RESOLUTION NO. 521

A RESOLUTION ADOPTING A MEDICAL REIMBURSEMENT CAFETERIA BENEFIT PLAN FOR THE EMPLOYEES OF THE CITY OF STAYTON.

WHEREAS, the Stayton City Council finds and determines that it is in the interest of the public, the city, and the city's employees that the city offer an Internal Revenue Code Section 125 medical reimbursement cafeteria benefit plan to its employees as an insured plan through the League of Oregon Cities' Employee Benefit Services Trust; and

WHEREAS, the Medical Reimbursement Plan, called the Health Expense Layaway Plan (HELP), set forth as Exhibit A (hereafter, the "Plan") provides sufficient flexibility to permit employees of the City of Stayton to select benefits that most suit their needs by providing a choice between cash wages and the option to set aside wages to cover anticipated annual out-of-pocket health care expenses allowed under the Internal Revenue Code; and

WHEREAS, the Plan as set forth will encourage employees and the city to establish a partnership to educate employees and their families about appropriate health care utilization, to share responsibility for health care costs, and to pursue future means of moderating insurance premium increases;

NOW, THEREFORE, be it resolved by the Stayton City Council that the city should, and hereby does, adopt an employee medical reimbursement cafeteria benefit plan, attached hereto as Exhibit A, and fully incorporated by reference.

Adopted by the Stayton City Council this 1st day of November 1993.

Date: 11-03-93 By: William VanVleet
WILLMER VAN VLEET, Mayor

Date: 11-02-93 Attest: David W. Kinney
DAVID W. KINNEY, City Administrator

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EXHIBIT A

"HELP"

HEALTH EXPENSE LAYAWAY PLAN

PLAN DOCUMENT

HEALTH EXPENSE LAYAWAY PLAN
PLAN DOCUMENT

ARTICLE 1

Introduction

The EBS Trust Participant City of Stayton has adopted this Plan in order to allow its eligible employees to choose among different types of benefits and cash based on their own particular goals, desires and needs.

It is the intention of the EBS Trust Participant that the Plan quality as a "Cafeteria/Medical Reimbursement Plan" within the meaning of Section 125 of the Internal Revenue Code of 1986, as amended.

The effective date of this Plan is 1 January 1994.

ARTICLE 2

Definitions

Each word and phrase defined in this Article 2 shall have the following meaning whenever such word or phrase is capitalized and used herein unless a different meaning is clearly required by the context of the Plan.

Section 2.01 Account The individual account established on the books of the Employer's under Section 13.01 in the name of each Member for the purpose of accounting for premium contributions allocated to and benefits paid for a Member.

Section 2.02 Governing Body is the elected or appointed board that governs the City of Stayton.

Section 2.03 Claimant A Member or the Member's eligible dependent who has submitted a claim under the plan.

Section 2.04 Code The Internal Revenue Code of 1986, as amended from time to time. Reference to any section or subsection of the Code includes reference to any comparable or succeeding provisions of any legislation which amends, supplements or replaces such section or subsection.

Section 2.05 Employer CITY OF STAYTON.

Section 2.06 Compensation A Member's wages or salary including overtime, as determined by the Employer, for personal services rendered in the course of employment and contributions under Sections 4.01 on a Member's behalf.

Section 2.07 Dependent A Member's dependent as defined in the Employers health plan that describes the employer provided health coverage.

Section 2.08 Elective Premium Contributions An elected amount of dollars the Member has requested to be withheld from his or her salary to be contributed to the medical reimbursement account as described in Article 4.

Section 2.09 Eligible Employee Shall mean an Eligible employee who is eligible for coverage under the employer provided medical plan.

Section 2.10 Employee Any person employed who is eligible for benefits under a Medical Plan but excluding any person covered by a collective bargaining agreement unless coverage under this Plan is provided for under the collective bargaining agreement.

Section 2.11 Health Care Expense An expense incurred by a Member on behalf of the Member or the Member's spouse or dependent 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 plan adopted by the Employer and not used as a deduction on the Member's federal income tax return.

