USD 261, Haysville, Kansas
Employee Welfare Benefits Plan

Plan Document
and
Summary of Welfare Plan Benefits

Effective October 1, 2011

This document, together with the certificates of insurance, benefit booklets, summary plan descriptions and the benefit summary for each plan year, constitute the Plan Document and Summary of Welfare Plan Benefits for each of the Component Benefit Programs offered by USD 261, Haysville, Kansas. If these certificates, booklets or summaries are not attached, then this Plan Document and Summary of Welfare Plan Benefits is not complete and you should contact the USD 261 Business Office for a complete copy.

USD 261, Haysville, Kansas
Employee Welfare Benefits Plan

Plan Document and Summary of Welfare Plan Benefits

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INTRODUCTION

USD 261, Haysville, Kansas ("USD 261") maintains this Plan for the exclusive benefit of its eligible employees and their eligible spouses and dependents. Capitalized terms used in this Plan that are not otherwise defined shall have the meanings set forth in the Glossary.

Each Component Benefit under this Plan is maintained pursuant to a separate Component Benefit Program and is summarized in a certificate, booklet or summary issued by an insurance company, a summary plan description, benefits summary or another governing document prepared by USD 261. Eligibility for each of the Component Plans is employment for USD 261 in a position where you are expected to work 630 or more hours each year.

USD 261 is providing this "wrap-around" Plan Document and Summary of Welfare Plan Benefits to give you an overview of the Plan and provide certain information that may not be addressed in the Component Documents.

The Plan provides the Component Benefit Programs listed on Appendix A (as amended from time to time) attached hereto and incorporated herein.

Read All Documents. You must read this Plan Document and Summary of Welfare Plan Benefits along with the respective Component Document for each Component Benefit Program and the Benefits Summary for the applicable Plan Year to understand your benefits!

You must enroll to receive benefits. You must actually enroll to receive benefits under a Component Benefit Program, as explained in Section Three. Some of these Component Benefit Programs require you to make an annual election to enroll for coverage. The details of such annual election are described in the Component Documents and in the annual Benefits Summary.

This document and the Component Documents constitute the Plan Document and Summary of Welfare Plan Benefits for the Component Benefit Programs.

This Plan Document and Summary of Welfare Plan Benefits is not intended to give you any substantive rights to benefits that are not already provided by the Component Documents.

Component Benefit Programs are provided under an insurance contract, an insurance certificate or a governing plan document adopted by USD 261. If the terms of this Plan Document and Summary of Welfare Plan Benefits conflict with the terms of the Component Documents, then the terms of the Component Documents will control, rather than the terms of this Plan Document and Summary of Welfare Plan Benefits, unless otherwise required by law.

The terms of this Plan Document and Summary of Welfare Plan Benefits are designed to incorporate important differences between the fully insured Component Benefit Programs and the self-funded Component Benefit Programs. Nothing in this document or any of the Component Documents shall be construed as to change the funding nature of any Component Benefit Program, such as transferring a fully insured Component Benefit Program into a self-funded Component Benefit Program, or vice versa.

SECTION 1 - GLOSSARY

Capitalized terms used in the Plan have the following meanings:

Benefits Summary means the annual summary which describes the eligibility for participation in each of the Component Benefit Programs which are part of this Plan.

Code means the Internal Revenue Code of 1986, as amended.

Component Benefit means the specific benefit(s) contained within a certificate, booklet, the Benefits Summary for each Plan Year or other governing document in which an Employee participates.

Component Benefit Program means the program under which the specific Component Benefit(s) are provided.

Component Document(s) means the governing plan document for a Component Benefit Program.

Dental Plan means the dental benefit program maintained by USD 261.

Employee means any common-law employee of USD 261, Haysville, Kansas who is employed in a position where he or she is expected to work 630 or more hours each year, provided he/she is not excluded from participation by the terms of an applicable Component Benefit Program.

