enable parent and student internet viewers for all high schools.	• Reducing the need for parents to go to both eSIS Parent Assistant and the new internet viewer	• Parent account management and authentication could prove to be problematic
5	Make the gradebook available to all middle schools starting in the fall. We would plan to include attendance and report card generation as part of the package.	• Secure the resources necessary to adequately support this implementation on top of the high school expansion	• There may be variables involved with this implementation which require unanticipated support requirements
6	Continue expanded field testing of curriculum planner if 2010-11 pilots validate continued use of this module. This includes a K-5 pilot of the assessment system.	• Migrating from old curriculum support practices to new business processes – not trying to sustain both in parallel	• Spring 2011 pilots may indicate the module is not worthy of continued use
7	Continue to load instructional materials in the curriculum planner as they are created or adopted if pilots validate continued use.	• Continuing to perform the due diligence to secure digital rights to content	• A number of recent adoptions have not included adequate digital rights
8	If the system is deemed ready, pilot electronic referrals in one school and create an implementation plan to expand use to other schools.	• Make sure the discipline leadership team owns this work	• The current version does not do what we would like it to do
9	Complete all the work necessary for elementary levels to begin using the gradebook and curriculum planner in fall of 2012.	• We don't wait too late to start tackling the foundational elements necessary to expand into elementary	• There is a LOT of work to be done to prepare for elementary

#	**Phase Four Deliverables** (2012-13 academic year)	**Critical Success Factors**	**Constraints & Risks**
1	Make the gradebook and curriculum planner available to all teachers from all levels, programs, and schools.	• Meeting or exceeding expectations in the first three phases	• The budget outlook and other priorities which may supercede this project
2	Move all attendance to the gradebook.	• This will require substantial changes to our business processes	• eSIS will continue to operate as the district's system of record. • With Pearson's purchase of AAL (the eSIS company), we might have to slow down this project to integrate with a new SIS
3	Generate all progress reports and report cards from gradebook including a revised K-5 standards-based report card.	• Engage stakeholders at the degree needed to support the shift to a new report card	• Some of our standards are still in development and may still be by the time this work needs to be done
4	Enable student and parent internet viewers for all schools and programs.	• Reducing the need for parents to go to a SIS-based web viewer and the new gradebook internet viewer	• Managing this service to parents and students with the population being so great
5	Continue expanded use of curriculum planner including management of work samples and common assessments.	• By this time Student & Academic Services will need to have changed their business practices to completely own this module's implementation	• Curriculum needs may outpace our capacity to provide support through this module
6	Continue to load instructional materials in the curriculum planner as they are created or adopted.	• Continuing to perform the due diligence to secure digital rights to content	• We have not built into our adoption process the need to load and organize digital resources into the curriculum planner
7	Electronic referrals made available to all schools if system is deemed ready.	• Build upon our past experiences with this functionality	• The tool may never provide the service we need to meet our goals

BUDGET & RESOURCE REQUIREMENTS

Additional staff implementation resources will be required to effectively train and support teachers in the use of the Gradebook and Curriculum Planner, based on the results of the 2010-11 field test. A dedicated central teacher leader for each level (high, middle, and elementary) will be required to support the implementation, as well as a lead teacher at each school to serve as a site-based contact.

The project team is also requesting additional IT Functional Lead support, but we expect that we can deliver this service with a more effective project structure, so that is not reflected in the budget.

Expense	Current Budget	Addn. - Year 1	Year 2	Year 3	TOTAL
Software contract	$1,122,192				$,1,122,192
Computer servers	$ 128,156				$ 128,156
Teacher training/stipend	$ 150,607	$ 16,200	$ 18,000	$108,000	$ 292,807
Support services (GS and Vogt)	$ 110,000		$ 60,000	$ 60,000	$ 230,000
Staffing	$ 22,687	$190,000	$ 95,000	$ 95,000	$ 402,687
TOTAL	**$1,523,412**	**$206,200**	**$173,000**	**$263,000**	**$2,175,842.00**