Section 2.12 Highly Compensated Member An employee defined by Code Section 105(h)(5) or Code Section 414(q) as is appropriate.

Section 2.13 Member Any employee who has elected to participate in the Plan in accordance with Section 3.01 and who has not ceased to be an Employee.

Section 2.14 Non-elective Contributions The contributions made pursuant to Section 4.03.

Section 2.15 Period of Coverage The Plan Year, except that it may be a fraction of a Plan Year as provided in Section 5.05.

Section 2.16 Plan Health Expense Layaway Plan (H.E.L.P.) as set forth in this document.

Section 2.17 Plan Year The first Plan Year shall be from the effective date stated in Article 1 through the following December 31st. Thereafter, each subsequent Plan Year shall be the 12 month calendar year.

Section 2.18 Reimbursement Account A Member's Account established under Sections 8.01 for contributions and payments for Reimbursement Benefits.

Section 2.19 Reimbursement Benefits The Medical Reimbursement Account described in Sections 6.02.

Section 2.20 Plan Administrator The Plan Administrator shall be the Employer.

Section 2.21 Trust The Trust shall be the Employee Benefits Services Trust (EBS).

Section 2.22 Participant Any employee who has elected to participate in this plan and any of the employee's spouse or dependents.

Section 2.24 Medical Plan The regular group medical plan made available to the Member by the Employer.

ARTICLE 3

Eligibility Requirements

Section 3.01 Eligibility An Employee shall become eligible to participate in this plan as of the later of:

a. The date the Employee becomes eligible for coverage under a Medical Plan; or

b. The date of the Employee's coverage under this Plan through the adoption of this Plan by the Employee's employing entity;

Section 3.02 Notice and Enrollment Prior to the date an employee first becomes eligible to participate in this Plan, the Employer shall notify in writing each Employee who becomes eligible and shall explain the rights, privileges and duties of a Member of the Plan. Each Member may elect to participate as of the date on which he or she becomes eligible in accordance with Section 3.01 by completing and delivering to the Employer a salary reduction agreement and an election of benefits form.

Section 3.03 Termination of Eligibility A participant becomes ineligible to participate in the plan if the Participant transfers to an ineligible class of employees or terminates employment with the employer. Upon the termination of eligibility, the Participant's right to participate in the Plan terminates as of the date of such transfer or employment termination, except as specifically stated in the Plan or pursuant to the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), as amended.

ARTICLE 4

Contributions

Section 4.01 Medical Reimbursement Premium Contributions For any Plan Year, each Member may elect to have contributed to his or her Account a specified amount of his or her Compensation for such Plan Year subject to the maximum limitation set forth in Section 8.04.

Section 4.02 Pay reduction and Payroll Withholding A Member's compensation for a Plan Year shall be reduced by the amount of the contributions which he or she elects for such Plan Year under Section 4.01. Contributions shall be made only by way of payroll withholding which shall be made during a Member's applicable Period of Coverage.

Section 4.03 Non-elective Contributions For any Plan Year, the Employers may make further contributions to the Plan on behalf of Members. In the case of a Member who becomes eligible to participate in the middle of a Period of Coverage, as provided for in Section 5.05, the Employers' Non-elective Contribution will be a pro-rata amount based on the number of months left in the applicable Period of Coverage. Any such contributions shall be made only on a nondiscriminatory basis.

ARTICLE 5

Elections

Section 5.01 In General Elections of premium contributions and benefits shall be made at the time, in the manner and subject to the conditions specified by the Committee which shall prescribe uniform and nondiscriminatory rules for such elections.

Section 5.02 Election to Participate An eligible employee commences participation by filing an executed election form with his/her Employer. The election form shall be signed by the employee, and shall designate the Plan Year (or the remaining portion of the Plan Year, as the time period for which participation will be effective).

Section 5.03 Contributions and Benefits Members must elect the amount of premium contributions to be allocated to the H.E.L.P. account for an elected Period of Coverage. Contributions allocated to the H.E.L.P. Plan may never be used for any other benefits.

