**HAYSVILLE USD 261**

**WELFARE BENEFITS PLAN**

**HAYSVILLE USD 261**
**WELFARE BENEFITS PLAN**

Haysville USD 261 ("Employer") adopts this amended and restated Haysville USD 261 Welfare Benefits Plan ("Plan") for the benefit of its Eligible Employees. This Plan is an amendment and restatement of the Plan originally adopted effective September 1, 2002, as subsequently amended and restated effective October 1, 2015.

## ARTICLE I
## PURPOSE AND LEGAL STATUS OF THE PLAN

Section 1.01 Purpose of Plan. The purpose of this Plan is to provide Eligible Employees of the Employer a choice between taxable compensation and nontaxable benefits, and after-tax benefits offered by the Employer.

Section 1.02 Plan Status. It is the intent of the Employer that this Plan qualify as a "cafeteria plan" within the meaning of Section 125 of the Internal Revenue Code, as amended, and the regulations issued thereunder, and that any "qualified benefits" paid under this Plan be eligible for exclusion from the Participant's gross income for federal income tax purposes.

Section 1.03 Exclusive Benefit. It is intended that the Plan terms, including those related to coverage and benefits, be legally enforceable and that this Plan be maintained for the exclusive benefit of Employees and their covered dependents.

Section 1.04 Status of Plan. It is the intent of the Employer that this Plan, including any underlying Benefit Package Options, be considered to be a single plan. For purposes of COBRA continuation rights, however, each underlying Benefit Package Option shall be considered to be a separate plan.

*[The remainder of this page is intentionally left blank.]*

## ARTICLE II
## DEFINITIONS

Section 2.01 "After-Tax Benefit" means one (1) or more of the following plans:

(a) Haysville USD 261 Voluntary Life Plan ("Voluntary Life Plan");

(b) Haysville USD 261 Accidental Death and Dismemberment Plan ("Accidental Death and Dismemberment Plan");

(c) Haysville USD 261 Long Term Disability Plan ("Long Term Disability Plan");

(d) Haysville USD 261 Accident Plan ("Accident Plan");

(e) Haysville USD 261 Critical Illness Plan ("Critical Illness Plan"); and

(f) Haysville USD 261 Critical Illness and Cancer Plan ("Critical Illness and Cancer Plan.")

Section 2.02 "Annual Enrollment Period" means the period defined in Section 5.03(b) of this Plan.

Section 2.03 "Benefit Package Option" means a benefit that is offered under this Plan on a pre-tax basis or an option for coverage that is offered 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).

Section 2.04 "Claim" means any formal request for a Plan benefit or benefits made by a Claimant or his/her representative in accordance with the Plan's procedures for filing benefit claims as set forth in Article IX and/or Appendix C. A Claim does not include a request for a determination of an individual's eligibility to participate in the Plan, nor does it include a casual inquiry regarding the scope of coverage under the Plan. A communication regarding benefits that is not made in accordance with the Plan's procedures for filing a Claim will not be treated as a Claim.

Section 2.05 "Claimant" means a Participant who files a Claim for benefits pursuant to Article IX and/or Appendix C of this Plan.

Section 2.06 "Claims Administrator" means the Plan Administrator, unless the Employer retains another person to serve as the claims fiduciary for a Pre-Tax Benefit choice or an After-Tax Benefit choice with the authority to grant or deny claims for benefits.

Section 2.07 "COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time.

Section 2.08 "Code" means the Internal Revenue Code of 1986, as amended from time to time.

Section 2.09 "Compensation" means wages, salary and other remuneration paid to a Participant by the Employer, but does not include amounts contributed by the Employer to a qualified plan, other than elective deferrals made to a 401(k) plan or 403(b) plan or arrangements on behalf of the Participant, and does not include any other fringe benefits or medical benefits provided by the Employer.

Section 2.10 "Effective Date" means the original date on which this Plan took effect, which date is September 1, 2002 provided, however, that if this Plan is subsequently amended, such new or amended provisions shall be effective on such later date as shall be determined by the Employer.

Section 2.11 "Election Change Event" means an event which would allow a Participant to change the Participant's elections during a Plan Year, subject to the requirements of Article V and as set forth in more detail in Sections 5.06 through 5.15.

Section 2.12 "Eligible Employee" means an individual who is actively employed by the Employer in a regularly scheduled work week ordinarily equaling or exceeding thirty (30) hours per week, except that a transportation employee who is actively employed by the Employer in a regularly scheduled work week ordinarily equaling or exceeding twenty (20) hours per week is considered an Eligible Employee; subject to the following:

(a) Special Rules:

(i) *Seasonal Employees*. Seasonal Employees are not Eligible Employees under this Plan;

(ii) *Status During Leaves of Absence.* An Employee's status as an Eligible Employee shall be deemed to continue during any paid leave of absence approved by the Employer; during an unpaid leave of absence not to exceed six (6) months or, if the FMLA is applicable to the Employer, during a leave of absence taken pursuant to the FMLA;

(iii) *Status During Military Service.* An Employee ceases to be an Eligible Employee during the period of time such Employee enters active service in the armed forces of any country, except for temporary active service of two (2) weeks or less; and

(iv) *Medical, Dental, and/or Vision Plans.* An Eligible Employee who is participating in the Medical, Dental and/or Vision Plans and who terminates employment with the Employer before the end of the month will continue to participate in this Plan for purposes of participating in the Medical, Dental, and/or Vision Plans on a pre-tax basis through the end of the month in which the termination occurs.

(b) The following shall not be an Eligible Employee: any individual who is, with respect to the Employer, (i) a self-employed individual, or (ii) a two percent (2%) shareholder of an S corporation under Section 1372(b) of the Code; provided,

however, that any individual encompassed by this Subsection (b) shall be an Eligible Employee only for purposes of participating in an underlying After-Tax Benefit, or *on an after-tax basis* in an underlying Pre-Tax Benefit.

Note: The Pre-Tax Benefits and After-Tax Benefits may have additional eligibility requirements. Such additional requirements, if any, are set forth separately in this Plan document.

Section 2.13 "Employee" means an individual employed by the Employer, excluding those persons covered by a collective bargaining agreement and further excluding those persons classified by the Employer on its payroll records as "leased employees" as that term is used in Section 414(n) of the Code.

Section 2.14 "Employer" means Haysville USD 261.

Section 2.15 [Reserved]

Section 2.16 "FMLA" means the Family and Medical Leave Act of 1993, as amended from time to time.

Section 2.17 "Group Health Plan" means, for purposes of the HIPAA, COBRA, and FMLA provisions in Articles III, V, VII, and VIII, a Pre-Tax Benefit or an After-Tax Benefit that provides health care to the Participants in the Plan and their beneficiaries. The term includes the following benefits:

(a) Haysville USD 261 Medical Plan ("Medical Plan");

(b) Haysville USD 261 Dental Plan ("Dental Plan");

(c) Haysville USD 261 Health Flexible Spending Account ("Health FSA"); and

(d) Haysville USD 261 Vision Plan ("Vision Plan").

Section 2.18 "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time.

Section 2.19 "Participant" means an Eligible Employee who has entered the Plan pursuant to Section 3.01 and whose participation in the Plan has not been terminated pursuant to Section 3.02.

Section 2.20 "Plan" means the Haysville USD 261 Welfare Benefits Plan.

Section 2.21 "Plan Administrator" means the Employer. The Employer may designate from time to time one (1) or more individuals or other persons to carry out various administrative and other duties with respect to this Plan in a manner consistent with the terms of this Plan.

Section 2.22 "Plan Year" means the fiscal year of this Plan, the Medical Plan, and the Dental Plan, which is the twelve (12) consecutive month period beginning every October 1 and ending the subsequent September 30. The plan year for all other benefits in this Plan is the twelve (12) consecutive month period beginning every September 1 and ending the subsequent August 31.

Section 2.23 "Pre-Tax Benefits" means one (1) or more of the following:

(a) Haysville USD 261 Medical Plan;

(b) Haysville USD 261 Dental Plan;

(c) Haysville USD 261 Health Flexible Spending Account;

(d) Haysville USD 261 Dependent Care Assistance Plan ("DCAP"); and

(e) Haysville USD 261 Vision Plan.

Section 2.24 "Seasonal Employee" means an employee who is hired into a position for which the customary annual employment is six (6) months or less.