PROJECT MANAGEMENT STRUCTURE

EdBox Steering Committee

Name	Title	Role
Sara Allan	Executive Director, System Planning & Performance	Executive Sponsor
Nick Jwayad	Chief Information Officer	Executive Sponsor
Carla Randall	Chief Academic Officer	Executive Sponsor
Marcia Arganbright	Director, Student & Academic Services	Member at Large
Ewan Brawley	Assistant Director, Student & Academic Services	Member at Large
Mark Davalos	Deputy Superintendent	Deputy Superintendent Liaison
Melissa Goff	Director, Student & Academic Services	Member at Large
David Wood	Assistant Director, Student & Academic Services	Member at Large

Project Team

Name	Title	Role
Ken Brock	Director, System Planning & Performance	Project Manager
Kacy Anglim	Teacher on Special Assignment	Member at Large
Aaron Cooke	IT EdBox Lead	Assessments Logistics Lead Attendance Logistics Lead Data Warehouse Integration Lead
Lars Fjelstad	Application Developer, Information Technology	Member at Large
James Jung	Enterprise Architect, Information Technology	Hardware Installation Lead
Rick LaGreide	Teacher on Special Assignment	Curriculum Planner Lead
Tamara O'Malley	Teacher on Special Assignment	Grading Guidelines Lead
Stacey Partin	SIS Support Lead, Information Technology	Discipline Logistics Lead Version 8.x Upgrade Lead
Jill Vogt	Independent Contractor, Vogt LLC	Standards Logistics Lead
Tom Voight	Technology Training Specialist, IT	Member at Large
Lynn Wendt	Business Analyst, Information Technology	Internet Viewer Lead Information Management Lead
Michael Williams	Teacher on Special Assignment, IT	HS Implementation Lead Instructional Materials Lead
Bill Zumwalt	Senior Project Manager, Information Technology	Reports Lead

Gradebook Field Test Participation

School	Participating Teachers	Percent of Eligible
Benson	25	49%
BizTech	22	88%
Cleveland	24	33%
Franklin	27	47%
Grant	8	11%
Jefferson	28	87%
Young Women's Academy	10	58%
Lincoln	38	58%
Madison	38	74%
Pauling Academy	15	75%
Portland Evening Scholars	10	27%
Renaissance Arts Academy	17	70%
Roosevelt[1]	0	0%
Wilson	26	41%
Total[2]	288	45%

1 Roosevelt's scheduling in eSIS required a delay of implementation until the fall of 2011-2012
2 Teachers serving in more than one school have been counted more than once

Securing Digital Rights for Curriculum Materials

As Portland Public Schools begins to leverage the EdBox Curriculum Planner to deliver content to learners and teachers, we must recognize all curriculum materials will require an online presence. Ideally, content will be made available by publishers in unpackaged, disaggregated forms to enable teachers to manipulate and organize the content to best meet their students' needs. In some cases, we might be forced to reference links to content hosted by publishers or point users to large files or proprietary databases. In other cases, the digital reference may only be a title, image, and/or description with procedures for how to order the item. As we engage in our materials review process, we need to consider the following:

Considerations:

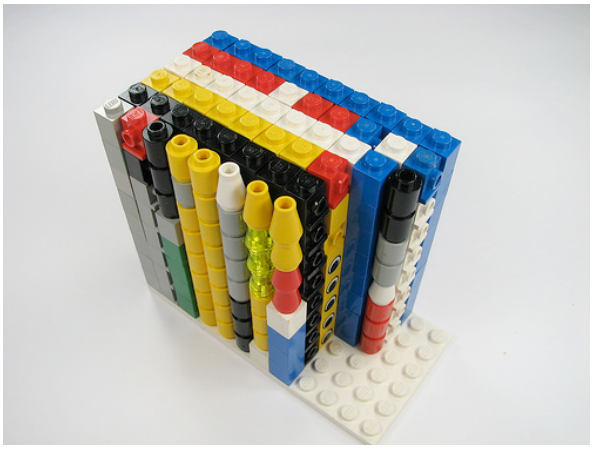
1. Ask publishers if they make all of their materials available in an electronic format. Do they provide audio narration of text in English and/or other languages? Are there digital support resources for parents? Are consumables provided in an electronic format for printing or delivery through the curriculum planner?
2. How does the publisher handle the alignment of materials to standards? As much as possible, we want materials to be loaded into the curriculum planner so teachers can search for resources by individual standard or learning target. Optimally, publishers would provide a database listing each component and its specific alignment to a standard or learning target. Publishers need to explain their recommended process to load and deliver their content through a third-party curriculum planner like the one we're beginning to implement.
3. What are the copyright and fair use limitations to distributing their content through a third-party, password-protected, curriculum planner? For instance, some of the publishers we've worked with in the past have only secured very specific, limited rights to fine arts images so those would not be able to be loaded directly into the curriculum planner. We need to ask publishers if any of their materials are governed by intellectual property rights that might limit permission to be loaded into a third-party system that all teachers, students, and parents can access.
4. Do any of the resources need to be installed on computers? Is CD media required? Materials adoptions which require manual installation of software and resources on work stations are much more difficult to manage. Instead, the preference is for all resources to be accessible via the Web or district network. We need to ask publishers to verify that this is possible. Computers crash and disks get lost. By making sure content is web-based, it assures access from any Internet enabled device.

Considerations Continued:

5. We need to make sure we ask publishers if any of their resources require additional hardware. Even the most trivial of items could lead to implementation problems if they are not considered. Some examples might be headphones, microphones, graphing calculators, or data probes.

6. In order for the PPS Information Technology department to support our newly adopted materials, they need to know technical specifications including things like memory and browser requirements. We need to make sure someone from IT is on our review committees. Publishers need to work with IT to address implementation and support questions in addition to the normal review process.

7. As publishers update their materials, we need to make sure we will have access to those corrections and updates without additional charge. We need to ask publishers about their proposed content updates and associated charges. Do they offer technical support? Are there any ongoing maintenance costs associated with the adoption? These are important points to be considered in contract negotiations.



8. We need to remember to take the long view in our materials adoption considerations. The materials we adopt now will continue to be used for many years. We don't want to be in a situation where we have to go back to publishers and re-negotiate rights for content we failed to attain the first time around or suffer not being able to make resources available through the EdBox Curriculum Planner because the rights are not possible to attain.

Educational Technology Standards for Students

1. **Creativity and Innovation**: Students demonstrate creative thinking, construct knowledge, and develop innovative products and processes using technology.
2. **Communication and Collaboration**: Students use digital media and environments to communicate and work collaboratively, including at a distance, to support individual learning and contribute to the learning of others.
3. **Research and Information Fluency:** Students apply digital tools to gather, evaluate, and use information.
4. **Critical Thinking, Problem Solving, and Decision Making:** Students use critical thinking skills to plan and conduct research, manage projects, solve problems, and make informed decisions using appropriate digital tools and resources.
5. **Digital Citizenship:** Students understand human, cultural, and societal issues related to technology and practice legal and ethical behavior.
6. **Technology Operations and Concepts:** Students demonstrate a sound understanding of technology concepts, systems, and operations.

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Report

Expenditure Contracts Exceeding $25,000 and through $150,000

Portland Public Schools ("District") Public Contracting Rules PPS-45-0200(6) (Authority to Approve District Contracts; Delegation of Authority to Superintendent) requires the Superintendent to submit to the Board of Education ("Board") at the "Board's monthly business meeting a list of all contracts in amounts over $25,000 and up to $150,000 approved by the Superintendent or designees within the preceding 30-day period under the Superintendent's delegated authority." Contracts meeting this criterion are listed below.