Section 5.04 Period of Coverage Except as provided in Sections 5.05 and 5.06, any Member electing contributions and benefits must make an irrevocable election for a Period of Coverage of an entire Plan Year.

Section 5.05 Fractional Periods Members who become eligible to participate in the middle of a Plan Year may elect to participate for a period lasting until the end of the current Plan Year. In such cases, the interval commencing the day after their elections are made and ending at the end of the current Period of Coverage shall be deemed to be their Period of Coverage. Such Members must elect to participate no later than thirty (30) days after becoming eligible to do so or within such other time limit as the Committee may prescribe.

Section 5.06 Timing of Elections Elections of contributions for a Period of Coverage shall be made prior to such Period of Coverage, provided that where a Member commences or recommences participation in the middle of a Period of Coverage, he or she shall make elections prior to commencement of participation.

Section 5.07 Changes of Elections Elections of premium contributions and/or benefits may not be changed in the middle of a Period of Coverage unless:

a. Such change is on account of and consistent, necessary and appropriate with a change in family status or such other change which in compliance with Code section 125 and the regulations thereunder, (examples: marriage or divorce of an employee, death of a spouse or dependent, the birth or adoption of a child of the employee, the employee switching from full-time to part-time employment or vice-versa, the taking of an unpaid leave of absence by the employee or spouse.

b. The EBS Trust Administrative policies permit such a change.

c. If applicable, such change is permitted by the Medical Plan covering the Member.

For purposes of this Section, a member must file an annual election form. A change from or to a zero amount of contributions shall be considered a change of an election. Changes in elections shall only be effective as to contributions and benefits following the effective date of such changes.

Section 5.08 Medical Plans Elections of contributions under Section 4.01 shall be subject to the rules governing elections of benefits under a Member's Medical Plan.

ARTICLE 6

Benefits

Section 6.01 Benefits Available Subject to Article 4, Members may elect one or more of the following benefits:

a. Medical Expense Reimbursement Benefits

b. Cash

Section 6.02 Medical Expense Reimbursement Benefits The Employers have adopted a Medical Expense Reimbursement Plan set forth in Article 9 designed to qualify as a nontaxable employee benefit under Code section 105(b). Members may elect benefits under such Plan subject to all of the requirements and restrictions contained in that Plan.

Section 6.03 Cash Benefits Members may also receive cash benefits in lieu of salary reduction to fund the benefits described in Sections 6.01 a. through 6.01 c. (Cash benefits in any Plan Year shall be equal to the maximum permissible salary reduction which the Member could elect under Section 4.01 for such Plan Year less salary reduction contributions actually elected by the Member under such section.)

ARTICLE 7

Limitations on Benefits

Section 7.01 Coverage Amounts for the Medical Reimbursement Account may only be paid for expenses incurred during the Period of Coverage elected for such benefit. Expenses shall be considered incurred when the medical care is provided during the period of coverage, and not when the Member is formally billed, charged for or pays the expenses.

Section 7.02 Amount of Benefits The maximum amount of Medical Reimbursement Benefits payable for a Plan Year shall be the amount of the Member's contributions plus the amount of Non-elective Contributions allocated to each benefit elected by the Member.

Section 7.03 Medical Reimbursement Uniform Coverage Subject to the maximum election permitted for Medical Expense Reimbursement benefits, the Member shall be entitled to receive at all times during the period of coverage the maximum amount of Reimbursement Benefits specified in Section 7.02 (except as properly reduced as of any particular time for prior reimbursements for the same period of coverage).

Section 7.04 Forfeitures Amounts remaining in a Medical Reimbursement Account shall be forfeited after payment of all timely presented claims for the benefit for expenses incurred during the applicable Period of Coverage. All claims must be presented within ninety (90) days after the applicable Period of Coverage to be considered as "timely presented".

Section 7.05 Medical Plan Coverage and limitations for a Member's Medical Plan benefits shall be as set forth in the Member's Medical Plan.