Section 2.25 "Spouse" means a person of the same or opposite sex to whom an Eligible Employee is legally married under the laws of the jurisdiction in which the marriage was entered into (as such laws existed at the time of marriage), regardless of whether the marriage would be recognized by the jurisdiction in which the couple currently resides. A common law marriage shall be considered to be a legal marriage if the common law marriage was validly entered into in a state that recognizes common law marriage. The Plan Administrator shall have the authority to determine whether a person is a Spouse, including the authority to request such documents as may be necessary, in its discretion, to establish the existence of a legal marriage (including the existence of a common law marriage). An individual will not be considered a "Spouse" for purposes of this Plan if (a) his/her marriage to the Eligible Employee has been terminated by a court having jurisdiction over one (1) or both parties to the marriage or (b) either party to the marriage is also lawfully married to another (third) person under the laws recognized by any state.

Section 2.26 "USERRA" means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended from time to time.

*[The remainder of this page is intentionally left blank.]*

## ARTICLE III
## PARTICIPATION IN THE PLAN

Section 3.01 Entry into the Plan.

(a) *General Rule.* An Eligible Employee becomes a Participant on the first day of the month following date of hire.

An Eligible Employee who has entered into the Plan pursuant to this Section is a Participant without regard to whether he/she elects to reduce his/her Compensation in order to purchase benefits under one (1) or more of the Pre-Tax Benefits and/or After-Tax Benefits.

(b) *Effective Date of this Plan.* Notwithstanding any other provision of this Plan, no Eligible Employee may become a Participant prior to the Effective Date of this Plan.

Section 3.02 Termination of Participation.

(a) *General Rule.* A Participant will cease participation in this Plan on the earlier of the following dates:

(i) The date on which this Plan terminates; or

(ii) The date on which the Participant ceases to be an Eligible Employee.

Although a Participant's participation under this Plan terminates on the above date, coverage or benefits under the Pre-Tax and After-Tax Benefits may continue if, and to the extent, provided by such Pre-Tax and After-Tax Benefits.

Section 3.03 Family and Medical Leave Act of 1993.

(a) *General Rule.* Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying unpaid leave under the FMLA, the Employer will, to the extent required by the FMLA, continue to maintain the Participant's benefits under a Group Health Plan on the same terms and conditions as though the Participant were still an active Employee (that is, the Employer will continue to pay its share of the premium to the extent the Participant opts to continue his/her coverage). If the Participant is a participant in the Health FSA, additional rules may apply to the Participant's coverage under the Health FSA as set forth in the Appendix for the Health FSA.

(b) *Options for Payment of Participant's Share of the Premium.* If the Participant opts to continue his/her coverage, the Participant may pay his/her share of the premium in one (1) or more of the following ways:

(i) The Participant may pay his/her share of the premiums with after-tax dollars while on leave (or with pre-tax dollars to the extent the Employee receives Compensation during the leave).

(ii) The Participant may pay his/her share of the premium pursuant to such other arrangement as may be agreed upon between the Participant and the Plan Administrator.

(c) *Return from FMLA Leave.* If the Participant's coverage ceases while the Participant is on FMLA leave, the Participant will be permitted to reenter the Plan immediately upon his/her return from FMLA leave on the same basis that the Participant was participating in the Plan prior to his/her leave, or as otherwise required by the FMLA.

*[The remainder of this page is intentionally left blank.]*

## ARTICLE IV
## OPTIONAL BENEFITS

Section 4.01 Pre-Tax Benefits. Each Participant may elect to reduce his/her Compensation and have the amount applied by the Employer toward the cost of benefits available under one (1) or more of the Pre-Tax Benefits under this Plan. For those benefits that are provided through a policy of insurance, the monthly premiums are determined by the applicable insurance company and may change from time to time.

(a) *Terms and Conditions of the Pre-Tax Benefits.* The terms and conditions of the Pre-Tax Benefits are as follows:

(i) *Medical Plan*. Participants may elect to receive medical coverage through the Medical Plan. The terms and conditions of this Pre-Tax Benefit are set forth in Appendix A.

(ii) *Dental Plan*. Participants may elect to receive dental coverage through the Dental Plan. The terms and conditions of this Pre-Tax Benefit are set forth in Appendix B.

(iii) *Health Flexible Spending Account.* Participants may elect to make contributions to the Health FSA. A Health FSA enables Participants to elect pre-tax salary reduction and receive reimbursements for their unreimbursed Qualified Medical Expenses incurred during a Plan Year. The Employer intends that this benefit qualify under Section 105(h) of the Code so that the Employer's reimbursements from the Health FSA are excludable from the Participant's gross income. The terms and conditions of this Pre-Tax Benefit are set forth in Appendix C.

(iv) *Dependent Care Assistance Plan*. Participants may elect to make contributions to the DCAP. A DCAP enables Participants to elect pre-tax salary reduction and receive reimbursements for their Qualified Dependent Care Expenses incurred during a Plan Year. The Employer intends that this benefit qualify under Section 129 of the Code so that the Employer's reimbursements from the DCAP are excludable from the Participant's gross income. The terms and conditions of this Pre-Tax Benefit are set forth in Appendix D.

(v) *Vision Plan*. Participants may elect to receive vision coverage through the Vision Plan. The terms and conditions of this Pre-Tax Benefit are set forth in Appendix E.

(b) *Election of Pre-Tax Benefits.* The election of a Pre-Tax Benefit is subject to the terms and conditions of Article V.

(c) *Cessation of Participation in a Pre-Tax Benefit.* Except as otherwise expressly provided in the Pre-Tax Benefit, a Participant will cease to be a participant in the Pre-Tax Benefit on the date that he/she ceases to be a Participant in this Plan.

Section 4.02 After-Tax Benefits. Each Participant may elect to have the cost of one (1) or more of the After-Tax Benefits deducted from his/her Compensation on an after-tax basis. The monthly premiums for insurance coverage are determined by the applicable insurance company and may change from time to time.

(a) *Terms and Conditions of the After-Tax Benefits.* The terms and conditions of the After-Tax Benefits are as follows:

(i) *Voluntary Life Plan*. Participants may elect to receive voluntary life coverage through the Voluntary Life Plan. The terms and conditions of this After-Tax Benefit are provided in Appendix F.

(ii) *Accidental Death and Dismemberment Plan*. Participants may elect to receive accidental death and dismemberment coverage through the Accidental Death and Dismemberment Plan. The terms and conditions of this After-Tax Benefit are provided in Appendix G.

(iii) *Long Term Disability Plan*. Participants may elect to receive long term disability coverage through the Long Term Disability Plan. The terms and conditions of this After-Tax Benefit are provided in Appendix H.

(iv) *Accident Plan*. Participants may elect to receive accident coverage through the Accident Plan. The terms and conditions of this After-Tax Benefit are provided in Appendix I.

(v) *Critical Illness Plan*. Participants may elect to receive critical illness coverage through the Critical Illness Plan. The terms and conditions of this After-Tax Benefit are provided in Appendix J.

(vi) *Critical Illness and Cancer Plan.* Participants may elect to receive critical illness and cancer coverage through the Critical Illness and Cancer Plan. The terms and conditions of this After-Tax Benefit are provided in Appendix K.

(b) *Election of After-Tax Benefits.* A Participant may make and/or change his/her elections with respect to an After-Tax Benefit at any time in accordance with the rules and procedures established by the Plan Administrator. Any such election change shall take effect on the earliest administratively practicable date after the request to change an after-tax election is received by the Plan Administrator.

*[The remainder of this page is intentionally left blank.]*

## ARTICLE V
## ELECTION OF PRE-TAX BENEFITS

Section 5.01 Benefit Plans. Each Participant may elect to receive the Participant's entire Compensation in cash or to reduce the Participant's Compensation and have the Employer apply the amount by which the Participant's Compensation is reduced toward the cost of benefits that are available on a pre-tax basis under this Plan.

Section 5.02 Method of Making an Election. In order to purchase a Pre-Tax Benefit through this Plan, a Participant must execute an agreement to reduce his/her Compensation on the salary reduction form provided by the Plan Administrator. The Plan Administrator may require such agreement to be completed and submitted in electronic form through the use of the Internet, an Intranet, a telephone system, or such other system as the Plan Administrator may prescribe.

Section 5.03 Timing of Elections.

(a) *Initial Elections for New Participants.* To make an election to purchase Pre-Tax Benefits through this Plan, a new Participant must execute a salary reduction form and deliver it to the Plan Administrator no later than thirty (30) days after the date the Participant becomes a Participant in this Plan.