Flexible Benefits Cafeteria Plan means the Plan established by USD 261 which includes (1) a Health Flexible Spending Account, (2) Dependent Care Expense Reimbursement, and (3) Before Tax Medical and Dental Premiums. It allows you to use pre-tax dollars to pay uninsured medical expenses, to pay for medical care of you and/or your eligible Dependents and to pay your share of the contributions or premiums for USD 261's Health and Dental Plans.

Health Plan means the HMO, PPO, and Rx Medical Benefit Program offered by USD 261.

Plan Administrator means USD 261.

Plan means the USD 261, Haysville, Kansas Employee Welfare Benefits Plan.

USD 261 means Unified School District 261, Haysville, Kansas, and any successor thereto.

SECTION 2 - GENERAL PLAN IDENTIFYING INFORMATION

Name of the Plan	USD 261, Haysville, Kansas Employee Welfare Benefits Plan
Type of Plan	Employee Welfare Benefits Plan
Address of Plan	USD 261 Business Office 1745 West Grand Haysville, Kansas 67060 316-554-2200
Agent for Service of Legal Process	USD 261 Business Office 1745 West Grand Haysville, Kansas 67060 316-554-2200
Plan Sponsor	USD 261 Business Office 1745 West Grand Haysville, Kansas 67060 316-554-2200
Effective Date	October 1, 2011
Plan Year End	September 30
Plan Administrator	USD 261 Business Office 1745 West Grand Haysville, Kansas 67060 316-554-2200
Funding Medium and Type of Plan Administration	Some Component Benefit Programs under the Plan are self-funded by USD 261 and some are fully insured under applicable insurance contracts. Contributions for the Component Benefit Programs may be made in part by USD 261 and in part by employee payroll deductions or may be made solely by employee payroll deductions. The Plan Administrator provides a schedule of the applicable contributions during the initial and subsequent open enrollment periods in its annual Benefits Summary.

Funding Medium and Type of Plan Administration (Cont'd)

The Flexible Benefits Cafeteria Plan is solely self-funded by Employee payroll deduction contributions.

The insured and self-funded Component Benefit Programs are listed on Appendix A. The insurance companies listed on Appendix A are responsible for paying benefits and administering the insurer's program.

SECTION 3 - ELIGIBILITY AND PARTICIPATION REQUIREMENTS

3.1 Requirements for Employee Eligibility (All Programs)

You are eligible for participation in any of the Component Benefit Programs if you are employed by USD 261 in a position where you are expected to work 630 or more hours each year.

Certain Component Benefit Programs require an annual election to enroll for coverage. Information about enrollment procedures, including when coverage begins and ends for the various Component Benefit Programs, is found in the Component Documents. Once eligible, you may begin participating in the Plan upon your election to participate in a Component Benefit Program in accordance with the terms and conditions established for that program.

3.2 Need for Enrollment: Time Limits (All Programs)

You must enroll yourself and/or your spouse and dependents as described in the Component Documents and the annual Benefits Summary. Additional information will be requested to verify your eligibility. If you are a new employee, you must enroll within the time limits specified in the applicable Component Document(s). Thereafter, enrollment generally is limited to the annual open enrollment period that occurs each year.

3.3 Special Enrollment Rights

In certain circumstances, enrollment may occur outside the open enrollment period, as explained in the Component Documents.

3.4 Required Contribution Payments

Depending upon your employment status, USD 261 may pay a portion of your contribution payment required under a Component Benefit Program option.

3.5 When Coverage Begins

As determined by USD 261, coverage may begin at different times for each of the Component Benefit Programs. For specific information about when coverage begins, please read the eligibility information contained in the Component Documents.

3.6 Termination of Participation

Your eligibility for Plan benefits will terminate as provided in the specific Component Benefit Program. Generally, this termination will occur either at the end of the month in which you terminate employment with USD 261 or on your employment termination date. Depending upon which Component Benefit Programs you are participating in, other circumstances will also result in the termination of your benefits as specified in the Component Documents.