ARTICLE 8

Medical Expense Reimbursement Program

Section 8.01 In General Members covered by H.E.L.P. may submit claims for the reimbursement of a Member's eligible Medical Expenses from premium contributions allocated to the H.E.L.P. account for Medical Expense Reimbursement Benefits.

Section 8.02 Separate Plan This Article is intended to qualify as a separate written accident and health plan within the meaning of Code Section 106. It is intended that reimbursements under this program be eligible for exclusion from gross income of Participants under Code Section 105(b). Accordingly, this program shall be interpreted and construed in accordance with Code Sections 105(e) and 106 and any regulations or other interpretations thereunder.

Section 8.03 Definitions For purposes of this Article, the following special definitions shall apply:

a. "Benefits" means Medical Expense Reimbursement Benefits under this Program.

b. "Dependent" means a dependent as defined in the employers health plan.

c. "Highly Compensated Employee" means a Member who is defined as a Highly Compensated Employee by Code Section 105(h)(5) or Code Section 414(q), as is appropriate.

d. "Medical Expenses" means amounts not compensated for by insurance or otherwise which are paid or incurred by or on behalf of a Member, a Member's spouse or a Member's Dependents and incurred for the following items to the extent they are covered by Code Section 213(d):

   1. The diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body; or

   2. For transportation primarily for and essential to medical care referred to in 1 above.

Section 8.04 Maximum Election The amount of coverage that may be elected under this Medical Expense Reimbursement Program shall not exceed $3,000.00 for a Plan Year.

Section 8.05 Covered Expenses The Plan shall only cover Medical Expenses incurred during the Period of Coverage the Member has elected for Benefits. Expenses shall be considered incurred when the medical care is provided and not when the Member is formally billed, charged for or pays the Expenses.

Section 8.06 Uniform Coverage

a. Subject to the maximum election of Section 8.04, the Member shall be entitled to receive at all times during the period of coverage the maximum amount of Reimbursement Benefits specified in Section 7.02 (except as properly reduced as of any particular time for prior reimbursements for the same period of coverage).

b. In the event that the "uniform coverage" rule entitles a Member to receive a medical expense reimbursement which exceeds the Member's medical expense account balance at the time the claim is submitted, the will nevertheless pay the claim in accordance with its agreement with the Trust up to the applicable maximum Medical Reimbursement Benefits as set forth in Section 7.02 (except as properly reduced as of any particular time for prior reimbursements for the same period of coverage).

Section 8.07 Reduction of Benefits The EBS Trust may direct the Employer to reduce the amount of Benefits payable to a Member to the extent the Trust deems necessary to assure that the Program does not discriminate in favor of Highly Compensated Members in violation of Code Sections 125 or any other applicable provision of law. Any such reduction of Benefits shall be made by the Governing Body on a reasonable and nondiscriminatory basis. Contributions which may not be paid out because of benefit reductions imposed by this Section 8.08 shall be forfeited.

Section 8.08 Other Provisions Other matters concerning contributions, elections, benefits, claims, and the like shall be governed by the general provisions of the Plan.

ARTICLE 9

Claims for Benefits

Section 9.01 Claims for Reimbursement Benefits Claims for Reimbursement Benefits totaling at least $1.00 may be made at any time. Claims for Reimbursement Benefits totaling less than $1.00 may be made only in the event of a final claim following termination of participation or the run-out period at the end of the Plan Year, if any.

Section 9.02 Reimbursable Claims A Member or a Member's dependent may claim reimbursement for an expense only if the following conditionshave been satisfied:

a. The claimant incurred the claimed expense during the effective dates of the Plan specified in Article 1.

b. The expenses were incurred while the participant was enrolled and participating in the Plan as specified in Article 3.

c. After deductions for previous claims during the Plan Year, the balance remaining of the maximum amount of Reimbursement Benefits specified in Section 7.02 is sufficient to pay the cliam.

d. For purposes of this Section, an expense is incurred only when the service or product is provided and not when the participant is billed for the service or product.