(b) *Annual Elections for Current Participants.* At least thirty (30) days prior to the beginning of each Plan Year, the Plan Administrator must provide each Participant with the opportunity to make elections for the following Plan Year. Participants desiring to make elections during the Annual Enrollment Period for the next Plan Year must do so in the manner and within the deadlines prescribed by the Plan Administrator. Elections made during the Annual Enrollment Period shall become effective for the following Plan Year.

(c) *Election Changes during a Plan Year.* A Participant may change his/her elections with respect to a Pre-Tax Benefit during a Plan Year *only if* an election change is permitted as a result of one (1) or more of the events listed in Sections 5.06 through 5.15. Such events may be referred to generally in Plan documents as an "Election Change Event." Except as otherwise provided in this Article V, any election change as a result of an event qualifying as an Election Change Event must be made no later than thirty (30) days after the event. Election changes made as a result of an Election Change Event may *not* be given retroactive effect except as specifically set forth below. Additional restrictions and/or rules may apply to election changes made during a Plan Year with respect to a Health FSA and/or a DCAP.

Section 5.04 Failure to Make an Election.

(a) *Failure to Make Initial Election.* A Participant's failure to return a completed salary reduction form by the required date as set forth in Section 5.03(a) constitutes an election to receive the Employee's entire Compensation for the Plan Year in cash.

In such an event, no portion of the Employee's Compensation will be applied toward the cost of any benefits available under any of the Pre-Tax Benefits. Such an Employee will not be permitted to change such an election until (i) the next Annual Enrollment Period *or* (ii) the Employee experiences an Election Change Event, as a result of which an election change would be permitted under this Article V.

(b) *Failure to Change Existing Elections During Annual Enrollment Period.* Once a Participant has completed a salary reduction form for a Plan Year, a failure to complete a new form for a subsequent Plan Year during the Annual Enrollment Period constitutes an election to receive the Employee's entire Compensation for the Plan Year in cash.

Section 5.05 Irrevocability of an Election Once Made. Once the Annual Enrollment Period has passed, a Participant shall not be permitted to revoke, amend, or change the elections the Participant has made for the affected Plan Year except as provided in this Article V.

Section 5.06 Election Change Due to Change in Status. After a Plan Year has commenced, a Participant shall be permitted to revoke an election in its entirety (or revoke the election and make a new election) for the balance of that Plan Year, if the Participant experiences a Change in Status as defined below and the consistency requirements of this Section are satisfied.

(a) *Change in Status*. The following events constitute a Change in Status:

(i) *Change in Marital Status.* A change in the Participant's legal marital status, including the following: marriage, divorce, the death of a Spouse, legal separation, and annulment.

(ii) *Change in Number of Dependents.* A change in the number of the Participant's dependents, including the following: birth, death, adoption, and placement for adoption.

(iii) *Change in Employment Status.* Any of the following events that change the employment status of the Participant, the Participant's Spouse, or the Participant's dependents:

(A) A termination or commencement of employment;

(B) A commencement of or return from an unpaid leave of absence;

(C) A change in worksite, if such a change affects eligibility under this Plan or a Pre-Tax Benefit;

(D) A change in employment status, such as a change from salaried to hourly employment, if the change affects the eligibility of the Participant, the Participant's Spouse, or the Participant's

dependents under this Plan or under a Pre-Tax Benefit or if the change affects the eligibility of the Participant, the Participant's Spouse, or the Participant's dependents under a cafeteria plan or welfare benefit plan maintained by an employer (other than the Employer) employing the Participant, the Participant's Spouse, or the Participant's dependents; or

(E) A strike or lockout.

(iv) *Change in Dependent Eligibility.* An event that causes the Participant's dependent(s) to satisfy or cease to satisfy the eligibility conditions for coverage under a Pre-Tax Benefit on account of the dependent's attainment of a certain age, student status, or any similar circumstances.

(v) *Change in Residence.* A change in the place of residence of the Participant, the Participant's Spouse, or the Participant's dependent(s), if such a change affects eligibility under this Plan or a Pre-Tax Benefit.

(b) *Consistency*. An election change that is made on account of a Change in Status must be consistent with that Change in Status. Whether a particular election change is consistent with a Change in Status will be determined by the Plan Administrator in accordance with Internal Revenue Service ("IRS") regulations.

Section 5.07 Election Change Due to Exercise of HIPAA Special Enrollment Rights.

(a) *HIPAA Special Enrollment Rights.* After a Plan Year has commenced, a Participant may revoke his/her prior election for health coverage and make a new election for such coverage, if the Participant, the Participant's Spouse, or a dependent of the Participant is entitled to special enrollment rights under a group health plan of the Employer as described under either (i), (ii), (iii), or (iv) below:

(i) *Eligibility for a State Premium Assistance Subsidy under the Plan from Medicaid or SCHIP.* A Participant or his/her Spouse or dependent becomes eligible for a state premium assistance subsidy under a group health plan of the Employer from either Medicaid or a state's children's health insurance program (SCHIP);

(ii) *Loss of Eligibility for Medicaid or SCHIP Coverage.* The Medicaid or SCHIP coverage of a Participant or his/her Spouse or dependent is terminated as a result of a loss of eligibility;

(iii) *Loss of Other Coverage.* Medical coverage was declined under a group health plan sponsored by the Employer because the Employee and/or dependent was covered under another group health plan or had other health insurance coverage, and eligibility for such coverage is subsequently lost. A loss of eligibility for such other coverage includes the following:

(A) Loss of eligibility for coverage as a result of legal separation, divorce, cessation of dependent status, death, termination of employment, reduction in hours, or exhaustion of the maximum COBRA period;

(B) Loss of eligibility for coverage through an HMO in the individual market because the individual no longer resides, lives, or works in a service area (whether or not the choice of the individual); and

(C) In the case of coverage offered through an HMO in the group market that does not provide benefits to an individual who no longer resides, lives, or works in the service area (whether or not the choice of the individual), and no other benefit package is available to the individual.

A loss of eligibility does not include a loss resulting from the failure of the Employee or dependent to pay premiums on a timely basis or a termination of coverage for cause (e.g., fraud).

(iv) *Acquisition of a New Dependent.* The Participant acquires a new dependent as a result of marriage, birth, adoption, or placement for adoption.

(b) *New Election Must Correspond and be Consistent with HIPAA Special Enrollment Rights.* A change in elections pursuant to this Section must correspond and be consistent with the exercise of the special enrollment rights provided under Code § 9801(f).

(i) *Increase in Salary Reductions.* A Participant may elect to increase the amount by which his/her Compensation is reduced by no more than the additional cost of the benefits provided under the group health plan as a result of the enrollment of the Participant, the Participant's Spouse, and/or a dependent of the Participant in the group health plan.

(ii) *Decrease in Salary Reductions.* A Participant may elect to decrease the amount by which his/her Compensation is reduced by no more than the cost of the premium assistance received by the Participant and/or his/her dependents.

(iii) *Election to Add Previously Eligible Dependents.* An election to add previously eligible dependents as a result of a loss of other coverage or the acquisition of a new Spouse or dependent child shall be considered to be consistent with the special enrollment rights.

(c) *Status Change Form.* Each Participant must complete a status change form and submit such form to the Plan Administrator no later than sixty (60) days after the date of the event giving rise to the exercise of a HIPAA special enrollment right under (a)(i) or (a)(ii) above, or no later than thirty (30) days after the date of the event giving rise to the right to exercise the special enrollment rights under (a)(iii) or (a)(iv) above.

(d) *Effective Date of Medicaid/SCHIP Provisions.* The effective date of the HIPAA special enrollment right provisions set forth in Subsections (a)(i) and (a)(ii) is April 1, 2009.

(e) *Approval of Change.* Any change in election resulting from the exercise of the special enrollment rights provided under Code § 9801(f) is subject to the review and approval of the Plan Administrator.