Coverage for your spouse and dependents stops when your coverage stops and for other reasons specified in the Component Documents (for example, divorce, dependent's attaining the age limit, and other reasons). Benefits will also cease for you, your spouse and dependents upon termination of the Plan.

3.7 COBRA Continuation Coverage

If medical or dental coverage for you, your eligible spouse, or your eligible dependents ceases because of certain "qualifying events" (e.g., termination of employment, reduction in hours, divorce, death, or a child's ceasing to meet the Plan's definition of dependent) specified in a federal law called COBRA, then you, your eligible spouse, or your eligible dependents may have the right to purchase continuing coverage under the Plan for a limited period of time. For more information about COBRA, please contact the USD 261 Business Office.

If you or your eligible family members qualify for such continuation coverage, then the **Health and Dental Plan** will be treated as a separate plan from the **Vision Plan**. In addition, the **Health Flexible Spending Account** part of the **Flexible Benefits Cafeteria Plan** will be treated as a separate plan from the Dependent Care Expense Reimbursement and Before Tax Medical and Dental Premiums parts of the Flexible Benefits Cafeteria Plan, neither of which provide COBRA coverage.

3.8 USERRA Continuation Coverage

Continuation and reinstatement rights may also be available if you are absent from employment due to service in the Uniformed Services pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). More information about coverage available pursuant to USERRA is included in the Component Benefit Programs.

> **For some Component Benefit Programs, you may have rights under COBRA and USERRA.** For Component Benefit Programs to which COBRA and USERRA apply, your rights under COBRA and USERRA are similar but not identical. Any election that you make pursuant to COBRA will also be an election under USERRA. COBRA and USERRA may both apply with respect to the continuation coverage elected. If COBRA or USERRA give you or your covered dependents different rights or protections, the law that provides the greater benefit will apply. The administrative policies and procedures for COBRA also apply to USERRA coverage, unless compliance with the procedures is precluded by military necessity or is otherwise unreasonable under the circumstances.

3.9 Family and Medical Leave

If a Participant is on a leave of absence under the Family and Medical Leave Act ("FMLA"), the Participant may continue coverage under a Component Benefit Program that is a medical plan. Such coverage is subject to the FMLA and to the terms of the Component Benefit Program. Such coverage is also subject to the following conditions:

- The Participant must pay any required employee contribution; and
- The Participant must obtain written approval of leave from USD 261.

Coverage will be continued for up to the greater of:

- The leave period required by the FMLA; or
- The leave period required by a similar state law.

If coverage is not continued during an FMLA absence, when the Participant returns to actively at work status:

- No new waiting period will apply; and
- Any preexisting condition exclusion shall not apply.

SECTION 4 - PLAN BENEFITS SUMMARY

4.1 Benefits

The Plan provides you and your eligible dependents with benefits under the Component Benefit Programs described in Appendix A.

4.2 Premiums and Contributions

The cost of the benefits provided through the Component Benefit Programs will be funded in part by USD 261 payments called premiums (for fully insured plans) and contributions (for self-funded plans) and in part by employee premiums and contributions. USD 261 will determine and periodically communicate your share of the cost of the benefits provided through each Component Benefit Program, and it may change that determination at any time.

USD 261 will make its premiums or contributions in an amount that (in its sole discretion) is sufficient to fund the benefits or a portion of the benefits that are not otherwise funded by employee premiums or contributions. With respect to fully insured Component Benefit Programs, USD 261 will pay its own premiums and employee premiums to the insurance carriers specified in Appendix A. Any experience credits or refunds under an insured plan will be applied in accordance with the applicable insurance contract or policy. With respect to benefits that are self-funded, USD 261 will use its own contributions and employee contributions to pay benefits directly to or on behalf of you and your eligible family members from general assets of USD 261 or from any assets held in trust (where applicable) for that purpose.