Section 9.03 Claim Substantiation The Member shall substantiate a claim for reimbursement or an expense by providing the following:

a. a written statement from an independent third party stating that the expense has been incurred and the amount of such expense; and

b. the written statement from the member that the expense has not been reimbursed or is not reimbursable under any other coverage.

Section 9.04 Time Limit on Claiming Benefits Claims Reimbursement Benefits shall be paid only if presented ninety (90) days or less after the applicable Period of Coverage. Claims for Reimbursement Benefits presented more than ninety (90) days after the end of the applicable Period of Coverage will not be paid.

Section 9.05 Medical Plans Claims under a Member's Medical Plan shall be governed by the terms of such Plan.

ARTICLE 10

Claims Appeal

Section 10.01 Claim Consideration Period Except as otherwise provided by this Article, the Insurer shall accept or deny a claim within ninety (90) days after the participant has submitted a claim. This ninety (90) day period shall be the "claim consideration period."

Section 10.02 Extension Periods The Trust may, at its discretion, reasonably extend the time beyond the claim consideration period in which to accept or deny a claim. The extension or extensions shall be in increments of thirty (30) days and shall be taken by giving written notice of the extension to the participant during the claim consideration period or any extension period.

Section 10.03 Claims Denial A claim shall be considered denied as follows:

a. If a written denial, including the reasons for denial, is given to the member; or

b. If no written acceptance or denial of the claim has been given to the participant by the last day of the claim consideration period and all extension periods.

Section 10.04 Claims Appeal The member may appeal the Insurer's denial to the Trust as specified in this Section.

a. The member shall file with the Trust a Request for Review in a form designated by the Trust.

b. The member shall file the Request for Review not later than sixty (60) days following the date of notice of denial of the claim or, where no notice is given, the date the denial is deemed to have occurred. The claim shall remain denied if the member fails to file the Request for Review within the time specified by this section. This limitation may be waived on grounds of reasonable negligence, mistake or inadvertence according to the discretion of the Trust.

c. Except as otherwise provided by this section, the Trust shall accept or deny the claim and notify the participant of its decision within sixty (60) days after its receipt of the Request for Review. If special circumstances exist (such as the need for additional investigation or a hearing), the Trust may extend the deadline for its decision to 120 days from the date after its receipt of the Request for Review.

d. The Trust's decision shall include the reasons for the decision with reference to the provisions in the Plan Document which govern the decision.

ARTICLE 11

Continuation Coverage

Section 11.01 Non-Health Plan A participant's loss of eligibility to participate in H.E.L.P. shall terminate the participant's salary reduction elections as of the last day of the month in which the loss of eligibility occurs.

Section 11.02 Health Plans

a. If an event which would otherwise cause a participant to lose eligibility to participate in H.E.L.P. is a qualified event, the participant may be entitled to elect to pay premiums and continue participation as required by federal law.

b. Upon the occurrence of an event which terminates a participant's eligibility to participate in a group health plan, the Employer shall inform the participant of continuation rights and the procedure for electing continued coverage.

c. The participation of a participant who is not eligible for continued coverage or who does not elect to continue will terminate on the last day of the month in which the event of ineligibility occurs. In this case, the participant may submit and be reimbursed only for claims incurred during the plan year prior to the date of termination.

d. A Participant who is eligible and elects to continue participation in a Health Plan may pay the premiums from pre-tax compensation paid by the Employer, including severance pay, or from other after-tax funds.

ARTICLE 12

Nondiscrimination

Section 12.01 Reduction of Contributions and Benefits The Employer may reject any election and reduce the amount of contributions or nontaxable benefits to the extent the Trust deems necessary to assure that the Plan does not discriminate in favor of Highly Compensated Members in violation of Code section 125 or any other applicable provision of law under the provisions of Code section 125(b)(2). Any rejection of elections or any reduction of contributions or benefits shall be made by the Trust on a reasonable and nondiscriminatory basis. Contributions which may not be paid out because of benefit reductions imposed by this Section 12.01 shall be forfeited.