Section 5.08 Election Change Due to Mid-Year Enrollment in a Qualified Health Plan Under the Marketplace. After a Plan Year has commenced, a Participant may revoke his/her prior election for health coverage and make a new election for such coverage if the Participant enrolls in a Qualified Health Plan through the Health Insurance Marketplace (commonly referred to as the "Exchange" or "Marketplace"), established by the Patient Protection & Affordable Care Act, by virtue of having become eligible for a special enrollment period in the Marketplace or having enrolled during the Marketplace's annual open enrollment period, so long as both of the following conditions are satisfied:

(a) The revocation of the Participant's election corresponds to the intended enrollment of the Participant, and any Spouse or dependents who cease coverage due to the revocation, in a Qualified Health Plan through the Marketplace; and

(b) The new coverage under the Marketplace's Qualified Health Plan in which the Participant (and, if applicable, the Participant's Spouse and/or dependents) enrolls takes effect no later than the day immediately following the day that the Participant's coverage under the Medical Plan is terminated. (The Plan Administrator may rely on the Participant's reasonable representation regarding the intention to enroll in a Qualified Health Plan under the Marketplace and the effective date of such coverage.)

Section 5.09 Election Change Due to Change in Coverage (Does not apply to Health FSA).

(a) *Cessation or Significant Curtailment in Coverage.*

(i) *Significant Curtailment Without Loss of Coverage.* If the Plan Administrator determines that coverage under a Benefit Package Option is significantly curtailed (but not lost) during the Plan Year, the Participant may revoke his/her election for coverage under that Benefit Package Option and may elect coverage, on a prospective basis only, under another Benefit Package Option providing similar coverage. Coverage under a plan is deemed "significantly curtailed" only if there is an overall reduction in coverage provided to Participants under the plan so as to constitute reduced coverage to Participants in general.

(ii) *Significant Curtailment With Loss of Coverage.* If the Plan Administrator determines that coverage under a Benefit Package Option is significantly curtailed during the Plan Year and that the curtailment constitutes a loss of coverage with respect to a Participant (or the Participant's Spouse or

dependent), the Participant may revoke his/her election for coverage under that Benefit Package Option and may elect coverage, on a prospective basis only, under another Benefit Package Option providing similar coverage. If no similar Benefit Package Option is available, the Participant may elect to drop coverage. For purposes of this Section 5.09(a)(ii), a loss of coverage means a complete loss of coverage under the Benefit Package Option or other coverage option (including the elimination of a Benefits 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). In addition, the Plan Administrator, in its sole discretion and in accordance with prevailing IRS guidance, may determine that the following constitutes a loss of coverage:

(A) 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);

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

(C) Any other similar fundamental loss of coverage.

(iii) *Determinations to be Made by the Plan Administrator.* The Plan Administrator, in its sole discretion, shall decide, in accordance with prevailing IRS guidance and based upon the surrounding facts and circumstances, whether a curtailment is "significant," whether a curtailment represents a loss of coverage with respect to a particular individual, and whether a substitute Benefit Package Option provides "similar coverage."

(b) *Addition or Improvement of a Benefit Package Option.* If, during the Plan Year, a new Benefit Package Option or a new coverage option is added, or if coverage under an existing Benefit Package Option or existing coverage option is significantly improved during the period of coverage, a Participant may elect to add the new Benefit Package Option/coverage option, or the improved Benefit Package Option/coverage option, and to make corresponding changes with respect to other Benefit Package Options providing similar coverage. Any such change will take effect on a prospective basis only. The Plan Administrator, in its sole discretion, shall decide, based upon the surrounding facts and circumstances and in accordance with prevailing IRS guidance, whether a new Benefit Package Option/coverage option has been added, whether an existing Benefit Package Option/coverage option has been significantly improved, and/or whether another Benefit Package Option/coverage option constitutes "similar coverage."

(c) *Change in Coverage of Spouse or Dependent under Plan of Another Employer ("Election Lock").* After the Plan Year has commenced, a Participant may change his/her elections on a prospective basis only if the change is on account of and corresponds with a change made under the plan of the employer of the Participant's Spouse, the Participant's former Spouse, or the Participant's dependent. Any such change is permitted only if (i) the cafeteria plan of such other employer permits its participants to make only those election changes that are permitted under proposed or final IRS regulations under Code Section 125; or (ii) the period of coverage under the plan of such other employer is different than the Plan Year for this Plan. The Plan Administrator, in its sole discretion, shall decide, in accordance with prevailing IRS guidance, whether a requested change is on account of and corresponds with a change made under the plan of the employer of the Participant's Spouse, former Spouse, or dependent. The Plan Administrator may request and receive any documents it reasonably considers necessary to make such a determination.

(d) *Loss of Coverage Under Other Group Health Coverage.* After the Plan Year has commenced, a Participant may change his/her elections on a prospective basis only to add coverage for the Participant or the Participant's Spouse or dependent if the Participant or the Participant's Spouse or dependent loses coverage under any group health coverage sponsored by a governmental or educational institution. For purposes of this provision, this includes the following: (i) A state's children's health insurance program (SCHIP) under Title XXI of the Social Security Act; (ii) a medical care program of an Indian Tribal government or a tribal organization; (iii) a state health benefits risk pool; or (iv) a foreign government group health plan.

Section 5.10 Election Change Due to FMLA Leave. A Participant who is taking leave under the FMLA may revoke an existing election of accident or health plan coverage and may make such other election for the remaining portion of coverage as may be permitted under Section 3.03 of this Plan. Additionally, such a Participant may also be permitted to change his/her elections under Section 5.06(a)(iii), provided the requirements of that section are satisfied.

Section 5.11 [Reserved]

Section 5.12 Election Change Due to Issuance of a Judgment, Decree, or Order. If a judgment, decree, or order (an "Order") resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order) requires accident or health coverage to be provided for a Participant's dependent child, including a foster child who is a dependent of the Participant, a Participant may (a) change his/her election to provide coverage for the dependent child, provided that the Order requires the Participant to provide such coverage; or (b) change his/her election to revoke coverage for the dependent child if the Order requires that another individual, including the Participant's Spouse or former Spouse, provide coverage under that individual's plan for the dependent child and such coverage is, in fact, provided.

Section 5.13 Election Change Due to Medicare/Medicaid Entitlement. If a Participant, a Participant's Spouse, or a Participant's dependent who is entitled to receive benefits under a Group Health Plan becomes entitled to Medicare or Medicaid (other than coverage consisting solely of benefits of Section 1928 of the Social Security Act providing for pediatric vaccines), the Participant may reduce his/her election to reflect the reduction or cancellation of the coverage provided to such person under the Group Health Plan. Additionally, if a Participant, a Participant's Spouse, or a Participant's dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, the Participant may increase his/her election to reflect the increased cost of providing coverage under the Group Health Plan. Any change made under this Section shall take effect on a prospective basis only. The Plan Administrator may request and receive any documents it reasonably considers necessary to make such a determination. The right to drop or add coverage under a Group Health Plan is governed by and subject to the terms of the Group Health Plan. This Section does not apply to a Health FSA.

Section 5.14 Election Change Due to Significant Change in Cost.

(a) *Increase in Participant's Share of the Cost.* If the Participant's share of the premium for coverage under a Benefit Package Option (other than a Health FSA) increases by a significant amount during a Plan Year, the Participant may either increase his/her election by a corresponding amount on a prospective basis or the Participant may revoke his/her election and, in lieu thereof, receive coverage under another Benefit Package Option (if any) providing similar coverage. If similar coverage is not available under another Benefit Package Option, the Participant may revoke his/her election without electing coverage under another Benefit Package Option.

(b) *Decrease in Participant's Share of the Cost.* If the Participant's share of the premium for coverage under a Benefit Package Option (other than a Health FSA) decreases by a significant amount during a Plan Year, the Participant may decrease his/her election by a corresponding amount on a prospective basis or, if the Participant is not currently enrolled in the Benefit Package Option, the Participant may elect to become covered under that Benefit Package Option.

(c) *Other Provisions.* The Plan Administrator, in its sole discretion, shall decide, in accordance with prevailing IRS guidance, whether a change in cost is significant and what constitutes "similar coverage" based upon all of the surrounding facts and circumstances.

(d) *Special Provisions Applicable to DCAPs.* This Section does not apply to a DCAP unless the change in cost is imposed by a dependent care provider who is not related (as that term is used in IRS regulations) to the Participant.

Section 5.15 Election Change Required by the Plan Administrator. The Plan Administrator may, at any time, require any Participant or class of Participants to amend the amount by which they have elected to reduce their Compensation for a Plan Year if the Plan Administrator determines such action is necessary or advisable to (a) satisfy any Code nondiscrimination requirements applicable to this Plan or any Pre-Tax Benefit; (b) prevent any

Employee or class of Employees from having to recognize more income for federal income tax purposes from the receipt of benefits from any Pre-Tax Benefit than would otherwise be recognized; or (c) maintain the qualified status of benefits received under this Plan. In the event contributions need to be reduced for a class of Participants, the Plan Administrator will reduce the amount by which each affected Participant has elected to reduce his/her Compensation, beginning with the Participant in the class who had elected to reduce his/her Compensation by the highest amount, continuing with the Participant in the class who had elected the next highest amount, and so forth, until the defect is corrected.