Employee contributions toward the cost of a particular benefit will be used in their entirety prior to using USD 261 contributions to pay for the cost of the benefit.

> The following three notices apply to the Health Plan options only. These notices are subject to the provisions of the Component Documents.

4.3 Newborns and Mothers Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance, generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother of the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, a health plan may pay for a shorter stay if the attending physician (e.g., your physician, nurse or a physician assistant), after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, health plans may not set the level of benefits for out of pocket costs so that any later portion of the 48 hour (or 96 hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a health plan may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours).

4.4 Reconstructive Surgery Following Mastectomy

The Women's Health and Cancer Rights Act of 1998 (WHCRA) requires group health plans to provide coverage for breast reconstruction, prostheses, and complications following a mastectomy. The law mandates that a Participant or dependent who is receiving benefits for a mastectomy and who elects breast reconstruction in connection with the mastectomy, will also receive coverage for:

- All stages of reconstruction of the breast on which a mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of all stages of mastectomies, including lymphedemas.

  This coverage will be provided in a manner determined in consultation with the attending physician and the patient, and will be subject to the same annual deductible, coinsurance and/or copayment provisions and any other applicable provisions under the Health Plan. If you have any questions about coverages for mastectomies and post-operative reconstructive surgery, please contact the Business Office at (316) 554-2200.

4.5 Patient Protection and Affordable Care Act of 2010

This Plan and the Health Plan have been amended to comply with the Patient Protection and Affordable Care Act of 2010 in the following respects:

- Dependents covered to age 26
- No lifetime maximum
- Preventive services which includes:
  - Routine screenings; and
  - Check-ups and counseling to prevent illness or disease.

The Dental Plan has also been amended to cover dependents to age 26.

The Health Flexible Spending Account, which is part of the Flexible Benefits Cafeteria Plan has been amended to only provide reimbursements for over-the-counter drugs that are prescribed by a physician.

Compliance with PPACA is subject to the provisions of the applicable Component Benefit Program.

SECTION 5 - PLAN ADMINISTRATION

5.1 Plan Administrator

The Plan Administrator for this Plan and for the separate Component Benefit Programs is USD 261. The Plan Administrator may utilize claims administrators or other service providers to act on its behalf as noted in the Component Documents.

5.2 Power of Plan Administrator

Subject to the limitations of the Plan and Component Documents, the Plan Administrator will from time to time establish rules for the administration of the Plan and transaction of its business. The Plan Administrator will rely on the records of USD 261 with respect to any and all factual matters dealing with the employment and eligibility of an employee. The Plan Administrator will resolve any factual dispute, giving due weight to all evidence available to it. The Plan Administrator shall have such powers and duties as may be necessary to discharge its functions hereunder, including but not limited to, the sole and absolute discretion to:

- Construe and interpret the Plan;
- Decide the questions of eligibility to participate in the Plan (and any Component Benefit Program); and
- Determine the amount, manner and time of payment of any benefits to any covered person.

The Plan Administrator will have discretionary authority to make such decisions.

5.3 Outside Assistance

The Plan Administrator may employ such counsel, accountants, claims administrators, consultants, actuaries and other person or persons as the Plan Administrator shall deem advisable. The Plan shall pay the compensation of such counsel, accountants, and other person or persons and any other reasonable expenses incurred by the Plan Administrator in the administration of the Plan.

5.4 Delegation of Powers

In accordance with the provisions hereof, the Plan Administrator has been delegated certain administrative functions relating to the Plan with all powers necessary to enable the Plan Administrator properly to carry out such duties. The Plan Administrator as such shall have no power in any way to modify, alter, add to, or subtract from any provisions of the Plan other than expressly provided in this Plan Document and Summary of Welfare Plan Benefits or other applicable Component Document.