Section 12.02 Prohibition of Discrimination Any discretionary acts to be taken under the terms and provisions of this Plan by the Trust or by the Employer shall be uniform in their nature and application to all those similarly situated. No discretionary acts shall be taken that would be discriminatory under the provisions of the Code relating to medical reimbursement plans as such provisions now exist or may from time to time be amended.

ARTICLE 13

Accounts

Section 13.01 Accounts A separate Account shall be maintained for each Member to reflect the amount of contributions on his or her behalf under Article 4 and the cost of all benefits paid to the Member or on the Member's behalf under the Plan.

Section 13.02 Contributions Made Contributions on behalf of a Member shall be credited to the Account.

Section 13.03 Benefits Provided The cost of benefits provided to a Member shall be charged to the Account.

Section 13.04 Assignment of Benefits Any interest in a Member's Account may not be assigned, transferred or alienated in any manner whatsoever and shall not be subject to claims, liens, garnishment or levies from any third parties.

ARTICLE 14

Administration of the Plan

Section 14.01 Administrative Powers and Duties The Employer shall have the power to take all actions required to carry out routine activities (eg. employee enrollment, payroll withholding etc.) associated with the Plan and shall further have the following powers and duties, which shall be exercised in a manner consistent with the provision of the Plan:

a. To decide all questions as to eligibility to become a Member in the Plan;

b. To file or cause to be filed all such annual reports, returns, schedules, descriptions, financial statements and other statements as may be required by any federal or state statute, agency, or authority;

c. To communicate to the Trust and under this Plan in writing all information required to carry out the provisions of the Plan;

h. To notify the Members of the Plan in writing of any amendment or termination of the Plan, or of a change in any benefits available under the Plan;

i. To prescribe such forms as may be required for Employees to make elections under this Plan; and

j. To do such other acts as it deems reasonably required to administer the Plan in accordance with its provisions, or as may be provided for or required by law.

Section 14.02 Fiduciary Duties The Employer shall discharge its duties in the interest of Members and their beneficiaries.

Section 14.03 Allocation or Delegation of Duties and Responsibilities In furtherance of their duties and responsibilities under this Plan, the Employer and the Trust may contract with agents, administrators, insurance companies, and others.

Section 14.04 Contractors The Contractors allowed by this Article shall not be responsible for legal, tax and plan status issues. Such responsibilities shall be the exclusive duties of the Trust and the Employer. The duties of the contractors shall not be discretionary and they shall not be Administrators nor Named Fiduciaries of the Plan as these terms are defined in ERISA.

Section 14.05 Claims Procedure Medical Plans shall be administered by the administrators of such plans and all claims for benefits under such plans shall be governed by the terms of such plans.

ARTICLE 15

Amendment and Termination

Section 15.01 Amendment of Plan The Trust may amend any or all provisions of this Plan at any time by written instrument identified as an amendment of the Plan effective as of a specified date.

Section 15.02 Termination of Plan This Plan may be terminated in whole or in part at any time by the Trust or Employer.

Section 15.03 Preservation of Rights Termination or amendment of the Plan shall not affect the rights of any Member in his or her Account or the right to claim reimbursement for expenses incurred prior to such termination or amendment as the case may be, to the extent such amount is payable under the terms of the Plan prior to the effective date of such termination or amendment.

ARTICLE 16

Adoption of Plan

Section 16.01 In General The Plan may be adopted by the Governing Body by passing a resolution which shall specify which of its employee's are covered by the Plan and the effective date or dates of the adoption.