Section 5.16 [Reserved]

Section 5.17 Requesting and Approving Election Changes. A Participant desiring to make a change in his/her elections pursuant to this Article V must complete and submit a status change form and/or such other forms as the Plan Administrator may require. If an election change is to take effect during a Plan Year, the Plan Administrator may require the Participant to provide such proof as it reasonably considers necessary of the events underlying the request for an election change, including, but not limited to, a marriage certificate, divorce decree, birth certificate, confirming letter from the Spouse's current or former employer, or any other relevant documents. All such requests for an election change must be reviewed and approved by the Plan Administrator before the election change is given effect. All such requests must be submitted within thirty (30) days after the date giving rise to the request for an election change, except as provided in Section 5.07(c) with regard to certain HIPAA special enrollment rights that allow such requests to be submitted within sixty (60) days after the date giving rise to the request for an election change.

Section 5.18 Effective Date of Election Changes. Except as specifically provided in this Section, an election change made during the middle of a Plan Year will be given prospective effect only and will take effect as of the first administratively practicable date following the date on which the Plan Administrator approves the new elections that are being made.

(a) *Special Rule for Newly Adopted Dependent Children and Newborns.* Notwithstanding the general rule stated in this Section, and subject to the provisions of the underlying Group Health Plan, an election to increase the amount by which the Participant's Compensation is reduced in order to fund the increased cost of providing benefits under a Group Health Plan to a newly adopted dependent child or newborn may be given retroactive effect to the date of birth or date of adoption.

Section 5.19 Special Rule for Health FSAs. If an election change is permitted under the provisions of this Article V, a Participant may change his/her election as follows:

(a) A Participant may begin to participate in the Health FSA for the balance of the Plan Year; or

(b) A Participant may increase his/her election amount as long as the election does not exceed the maximum election amount permitted under the Plan; or

(c) A Participant may decrease the election amount, provided, however, that the amount elected may not be less than the amount Participant has already been reimbursed.

Section 5.20 Maximum Benefits. The maximum benefits under this Plan are the maximum benefits specified in the Pre-Tax Benefits and After-Tax Benefits.

*[The remainder of this page is intentionally left blank.]*

## ARTICLE VI
## PLAN ADMINISTRATION

Section 6.01 Plan Administrator. The administration of this Plan shall be under the supervision of the Plan Administrator. The Plan Administrator shall have the responsibility of ensuring that this Plan is carried out, in accordance with its terms, for the exclusive benefit of the persons entitled to participate in this Plan.

Section 6.02 Powers of the Plan Administrator. The Plan Administrator shall have such powers and duties as it considers necessary or appropriate to discharge its duties under this Plan. The powers of the Plan Administrator shall include, but are not limited to, the following:

(a) Establish rules and procedures for the purpose of administration of this Plan;

(b) Require each Participant to supply such information and sign such documents as may be necessary to administer this Plan. In the case of Participant elections, election changes, and other information supplied by the Participant, this power includes requiring elections, election changes, and other information to be submitted using electronic media, subject to and to the extent permitted under applicable IRS and Department of Labor ("DOL") regulations;

(c) Communicate with Participants through electronic media, subject to and to the extent permitted under applicable IRS and DOL regulations;

(d) Interpret, construe, and carry out the provisions of this Plan, and render decisions on the administration of this Plan, including factual and legal determinations as to whether any individual is eligible to be enrolled in and/or receive any benefit under the terms of this Plan; and

(e) Appoint such agents, attorneys, accountants, consultants, Claims Administrators, and any other persons as may be needed for proper administration of this Plan.

In exercising these powers, the Plan Administrator shall act in its sole discretion, giving due regard for the reason and purpose for which this Plan is established and maintained. Any construction of the terms of any plan document and any determination of fact adopted by the Plan Administrator shall be final and legally binding on all parties.

The Plan Administrator shall have no power to waive, alter, or fail to apply the terms of this Plan.

Section 6.03 Plan Must Be Nondiscriminatory. The Plan Administrator shall administer this Plan in a nondiscriminatory manner so all persons similarly situated will receive substantially similar treatment.

*[The remainder of this page is intentionally left blank.]*

# ARTICLE VII
# HIPAA MEDICAL PRIVACY
# FOR THE HAYSVILLE USD 261 MEDICAL PLAN, HAYSVILLE USD 261 DENTAL PLAN, AND HAYSVILLE USD 261 HEALTH FLEXIBLE SPENDING ACCOUNT

## PART I
## PREAMBLE

Section 7.01 Purpose and Effective Date. This HIPAA Medical Privacy Article is adopted in response to the provisions of the Medical Privacy Regulations issued under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Section 7.02 Application of Article VII. The Haysville USD 261 Welfare Benefits Plan is a "hybrid entity." As such, the Plan has made a separate hybrid entity designation to define the medical components from the non-medical components of the Plan.

This Article shall *only* apply to the Haysville USD 261 Medical Plan, Haysville USD 261 Dental Plan, and the Haysville USD 261 Health Flexible Spending Account (hereafter referred to as the "Group Health Plan").

All other benefits provided by the Employer through the Haysville USD 261 Welfare Benefits Plan are either (a) not "group health plans" as defined by HIPAA or (b) provided solely through an insurance contract with a health insurance issuer or HMO and do not create or receive protected health information (PHI) other than "summary health information" as defined in 45 C.F.R. Section 164.504(a) or enrollment and disenrollment information.

The Article shall supersede the provisions of the Group Health Plan to the extent those provisions are inconsistent with the provisions of this Article.

## PART II
## DISCLOSURE OF PROTECTED HEALTH INFORMATION TO THE EMPLOYER

Section 7.03 Prohibition Against Disclosing Protected Health Information to the Employer. Except as permitted by this Part II, the Group Health Plan and/or a health insurance issuer with respect to the Group Health Plan may not disclose PHI to the Employer.

Section 7.04 Definitions. For purposes of this Part II, the following definitions shall apply. These definitions are based on and shall be construed and applied in a manner that is consistent with the definitions set forth in Part 160 and Part 164 of Title 45 of the Code of Federal Regulations.

(a) "*Breach*" means the unauthorized acquisition, access, use, or disclosure of PHI which compromises the security or privacy of such PHI. The following three (3) types of unauthorized acquisition, access, use, or disclosure are excluded from the definition of a "breach:"

(i) Any unintentional acquisition, access, or use of PHI by an Employee or individual acting under the authority of the Group Health Plan if such acquisition, access, or use was made in good faith and within the course and scope of employment or other professional relationship of such Employee or individual, respectively, with the Group Health Plan, and the information is not further acquired, accessed, used, or disclosed by any person in a manner not permitted by the HIPAA Medical Privacy or Security Rules;

(ii) Any inadvertent disclosure from an individual who is otherwise authorized to access PHI at a facility operated by the Group Health Plan to another similarly situated individual at the same facility so long as the information received is not further used or disclosed in a manner not permitted by the HIPAA Medical Privacy or Security Rules; and

(iii) Any disclosure to an unauthorized person where the PHI that was disclosed would not reasonably have been retained by such person.

(b) "*De-identified Health Information*" means health information that does not identify an individual and for which there is no reasonable basis for believing that the information may be identified with a specific individual. Health information will be considered to be De-identified Health Information if the information listed in Section 164.514(b)(2)(ii) of Title 45 of the Code of Federal Regulations has been removed. Information that must be removed, pursuant to this Section of the regulations, includes (but is not limited to) names, geographical locations more specific than the first three (3) digits of a ZIP code, dates (except for the year of birth), telephone and fax numbers, and Social Security numbers.

(c) "*Electronic Media*" means:

(i) Electronic storage media including memory devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical tape, or digital memory card; or

(ii) Transmission media used to exchange information already in electronic storage media. Transmission media include, for example, the Internet, extranet (using Internet technology to link a business with information accessible only to collaborating parties), leased lines, dial-up lines, private networks, and the physical movement of removable/transportable electronic storage media. Certain transmissions, including paper, facsimile, and voice via telephone are not considered to be transmissions via electronic media, because the information being exchanged did not exist in electronic form before the transmission.