5.5 Insurance Companies

Each Insurance Company that insures the benefits offered under a Component Benefit Program (as listed in Appendix A) is responsible for (a) determining the amount of any Component Benefits under such Program; (b) prescribing claims procedures to be followed and the claim forms you should use pursuant to the Program; and (c) payment of all benefits under the

Program. USD 261 does not assume any responsibility for paying claims under any insured Component Benefit Program.

5.6 Your Questions

If you have any general questions regarding the Plan or regarding your eligibility for, or the amount of, any benefit payable under the self-funded Component Benefit Programs, please contact the Business Office at (316) 554-2200.

If you have questions regarding eligibility for, or the amount of, any benefits payable under a fully insured Component Benefit Program, please contact the applicable insurance company as provided in the Component Document or the Business Office at (316) 554-2200. The telephone number of each insurance company is in the Benefits Summary.

SECTION 6 - CIRCUMSTANCES THAT MAY AFFECT BENEFITS

6.1 Denial, Recovery or Loss of Benefits

Your benefits (and, except in some cases in the event of your death, the benefits of your eligible spouse and eligible dependents) will cease when your participation in a Component Benefit Program terminates. Your benefits will also cease upon termination of a Component Benefit Program.

6.2 Rescission of Coverage

The Plan Administrator reserves the right to rescind coverage under any Component Benefit Program if an employee, spouse or child becomes covered under the Component Benefit program or receives benefits as a result of an act, practice or omission that constitutes fraud or is due to the intentional misrepresentation of a material fact, both of which are prohibited by this Plan. Rescission is a cancellation and discontinuance of coverage, retroactive to the date the employee, spouse or child became covered or received a benefit as a result of fraud or the intentional misrepresentation of a material fact. The Plan Administrator will provide at least 30 days advance notice to an employee, spouse or child of its intent to rescind coverage with an explanation of the reason for the intended rescission. The rescission shall not apply to benefits paid more than one year before the date of such advance notice. A cancellation or discontinuance of coverage is not a rescission if:

- The cancellation or discontinuance of coverage only has a prospective effect;
- The cancellation or discontinuance of coverage is only retroactive to the extent it is attributable to the timely failure to pay premiums (including COBRA premiums) toward the cost of coverage; or
- A rescission is subject to the terms and provisions described in the applicable Component Document.

6.3 Reimbursement and Subrogation

In certain circumstances, the Plan may recover overpaid benefits through its rights to subrogation and reimbursement. These Plan rights are described in detail in the Component Documents.

SECTION 7 - AMENDMENT OR TERMINATION OF THE PLAN

7.1 Right to Amend, Merge or Consolidate

USD 261 reserves the right to merge or consolidate the Plan or any individual Component Benefit Program, and to make any amendment or restatement to the Plan or any individual Component Benefit Program from time to time, including those which are retroactive in effect. Such amendments may be applicable to any covered person.

7.2 Right to Terminate

The Plan and its individual Component Benefit Programs are intended to be permanent, but USD 261 may at any time and without notice, terminate the Plan or any individual Component Benefit Program in whole or in part.

7.3 Effect on Benefits

Except as may otherwise be provided by applicable law or the Component Document, if the Plan or any individual Component Benefit Program is amended or terminated, covered persons may not receive benefits described in the Plan or in any individual Component Benefit Program after the effective date of such amendment or termination. Any such amendment or termination shall not affect a covered person's right to benefits for claims incurred prior to such amendment or termination. If the Plan or any individual Component Benefit Program is amended, covered persons may be entitled to receive different benefits or benefits under different conditions. However, if the Plan is terminated, all benefit coverage will end, including COBRA or other continuation benefits. This may happen at any time.

SECTION 8 - CLAIMS PROCEDURES

8.1 Claims for Fully Insured Component Benefit Programs

For purposes of determining the amount of, and entitlement to, benefits of a Component Benefit Program provided under an insurance contract (as listed on Appendix A), the insurer has the full power to interpret and apply the terms of the Plan under the applicable insurance contract.