Article 17

Miscellaneous

Section 17.01 Facility of Payment If the Plan Administrator deems any person entitled to receive any amount under the provisions of the Plan incapable of receiving or disbursing the same by reason of minority, illness or infirmity, mental incompetency, or incapacity of any kind, the Plan Administrator may, in its discretion, take any one or more of the following actions:

a. Apply such amount directly for the comfort, support and maintenance if such person;

b. Reimburse any person for such support previously supplied to the person entitled to receive any such payment;

c. Pay such amount to a legal representative or guardian or any other person selected by the Plan Administrator to disburse it for such comfort, support and maintenance, including without limitation, any relative who had undertaken, wholly or partially, the expense of such person's comfort, care and maintenance or any institution in whose care or custody the person entitled to the amount may be. The Plan Administrator may, in its discretion, deposit any amount due to a minor to his or her credit in any savings or commercial bank of the Plan Administrator's choice.

Section 17.02 Lost Payee In the event that a benefit reimbursement check cannot be sent to a member is returned as undeliverable and cannot be located following a reasonable search, the amount of that check or benefit shall be forfeited and paid to the Plan as a contribution. Any forfeited amount may be reinstated by the Trust's special contribution to the Pan and shall become payable if the member resubmits the claim during the Plan year or the runout period. If the claim is not resubmitted before the last day of the plan year or runout period, the forfeited amount shall remain forfeited.

Section 17.03 Indemnification To the extent permitted by law, the employer shall indemnify and hold harmless the Members, any Employee, and any other person or persons to whom the Employer has delegated fiduciary or other duties under the Plan, against any and all claims, losses or damages, expenses and liabilities arising from any act or a failure to act that constitutes or is alleged to constitute a breach of such person's responsibilities in connection with the Plan or under any other law, unless the same is determined to be due to gross negligence, willful misconduct or willful failure to act.

Section 17.04 Titles and Headings The titles and headings of the Articles and Sections of this instrument are placed herein for convenience of reference only, and in the case of any conflicts, the text of this instrument, rather than the titles or headings, shall control.

Section 17.05 Number Wherever used herein, the singular shall include the plural and the plural shall include the singular, except where the context requires otherwise.

Section 17.06 Applicable Law The provisions of this Plan shall be construed according to the laws of the State of Oregon, except as superseded by federal law, and in accordance with the Code and ERISA. The Plan is intended to be a cafeteria plan under section 125(d) of the Code and shall be construed accordingly.

Section 17.07 Right to Discharge Employees No provision of this Plan, whether express or implied, gives an Employee the right to remain in the employ of the Employer. All Employees shall remain subject to discharge from employment as if this Plan had never been adopted. Nothing in the establishment or modification of this Plan or payment of any benefit shall be construed as giving any participant or any other person any legal or equitable rights against the Employer except as specifically provided by this Plan.

Section 17.08 Legally Enforceable The Employer 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.

IN WITNESS WHEREOF, City of Stayton by action of its Governing Board, has caused this instrument to be executed by its officer thereunto duly authorized, this 1st day of November, 1993

effective November 1, 1993

BY CITY OF STAYTON

William VanVleet

Willmer Van Vleet

Mayor

ATTEST: David W. King

"HELP" MONTHLY PREMIUM COSTS

There are three components to monthly "HELP" program costs:

1) Administrative Cost per Employee per Month ($5)*
2) 2% of the Total Employee Contributions for the First Month of the Plan Year**

and

3) Employees' Aggregate Contributions for the Month

EXAMPLE:

1) NO. of EMPLOYEES 15 x $5 = **$75**

PLUS

2) 2% of TOTAL EMPLOYEE DEDUCTIONS FOR 1ST MONTH OF PLAN YEAR

5 Employees Deduct $25/Month	=	$125
5 Employees Deduct $50/Month	=	$250
5 Employees Deduct $100/Month	=	$500
TOTAL DEDUCTIONS	=	$875 X 2% = **$17.50**

PLUS

3) Aggregate Monthly Employee Contributions **$875.00**

TOTAL MONTHLY COST: **$967.000**

* Depending on monthly plan participant changes, this portion of the administrative cost can vary from month to month. (These changes also will change the total of the monthly employee contributions.)

** The 2% monthly rate is fixed for the entire plan year. Contributions mean the total dollar amount of monies deposited in "HELP" for the first month of the plan year. This represents 1/12 of all employee contributions for expenses estimated at the beginning of the plan year.