(d) "*Electronic Protected Health Information*" *("e-PHI")* is PHI that is transmitted or maintained in electronic media.

(e) "*Individually Identifiable Health Information*" means information for which each of the following conditions is met:

(i) The information is created or received by a health care provider, a health plan (including a group health plan or a health insurance issuer), an employer, or a health care clearinghouse;

(ii) The information relates to the past, present, or future physical or mental health of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual; and

(iii) The information either identifies the individual or provides a reasonable basis for believing that the information can be used to identify the individual.

(f) "*Plan Administration Functions*" means administrative functions performed by the Employer on behalf of the Group Health Plan. Plan Administration Functions do not include any functions performed by the Employer in connection with any other benefit or benefit plan.

(g) "*Protected Health Information (PHI)*" means Individually Identifiable Health Information except that PHI does not include employment records held by a covered entity in its role as an employer, educational records covered by the Family Educational Rights and Privacy Act, or health care records of post-secondary degree students.

(h) "*Security Incident*" (as defined in 45 C.F.R. 164,304) means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

(i) "*Security Rule*" shall mean the Security Standards and Implementation Specifications in 45 C.F.R. Part 160 and Part 164, subpart C.

(j) "*Summary Health Information*" means information that summarizes the claims history, claims expenses, and/or types of claims experienced by individuals for whom the Employer has provided medical coverage under the Group Health Plan and from which the identifying information listed in Section 164.514(b)(2)(ii) of Title 45 of the Code of Federal Regulations has been removed, except that geographical locations may be described using a five (5) digit ZIP code.

(k) "*Unsecured PHI*" means PHI that is not secured through the use of a technology or methodology specified by the Secretary of Health and Human Services through guidance issued by the Secretary.

Section 7.05 Enrollment and Disenrollment Information. The Group Health Plan and/or a health insurance issuer with respect to the Group Health Plan may disclose

Section 7.06 Plan Administration Functions. The Group Health Plan and/or a health insurance issuer with respect to the Group Health Plan may disclose PHI or e-PHI to the Employer if the Employer requires such information in order to carry out its responsibilities in connection with the administration of the Group Health Plan. Such responsibilities may include the following:

(a) Reviewing the performance of the Group Health Plan, including the performance of any insurance companies providing group health coverage for the Group Health Plan and the performance of any business associates of the Group Health Plan;

(b) Overseeing the adjudication of benefit claims, including the responsibility to provide coverage upon the initial submission of claims and the disposition of any Appeals that are filed with respect to claims that are denied in whole or in part;

(c) Overseeing the coordination of benefits and pursuing and/or responding to claims for subrogation;

(d) Conducting cost management and planning-related analysis, including the forecasting of expected health care costs based on current utilization of benefits;

(e) Detecting fraud or abuse;

(f) Determining whether charges for services are appropriate or justified;

(g) Requesting underwriting or premium rating and other activities related to the creation, renewal, or replacement of a contract of health insurance;

(h) Securing, placing, and/or receiving payments pursuant to a policy of stop-loss or excess loss insurance in the event the Group Health Plan is self-insured in whole or in part;

(i) Ensuring that the required premiums for the coverage provided under the Group Health Plan are obtained from the persons obligated to pay the same and remitting such premiums to the appropriate insurance carriers and/or third party service providers as may be necessary or appropriate;

(j) Providing assistance, upon request, to Participants and their covered dependents in addressing and resolving problems that they may encounter with the approval and payment of claims that have been submitted on their behalf;

(k) Reporting corporate finances with respect to current and projected health care costs;

(l) Providing information that is legally required in response to a court order, subpoena, discovery, or other process or to the Department of Health and Human Services ("HHS") in connection with its enforcement activities, but only

to the extent that the Employer is required to act on behalf of the Group Health Plan in providing such information and only if the Group Health Plan is permitted to make the disclosure under the provisions of the HIPAA Medical Privacy Regulations; and

(m) Performing other functions as required to effectively offer benefits under the Group Health Plan.

The use and disclosure of PHI or e-PHI pursuant to this Section 7.06 is subject to the provisions of Section 7.07.

Section 7.07 Conditions for Disclosure for Plan Administration Functions. With respect to any PHI or e-PHI that is disclosed to the Employer by the Group Health Plan and/or a health insurance issuer with respect to the Group Health Plan pursuant to Section 7.06, the Employer agrees to do the following:

(a) Not use or further disclose PHI or e-PHI other than as permitted or required by the Group Health Plan document or as required by law;

(b) Ensure that any agents or subcontractors to whom the Employer provides PHI or e-PHI received from the Group Health Plan agree to the same restrictions and conditions that apply to the Employer with respect to such PHI or e-PHI;

(c) Not to use or disclose PHI or e-PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plans of the Employer;

(d) Report to the Group Health Plan any use or disclosure of PHI or e-PHI that is inconsistent with the uses or disclosures permitted by this Group Health Plan to the extent it becomes aware of such information. If and as required by any applicable HHS regulations, this reporting requirement will also include reporting to the Group Health Plan any Breach of Unsecured PHI that it discovers, so that the affected individual(s), the media (if applicable), and HHS may be appropriately notified of the Breach as required by the regulations issued regarding breach notifications;

(e) Effective February 17, 2010, restrict the disclosure of PHI of an individual (unless the disclosure is otherwise required by law) where the disclosure is to the Group Health Plan for purposes of carrying out payment or health care operations (and not treatment) and the PHI pertains to a health care item or service for which the health care provider has been paid out-of-pocket in full;

(f) Make the PHI or e-PHI that it receives from the Group Health Plan and/or health insurance issuer available to the individual to whom it relates in accordance with the individual's right to access his/her own information as that right is set forth in Section 164.524 of Title 45 of the Code of Federal Regulations;

(g) Make PHI or e-PHI available for amendment and to incorporate any requested amendments in accordance with and to the extent required by Section 164.526 of Title 45 of the Code of Federal Regulations;

(h) Make available the information that is required to provide an accounting to an individual of the disclosures that have been made of the individual's PHI or e-PHI in accordance with and to the extent required by Section 164.528 of Title 45 of the Code of Federal Regulations;

(i) Make its internal practices, books, and records relating to the use and disclosure of PHI or e-PHI available to the Secretary of Health and Human Services for purposes of allowing the Secretary to determine compliance by the Group Health Plan with HIPAA's medical privacy and security requirements;

(j) If feasible, return or destroy all PHI or e-PHI received from the Group Health Plan or a health insurance issuer when such information is no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Employer may limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible;

(k) Ensure that adequate separation between the Employer and the Group Health Plan exists, as set forth in more detail in Part III;

(l) Provide a certification to the Group Health Plan as required by Section 7.08; and

(m) If the Employer creates, receives, maintains, or transmits any e-PHI (other than enrollment and disenrollment information and Summary Health Information, which are not subject to these restrictions) on behalf of the Group Health Plan, it will do the following:

(i) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the e-PHI;

(ii) Ensure that any agent (including subcontractors) to whom it provides such e-PHI agree to implement reasonable and appropriate security measures to protect the information; and

(iii) Report to the Group Health Plan any Security Incident of which it becomes aware.

Section 7.08 Certification by the Employer. In the absence of an authorization, the Group Health Plan may not disclose any PHI or e-PHI to the Employer unless and until the Group Health Plan is in receipt of a certification from the Employer. The Employer must certify in the certification that the Group Health Plan has been amended to incorporate the provisions required by Section 164.504(f)(2)(ii) of Title 45 of the Code of Federal Regulations. The Employer must further certify in the certification that the Employer agrees to the conditions of disclosure as set forth in Section 7.07 and in Part III.

## PART III
## ADMINISTRATIVE SAFEGUARDS

Section 7.09 Adequate Separation Between the Employer and the Plan. No person employed by the Employer may receive or have access to PHI or e-PHI from the Group Health Plan except as set forth in this Part III. The Employer will ensure that the provisions of this Part are supported by reasonable and appropriate security measures to the extent that the "authorized employees" have access to e-PHI. Further, this Part III does not apply to information that is not considered to be PHI or e-PHI, such as Summary Health Information and De-identified Health Information, or to information that the Employer receives in a way that is separate and independent from this Group Health Plan.