NEW CONTRACTS

Contractor	Contract Term	Contract Type	Description of Services	Contract Amount	Responsible Administrator, Funding Source
Robert Half Technology, Inc.	09/24/10 through 09/23/11	Personal / Professional Services PS 57846	BESC: Hourly professional services of an IT planning and administration analyst.	$72,800	N. Jwayad Fund 101 Dept. 5581
Macadam Forbes, Inc.	02/01/11 through 06/30/11	Personal / Professional Services PS 58158	BESC: Services related to evaluating District options on selling or leasing the BESC property and surrounding parcels, and on possible relocation of any and/or all central office needs resulting from such lease or sale.	$25,000	C. Sylvester Fund 101 Dept. 5510
Hello Foundation	02/14/11 through 05/01/11	Personal / Professional Services PS 58183	Provide Speech Language Pathologist Services at $90.00 per hour.	$45,421	J. Jackson Fund 101 Dept. 5414
Linguava Interperters	02/10/11 through 06/30/13	Personal / Professional Services PS 58186	District-wide: Translation and interpretation services related to TAG student testing.	$30,000	C. Randall Fund 101 Dept. 5487
Abby Haight	02/15/11 through 03/18/11	Personal / Professional Services PS 58187	BESC: Planning and development of capital bond program reports, fact sheets, web content, and related materials.	$26,000	S. Schoening Fund 405 Dept. 5511 Project C0100

AMENDMENTS TO EXISTING CONTRACTS

Contractor	Contract Term	Contract Type	Description of Services	Amendment Amount, Contract Total	Responsible Administrator, Funding Source
Alpine Internet Solutions, Inc.	01/01/11 through 03/31/11	Information Technology IT 56487 Amendment 2	District-wide: Three-month extension of contract for continued software maintenance, support services, and remote server monitoring for content management system; annual contract term changed to month-to-month.	$6,947 $58,885	N. Jwayad Fund 101 Dept. 5581

Contractor	Contract Term	Contract Type	Description of Services	Amendment Amount, Contract Total	Responsible Administrator, Funding Source
Cathy Spriggs	01/31/11 through 05/31/11	Personal / Professional Services PS 57409 Amendment 1	District-wide: Four-month extension of contract for continued consulting services related to Striving Readers grant program.	$11,099 $52,199	Fund 205 Grant G0718
Harder Mechanical Contractors, Inc.	02/14/11 through 12/31/11	Construction C 57665 Change Order 2	District-wide: Additional construction services related to heating valve replacement project; part of 2010 Recovery Zone project.	$90,000 $1,564,422	T. Magliano Fund 421 Dept. 5597 Project E0102

INTERGOVERNMENTAL AGREEMENTS ("IGAs")

No IGAs

N. Sullivan

BOARD OF EDUCATION
SCHOOL DISTRICT NO. 1J, MULTNOMAH COUNTY, OREGON

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REGULAR BUSINESS MEETING

March 14, 2011

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Purchases, Bids, Contracts

The Superintendent RECOMMENDS adoption of the following item:

Number 4432

RESOLUTION No. 4432

Personal / Professional Services, Goods, and Services Expenditure Contracts Exceeding $150,000 for Delegation of Authority

RECITAL

Portland Public Schools ("District") Public Contracting Rules PPS-45-0200 ("Authority to Approve District Contracts; Delegation of Authority to Superintendent") requires the Board of Education ("Board") enter into contracts and approve payment for products, materials, supplies, capital outlay, equipment, and services whenever the total amount exceeds $150,000 per contract, excepting settlement or real property agreements. Contracts meeting this criterion are listed below.

RESOLUTION

The Superintendent recommends that the Board approve these contracts. The Board accepts this recommendation and by this resolution authorizes the Deputy Clerk to enter into agreements in a form approved by General Counsel for the District.

NEW CONTRACTS

Contractor	Contract Term	Contract Type	Description of Services	Contract Amount	Responsible Administrator, Funding Source
Qwest	03/21/11 through 03/20/17	Personal / Professional Services PS 58208	District-wide: Acquisition and installation of telephone lines, voicemail, and Centrex services.	Not-to-exceed $1,600,000	N. Jwayad Fund 101 Dept. 5581