To obtain benefits from the insurer of a Component Benefit Program, you must follow the claims procedures under the applicable insurance contract, which may require you to complete, sign, and submit a written claim on the insurer's form.

The insurance company will decide your claim in accordance with its reasonable claims procedures. The insurance company has the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide a claim. If the insurance company denies a claim in whole or in part, then you will receive a written notification setting forth the reason(s) for the denial.

If a claim is denied, you may appeal to the insurance company for a review of the denied claim. The insurance company will decide the appeal in accordance with its claims procedures. If you do not appeal on time, then you will lose your right to file suit in a state court, as you will not have exhausted your internal administrative appeal rights (which generally is a prerequisite to bringing a suit in court).

The applicable insurance contract (including the certificate, booklet or summary) provides more information about how to file a claim and details regarding the insurance company's claims procedures.

8.2 Claims for Self-Funded Component Benefit Programs

For purposes of determining the amount of, and entitlement to, benefits under the Component Benefit Programs provided through the general assets of USD 261 or from those assets held in trust, the Plan Administrator has the full power to make factual determinations and to interpret and apply the terms of the Plan to the benefits provided under the self-funded Component Benefit Program.

To obtain benefits from a self-funded Component Benefit Program, you must complete, execute, and submit to the Plan Administrator a written claim on the form available from the Plan Administrator. The Plan Administrator has the right to secure independent medical advice and to require such other evidence as it deems necessary to decide a claim.

The Plan Administrator will decide your claim in accordance with the claims procedures in the Component Documents. If the Plan Administrator denies a claim in whole or in part, then you will receive a written notification setting forth the reason(s) for the denial.

If a claim is denied, you may appeal to the Plan Administrator for a review of the denied claim. The Plan Administrator will decide the appeal in accordance with the claims procedures in the Component Documents. If you do not appeal on time, then you will lose your right to file suit in

a court, because you will not have exhausted your internal administrative appeal rights (which generally is a prerequisite to bringing a suit in court).

See the certificate, booklet, summary or other applicable Component Document for more information about how to file a claim and for details regarding the claims procedures applicable to a claim.

8.3 Administrative Exhaustion Requirement

All claim review procedures provided for in a Component Document must be exhausted before any legal action is brought including a claim for benefits or for breach of fiduciary duty.

8.4 Limitation on Actions

To the extent not otherwise specified in an applicable Component Document, any legal action for the recovery of any benefits or breach of fiduciary duty must be commenced within one year after the program's claim review procedures have been exhausted.

8.5 Failure to File a Request

If you fail to file a request for review in accordance with the claims procedures outlined in an applicable Component Document, you shall have no right of review and shall have no right to bring action in any court. The denial of the claim shall become final and binding on all persons for all purposes.

SECTION 9 - PLAN INFORMATION

9.1 Fully Insured Component Benefit Contracts Control

Benefits under the fully insured Component Benefit Programs are provided solely pursuant to insurance contracts between USD 261 and the applicable insurance companies, as set forth in the applicable Component Documents. If the terms of this document conflict with the terms of the applicable Component Document, the terms of the applicable Component Document will control, unless superseded by applicable law.

9.2 Self-Funded Component Benefit Program Documents Control

Benefits under the self-funded Component Benefit Programs are provided solely pursuant to the applicable Component Document. If the terms of this Plan Document and Summary of Welfare Plan Benefits conflict with the terms of an applicable Component Document, the terms of a Component Document will control, unless superseded by applicable law.

9.3 Compliance with Federal Mandates

To the extent applicable, each Component Benefit Program will provide benefits in accordance with the requirements of all applicable laws and as described in, and subject to, the Component Document, including the following:

- Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA);
- Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA);
- Health Insurance Portability and Accountability Act of 1996 (HIPAA);
- Newborns' and Mothers' Health Protection Act of 1996 (NMHPA);
- Women's Health and Cancer Rights Act of 1998 (WHCRA);
- Genetic Information Nondiscrimination Act of 2008 (GINA);
- Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA);
- The Health Information and Technology Act of 2009 (HITECH); and
- Patient Protection and Affordable Care Act of 2010, as amended (PPACA).