Section 7.10 Authorized Employees. The following Employees ("Authorized Employees") are permitted to use and have access to PHI or e-PHI to the extent necessary to perform the plan administration functions, as set forth in Part II above, that the Employer performs for the Group Health Plan in order to provide benefits to Participants:

Superintendent of Schools
Assistant Superintendent for Business/Finance
Benefits Clerk

In the case of an unanticipated or unusual event, for a limited time and purpose only, Employees designated in writing by the Privacy Officer at the time of such event to resolve the unanticipated or unusual event may have access to PHI or e-PHI. For example, an employee in the IT department may need access, but only for the limited purpose of accessing a database containing PHI or e-PHI to correct a computer virus or similar problem, hardware defect, or other system issue. Similarly, in-house counsel of the Employer (if applicable), including counsel's support staff, may need access to PHI or e-PHI, but only for the limited purpose of assisting in the investigation of and otherwise responding to complaints alleging violations of the policies and procedures established by the Employer.

Such Employees accessing PHI or e-PHI due to an unanticipated or unusual event may be identified by names, job title, or any other designation that adequately identifies the Employees. In addition, the Employees shall receive proper training regarding the HIPAA medical privacy and security rules and shall comply fully with the Plan's policy and procedures. Any such appointment shall be documented and available for inspection and copying.

Section 7.11 Use Pursuant to an Authorization. Employees of the Employer may use and have access to PHI or e-PHI to the extent authorized by a valid authorization for the purposes set forth in the authorization.

Section 7.12 Consequences of Unauthorized Use of PHI or e-PHI. If it is determined that an Employee has obtained, used, or disclosed PHI or e-PHI in a manner or way that is not permitted by this Part III, the Employee will be subject to discipline by the Employer in accordance with policies and procedures established by the Employer.

*[The remainder of this page is intentionally left blank.]*

## ARTICLE VIII
## GROUP HEALTH PLAN CONTINUATION COVERAGE

This Article VIII applies only to Group Health Plans as that term is defined in Section 2.17. With respect to the Health FSA, however, the specific terms and conditions of continuation coverage as described in this Article are modified by Appendix C, Article C-IV.

Section 8.01 Continuation of Coverage under COBRA. If a "qualified beneficiary" loses (or would lose) coverage under this Plan as a result of a "qualifying event," the Plan Administrator will give that qualified beneficiary the opportunity to continue coverage by returning a COBRA election form and by paying the applicable premium. The qualified beneficiary's right to continue coverage under this Plan is subject to the following:

(a) *Qualified Beneficiary.* For purposes of this Section, a "qualified beneficiary" means the Participant, the Participant's Spouse, and the Participant's dependents, but only if such persons were covered under this Plan on the day before the "qualifying event." The term "qualified beneficiary" shall also include any children who are born to or adopted by the Participant while the Participant is continuing his/her coverage under COBRA.

(b) *Qualifying Event.* For purposes of this Section, a "qualifying event" means one (1) of the following if the qualified beneficiary would otherwise lose his/her eligibility for coverage under this Plan as a result of such an event:

(i) Termination of the Participant's employment (other than for "gross misconduct") or a reduction in the number of hours the Participant normally works.

(ii) Death of the Participant.

(iii) Divorce or legal separation of the Participant and the Participant's covered Spouse.

(iv) The Participant's entitlement to Medicare.

(v) A covered dependent no longer satisfies the conditions for being covered as a dependent of the Participant.

(vi) The Employer files a Chapter 11 bankruptcy (but only as to coverage that is being provided to a retired Participant and his/her Spouse and covered dependents *and* only if the Employer is terminating this Plan while continuing to offer group health coverage to some other group of Employees).

(c) *Election to Continue Coverage.* Any election to continue coverage that would otherwise be lost as a result of a qualifying event must be made within the time frame established by the COBRA statute and must be made in accordance with such reasonable procedures as the Plan Administrator may establish.

(d) *Premium for COBRA Continuation Coverage.* A qualified beneficiary who elects to continue coverage must pay the entire cost for such coverage along with an additional two percent (2%) charge or, with respect to an extension of the maximum coverage period due to a subsequent disability, an additional fifty percent (50%) charge. Premiums must be paid on a timely basis in accordance with such reasonable procedures as the Plan Administrator may establish.

(e) *Maximum Coverage Period.* The maximum period of time for which COBRA continuation coverage will be provided shall be as follows:

(i) *Termination of Employment or Reduction in Hours.* Eighteen (18) months if coverage is lost as a result of termination of the Participant's employment or a reduction in the Participant's hours.

(ii) *Disability Extension.* Twenty-nine (29) months if a qualified beneficiary is determined by the Social Security Administration to have been disabled at any time during the first sixty (60) days of COBRA coverage and the qualified beneficiary notifies the Plan Administrator of such determination while COBRA continuation coverage is still in effect and in accordance with such reasonable procedures as the Plan Administrator may establish.

(iii) *Employer Bankruptcy.* The lifetime of the Participant *if:*

(A) The Employer is providing coverage after the Participant has retired;

(B) The Employer files a Chapter 11 bankruptcy;

(C) The Employer terminates this Plan (or substantially eliminates coverage under this Plan with respect to a qualified beneficiary within a one-year period before or after such bankruptcy proceeding was filed); and

(D) The Employer continues to maintain a group health plan for any other group of employees.

In such an event, the surviving Spouse and surviving covered dependents of the Participant shall further be entitled to elect COBRA continuation coverage for an additional thirty-six (36) months following the death of Participant.

(iv) *Second Qualifying Event.* Thirty-six (36) months if a second qualifying event takes place while coverage is being continued following the original qualifying event and the second qualifying event is other than the termination of the Participant's employment or a reduction in the Participant's hours.

(v) *Any Other Qualifying Event.* Thirty-six (36) months for any qualifying event for which a shorter maximum coverage period is not set forth in this Subsection (e).

(f) *Termination of COBRA Continuation Coverage.* COBRA continuation coverage may be terminated prior to the expiration of the maximum coverage period if any one (1) of the following events occurs:

(i) A qualified beneficiary becomes covered under another group health plan;

(ii) A required premium is not paid within the applicable deadline (including any applicable grace period);

(iii) The Employer terminates this Plan and no longer offers coverage under a group health plan to any of its Employees;

(iv) After electing COBRA coverage, a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both);

(v) During a disability extension period, the disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled; or

(vi) Coverage would have been terminated under the same circumstances for a Participant or beneficiary not receiving continuation coverage (e.g., a Participant or beneficiary engages in fraudulent activities against the Plan).

(g) *Coverage Provided During COBRA Continuation Period.* The coverage provided during the COBRA continuation period shall be identical to the coverage provided to similarly situated persons covered under the Plan with respect to whom a qualifying event has not occurred. If coverage under the Plan is modified for any group of similarly situated persons, the coverage shall also be modified in the same manner for all qualified beneficiaries who have elected to continue their coverage under COBRA.

(h) *Calculation of COBRA Deadlines.* The maximum coverage period shall begin as of the date on which the qualified beneficiary would otherwise lose coverage as a result of the original qualifying event (as opposed to beginning on the date of the qualifying event itself). The deadline for the Employer to notify the Plan Administrator of a qualifying event (if applicable) and the deadline for a qualified beneficiary to notify the Plan of a qualifying event (if applicable) shall also be measured from the date that coverage is lost.

(i) *Construction and Application.* This Section shall be construed and applied in a way that is consistent with the requirements of the COBRA statute and COBRA regulations issued by the IRS and the DOL.

(j) *Employers Not Required to Offer COBRA Continuation Coverage.* This Section shall not apply to the Employer if the Employer is not required by law to offer COBRA continuation coverage. The Employer, for example, will not be not required to offer COBRA continuation coverage if the Employer qualified for the "small employer" exception to COBRA based on the number of employees that it employed during the previous calendar year. Generally, if this number is less than twenty (20), then the Employer is not subject to COBRA. In the event, however, that the Employer has twenty (20) or more employees as determined under COBRA (considering "controlled group" rules and special rules for part-time employees), this Article will apply as described above.

Section 8.02 USERRA Continuation Rights. A Participant who is absent from employment as a result of military service shall have the right to elect continuation coverage for a period of up to twenty-four (24) months. The Participant's right to continue coverage is subject to the following:

(a) *Payment of Premium.* The Participant must pay the applicable premium for any USERRA continuation coverage. For a leave of absence for less than thirty-one (31) days, the Participant may not be required to pay more than the Participant would have paid had the Participant not been on leave. For a leave of absence of more than thirty (30) days, Participant must pay the entire cost of coverage plus an additional two percent (2%).