AMENDMENTS TO EXISTING CONTRACTS

Contractor	Contract Term	Contract Type	Description of Services	Amendment Amount, Contract Total	Responsible Administrator, Funding Source
Talbot, Korvola, & Warwick, LLP	03/15/11 through 06/30/12	Personal / Professional Services PS 54521 Amendment 7	District-wide: One-year extension of contract for financial auditing services.	$235,000 $1,119,400	C.A. Kirby Fund 101 Dept. 5528
Lynch Mechanical Construction, LLC	03/31/11 through 12/31/11	Construction C 57666 Change Order 4	District-wide: Additional construction services related to plumbing fixture upgrades project; part of 2010 Recovery Zone project.	$210,000 $1,879,294	T. Magliano Fund 421 Various Depts. Project E0101
Club Z Tutoring	01/15/11 through 05/27/11	Personal / Professional Services PS 58028 Amendment 1	George 6-8, BizTech HS, Jefferson HS, and Roosevelt Campus: Additional funds for continued supplemental education services tutoring.	$385,000 $525,000	S. Kosmala Fund 205 Dept. 5407 Grant G1121

INTERGOVERNMENTAL AGREEMENTS ("IGAS")

No IGAs

N. Sullivan

Other Matters Requiring Board Action

The Superintendent RECOMMENDS adoption of the following item:

Number 4433

RESOLUTION No. 4433

Adoption of Amended Board Policy on Cafeteria Plan, Policy 5.10.090-P

RESOLUTION

The Board of Education for Portland Public Schools reviewed recommendations by the Finance, Audit and Operations Committee to amend the policy to align it with current federal requirements. Per District Policy (1.70.020-P), the Board of Education is required to place any new policy or updates to previous District policies on the District website for a 21-day public review. Having fulfilled this obligation and having received no public input on the proposed policy amendment, the Board of Education supports the proposed policy language for adoption.

PROPOSED POLICY:

ARTICLE 1

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

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 "Dependent Care Expenses" means expenses described in 10.4 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 10 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.

2.6 "Dependent" means, for purposes of 2.9, 2.16, 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 2.10 and Article 9, a Dependent means a person who is a Participant's dependent as defined in Code Section 105(b).

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

2.8 "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, 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); and

(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).

Notwithstanding the foregoing, substitute teachers and any employees who have regularly scheduled hours of employment but are less than half-time employees are excluded from the definition of "Eligible Employee" for purposes of the Premium Payment Benefit described in 4.1(a) only.

2.9 "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.

2.10 "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 program set forth in Article 9 and not used as a deduction on the Participant's federal income tax return.

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

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

2.13 "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.

2.14 "Plan Year" means, with respect to the health care reimbursement account program and the dependent care reimbursement account program, the calendar year (January 1 through December 31). 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 listed 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.

2.15 "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.

2.16 "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

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.

ARTICLE 4

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.

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 program set forth in Article 9.

(c) 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 10.

(d) 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.

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. 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).

(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 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.

ARTICLE 5

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 or credited against the cost of that benefit as determined by the Plan Administrator.

(c) 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) above in the Participant's Account established for such benefit.

(d) 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 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 reimbursement at any particular time during the Plan Year cannot be limited to the amount recorded in the 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).

(e) 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 a 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(d), 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 Contributions. The maximum benefits that any Participant may receive from this Plan for a Plan Year shall be 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 shall be $20 per month. Notwithstanding the foregoing, effective January 1, 2013, 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 shall equal $2,500 (plus cost-of-living adjustments permitted under applicable law).

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 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.

(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 health care reimbursement 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) Distribution 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 health care reimbursement 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 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

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 or a health 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 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

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

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

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. For each Plan Year, a Participant may elect any whole dollar amount of coverage under this health care reimbursement account program up to $3,000.

Notwithstanding the foregoing, effective for Plan Years beginning on and after January 1, 2013, 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).

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. 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 2.10. By submitting an expense for reimbursement, the Participant is making a representation that the expense is a Health Care Expense under 2.10. Whether an expense was incurred by an individual described in 2.10 is a material fact. The coverage of an individual who is not described in 2.10 may be rescinded if the requirements of this section are satisfied.

ARTICLE 10

10.1 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.

10.2 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.

10.3 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.

10.4 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.

10.5 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.

H. Harris / T. Burton

EXHIBIT A
PORTLAND PUBLIC SCHOOLS
CAFETERIA PLAN

Plan Years
(Referent Section 2.14)

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