9.4 Verification

The Plan Administrator shall be entitled to require reasonable information to verify any claim or the status of any person as an eligible employee or dependent. If the employee or dependent does not supply the requested information within the applicable time limits or provide a release for such information, such employee or dependent shall not be entitled to benefits under a Component Document.

9.5 Limitation of Rights

Nothing appearing in or done pursuant to the Plan shall be held or construed:

- To give any person any legal or equitable right against USD 261 or the Plan Administrator, any of its employees, or persons connected therewith, except as provided by law; or
- To give any person any legal or equitable right to any assets of the Plan or any related trust or Component Benefit Program contract or trust fund, except as expressly provide herein or as provided by law.

9.6 No Contract of Employment

Nothing contained in the Plan shall be construed as a contract of employment with USD 261, or as a right to be continued in the employment of USD 261, or as a limitation of the right of USD 261 to discharge any of the participants, with or without cause.

9.7 Governing Law

The Plan is intended to be construed, and all rights and duties hereunder are to be governed, in accordance with the laws of the State of Kansas, except to the extent such laws are preempted by federal law.

9.8 Severability

If any provision of the Plan is held invalid or unenforceable, its validity or unenforceability shall not affect any other provision of the Plan, and the Plan shall be construed and enforced as if such provision had not been included herein.

9.9 Caption

The captions contained herein are inserted only as a matter of convenience and for reference and in no way define, limit, enlarge or describe the scope or intent of the Plan nor in any way shall affect the Plan or the construction of any provision thereof.

9.10 Federal Tax Disclaimer

To ensure compliance with requirements imposed by the Internal Revenue Service, we inform you that to the extent this communication (including any Component Document) contains advice relating to a Federal tax issue, it is not intended or written to be used, and it may not be used, for the purpose of (a) avoiding any penalties that may be imposed on you or any other person or entity under the Internal Revenue Code or (b) promoting, marketing or recommending to another party any transaction or matter addressed herein. If you are not the original addressee of this communication, you should seek advice from an independent advisor based on your particular circumstances.

IN WITNESS WHEREOF, USD 261, Haysville, Kansas has adopted this Employee Welfare Benefits Plan this 18 day of January, 2012, to be effective October 1, 2011.

USD 261, Haysville, Kansas

By: _____

Its: Asst. Supt. For Business & Finance

APPENDIX A

Component Benefit Programs
(Effective October 1, 2011)

Health Plan (Insured)

- Preferred Health Systems (Coventry) medical and prescription drug insurance coverage, with three plan options, two HMO options and a PPO option

Dental Plan (Insured)

- Delta Dental of Kansas, Inc.

Flexible Benefits Cafeteria Plan (Self-Funded)

- Health Flexible Spending Account
- Dependent Care Expense Reimbursement Account
- Employee Before Tax Health, Dental and Vision Plan Premiums[1]

Disability Program Options (Insured)

- Short-Term Disability (Unum) – Employee After-Tax Premiums Required[2]

Life and AD&D (Insured)

- Optional Term (Unum) – Employee After-Tax Premiums Required[2]
- Accidental Death and Dismemberment (Unum) – Employee After-Tax Premiums Required[2]

Voluntary Benefits (Insured)

- Critical Illness (Unum) – Employee After-Tax Premiums Required[2]
- Accident (Unum) – Employee After-Tax Premiums Required[2]
- Vision (Surency)

Employee Assistance Program

- EMPAC

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[1] Before Tax Health, Dental and Vision Plan premiums must be paid through the Flexible Benefits Cafeteria Plan.

[2] Employee premiums for these coverages must be paid by after-tax employee payroll deduction contributions.