(b) *Failure to Apply for Reemployment.* Following completion of the Participant's military service, the Participant's right to continue coverage under USERRA shall end if the Participant does not apply for reemployment within the applicable time period set forth in USERRA (43 U.S.C. § 4312(c)).

(c) *Reasonable Procedures.* The Plan Administrator shall have the authority to adopt such reasonable procedures as the Plan Administrator may consider necessary or advisable in order to implement the provisions of this Section.

(d) *Construction and Application.* This Section shall be construed and applied in a way that is consistent with the requirements of the USERRA statute and any applicable regulations that may be issued by the DOL.

*[The remainder of this page is intentionally left blank.]*

## ARTICLE IX
## GROUP HEALTH PLAN CLAIMS PROCEDURES
## (Does Not Apply to the Health FSA)

Section 9.01 Where to File Claims. Any Claim for benefits which arises under a Group Health Plan shall be filed with the Claims Administrator.

Section 9.02 Persons Who May File Claims. Claims may be filed by the Claimant or by the Claimant's duly authorized representative.

(a) Prior to recognizing any such appointment of an authorized representative, the Claims Administrator may require proof that the representative has been duly appointed.

(b) Notwithstanding the foregoing rule, a health care professional with knowledge of the Claimant's medical condition shall be permitted to act as the authorized representative of the Claimant with respect to Urgent Care Claims.

(c) For purposes of these claims procedures, the deadlines applicable to a Claimant shall apply to his/her authorized representative in the event he/she elects to use an authorized representative in filing any Claim or Appeal.

Section 9.03 Claims Procedures for Fully-Insured Group Health Plans. Claims made for benefits, and any Appeals from the denial of such Claims, under the fully-insured Group Health Plans, shall be processed in accordance with the claims procedures of the insurer, which are set forth in the Certificate of Coverage. Unless stated otherwise in the policy of insurance, prior to initiating legal action concerning a Claim in any court, state or federal, against this Plan, any trust used in conjunction with this Plan, the Employer, the Claims Administrator, and/or the Plan Administrator, a Claimant must first exhaust the internal administrative remedies provided by the insurer. Failure to exhaust the internal administrative remedies provided by the insurer shall be a bar to any civil action concerning a Claim for benefits under this Plan. Once a Claimant has exhausted his/her administrative remedies, he/she may file a lawsuit challenging the denial of the Claim. Such lawsuit must be commenced no later than one hundred eighty (180) days after the Plan issues a final adverse benefit determination or, if external review is sought by the Claimant, no later than one hundred eighty (180) days after the Claim is denied in whole or in part on external review.

*[The remainder of this page is intentionally left blank.]*

## ARTICLE X
## TERMINATION AND AMENDMENT OF THE PLAN

Section 10.01 Termination and Amendment. The Employer may amend or terminate this Plan at any time by written instrument duly adopted by the Employer.

*[The remainder of this page is intentionally left blank.]*

## ARTICLE XI
## MISCELLANEOUS

Section 11.01 Construction. Words used in the masculine also apply to the feminine and words used in the feminine also apply to the masculine. Wherever the context dictates, the plural includes the singular and the singular includes the plural.

Section 11.02 Employment Not Guaranteed. Nothing contained in this Plan or in any other plan which is a part of the Plan, or any modification or amendment to this Plan, or in the creation of any account, or the payment of any benefit, gives any Employee, Participant, or beneficiary any right to continue employment, any legal or equitable right against the Employer, its Employees or agents, or against the Plan Administrator, except as expressly provided by this Plan.

Section 11.03 Funding and Expenses. All of the amounts payable under this Plan shall be paid from the general assets of the Employer. Any amounts that may be payable under any of the Pre-Tax Plans and After-Tax Plans shall be paid in accordance with the provisions of the plan document for such plans. All administrative costs of this Plan shall be borne by the Employer.

Section 11.04 Indemnification. To the extent permitted by law, the Employer shall indemnify and hold harmless any Employee to whom fiduciary responsibility with respect to this Plan is allocated or delegated, from and against any and all liabilities, costs, and expenses incurred by any such Employee as a result of any act, or omission to act, in connection with the performance of duties, responsibilities, and obligations under this Plan, other than such liabilities, costs, and expenses as may result from the gross negligence or willful misconduct of any such person.

Section 11.05 Information. The Plan Administrator may require each Participant to supply such information and sign such documents as may be necessary to implement this Plan.

Section 11.06 Limitation on Liability. A Plan fiduciary shall be entitled to rely upon information from any source assumed in good faith to be correct. No person shall be subject to any liability with respect to duties under this Plan unless that person acts fraudulently or in bad faith. No person shall be liable for any breach of fiduciary responsibility resulting from the act or omission of any other fiduciary or any person to whom fiduciary responsibilities have been allocated or delegated.

Section 11.07 Named Fiduciary. The named fiduciary of this Plan shall be the Employer. The Employer shall have complete authority to control and manage the operation and administration of this Plan.

Section 11.08 Negative Paychecks. The Employer shall have the power to adopt rules and procedures addressing the sequence in which amounts shall be deducted or withheld from the compensation payable from the Employer to a Participant in the event that such compensation is less than the combined total of the following:

(a) Taxes required to be withheld from the Participant's compensation;

(b) The amounts the Participant has elected to defer into a plan maintained by the Employer;

(c) The salary reductions elected by the Participant under this Plan or under any similar plan maintained by the Employer; and

(d) Such other amounts that the Employer may be required to withhold or deduct from the Participant's compensation.

If no such rules or procedures have been adopted, the Employer shall deduct amounts required to be withheld for taxes and amounts necessary to pay for the Participant's medical coverage prior to deducting any other amounts.

Section 11.09 No Guarantee of Tax Consequences. Neither the Plan Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Plan will be excludable from the Participant's gross income for federal or state income tax purposes, or that any other federal or state tax treatment will apply to or be available to any Participant.

Section 11.10 Nonassignability. The right of any Participant to receive any benefits under this Plan is not subject to alienation or assignment and is not subject to the claims of the creditors of the Participant except to the extent provided by law.

Section 11.11 Prohibition Against Retroactive Entry into the Plan. In the event that a person was determined to be ineligible to participate in the Plan due to the person's classification as an independent contractor and such classification is later determined by a court or administrative agency to have been incorrect, the person shall be eligible to enter the Plan on a prospective basis only. Except as may be required in connection with HIPAA special enrollment rights, no person shall be allowed to enter the Plan on a retroactive basis.

Section 11.12 Reimbursement of Payments Made in Error. The Plan shall have the right to reimbursement from any Participant, covered dependent, or assignee for any benefit overpayments attributable to mistake, clerical error, fraud, or any other reason contributing to benefit payments to which the Participant, covered dependent, or assignee was not entitled.

Section 11.13 Return of Premiums. If money is returned in any form by an insurance company that provided or is providing benefits under this Plan, including, but not limited to, a rebate of premiums previously paid or proceeds from demutualization, or rebates resulting from an insufficient "medical loss ratio" (MLR), the Plan Administrator shall have the discretion to apply such amounts to the payment of Plan expenses, the reduction of premiums, and/or benefit enhancements. The Plan Administrator shall further have the discretion to allocate such funds in any manner deemed appropriate.

Section 11.14 Rights to Employer's Assets. No Participant or beneficiary has any right to, or interest in, any assets of the Employer upon termination of employment or otherwise, except as provided from time to time under this Plan, and then only to the extent that the benefits payable under the component benefit plans are payable solely from the assets of the Employer.

Section 11.15 State Law. The laws of the state of Kansas will determine all questions arising with respect to the provisions of this Plan except to the extent superseded by federal law.

*[The remainder of this page is intentionally left blank.]*

IN WITNESS WHEREOF, the Employer adopts this amended and restated Plan effective the 1st day of October, 2015.

**HAYSVILLE USD 261**

By:_____
Clint Schutte, Assistant Superintendent for Business/Finance

## CERTIFICATION BY THE EMPLOYER TO THE PLAN

I hereby certify on behalf of the Employer that the Plan has been amended to incorporate the provisions required by 45 C.F.R. § 164.504(f)(2)(ii). Such provisions are only applicable to Group Health Plans within the Plan.

I further certify on behalf of the Employer that the Employer agrees to comply with the provisions of the Plan, as amended, governing the use and disclosure of PHI or e-PHI by the Plan to the Employer. This Certification is made pursuant to 45 C.F.R. § 164.504(f)(2)(ii).

**HAYSVILLE USD 261**

By:_____ Date: _____