R.D. DRENKOW & CO., INC.

♦ Employee Benefit Consultants and Administrators ♦

Waterloo ♦ Cedar Rapids ♦ Waverly

MEDICAL EXPENSE REIMBURSEMENT PLAN

For Employees of

Collins-Maxwell Community Schools

Dated July 1, 2010

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MEDICAL EXPENSE REIMBURSEMENT PLAN
For Employees of
Collins-Maxwell Community Schools

1. INTRODUCTION

Your Employer maintains this Plan for the exclusive benefit of eligible employees. Under the Plan, an employee can be reimbursed for covered expenses incurred by the employee, provided the expenses arenôt otherwise reimbursed by insurance or other programs.

The Plan is intended to qualify as an "self-insured medical reimbursement plan" under Section 105(h) of the Internal Revenue Code of 1986, as amended (the ñCodeò), and the reimbursements of qualifying expenses under the Plan are intended to be eligible for exclusion from participating employeesô gross income under Section 105(b) of the Code. The Plan is also intended to meet the requirements of Prop. Treas. Reg. §1.125-2, Q/A-7 (regarding special rules applicable to certain flexible spending arrangements that apply to plans such as this one, even though there may be no cafeteria plan or employee contributions.)

2. GENERAL INFORMATION ABOUT THE PLAN

Plan Name	Collins-Maxwell Community Schools Medical Expense Reimbursement Plan
Type of Plan	Welfare benefit plan providing reimbursements for certain medical expenses.
Plan Year	The twelve month period ending every June 30.
Plan Number	502
Effective Date	The effective date of the Plan as described in this document is July 1, 2010. The original date the Plan was effective was July 1, 2009.
Funding Medium	Benefits are paid directly out of the general assets of the Plan Sponsor. No special fund or trust exists from which benefits are paid. While the Plan Sponsor has complete responsibility for the payment of benefits out of its general assets, it may engage an outside paying agent to make benefit payments on its behalf.

Source of Contributions

Your Employer bears the entire cost of this Plan. Covered employees do not make contributions. However, former employees who elect COBRA coverage must pay for that coverage.

Plan Sponsor

Collins-Maxwell Community Schools
400 Metcalf
Maxwell, IA 50161
Telephone: 515-387-1115
EIN: 42-6036681

The Plan Sponsor is also the Plan Administrator and the Named Fiduciary.

Service of Legal Process

Legal process may be made upon the Plan Sponsor.

Type of Administration

The Plan is administered by a Third Party Administrator, who acts on behalf of the Plan Administrator. Questions about administration of the Plan may be addressed to:

R. D. Drenkow & Co., Inc.
P.O. Box 118
Waverly, Iowa 50677-0118
(319) 352-1623 or (800) 383-1623

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3. DEFINITIONS

Affiliated Employer

Any corporation which is a member of a controlled group of corporations (as defined in Code Section 414(b)) which includes the Plan Sponsor; any trade or business (whether or not incorporated) which is under common control (as defined in Code Section 414(c)) with the Plan Sponsor; any organization (whether or not incorporated) which is a member of an affiliated service group (as defined in Code Section 414(m)) which includes the Plan Sponsor; and any other entity required to be aggregated with the Plan Sponsor pursuant to Treasury regulations under Code Section 414(o).

Allowable Reimbursement

The amount of benefit payable under the terms of the Plan as determined by the Schedule of Benefits.

Benefit Payment for covered expenses by the Plan.

Covered Expenses Expenses that are subject to reimbursement under the terms of the Insurance Contracts.

Eligible Employee Any Employee who has satisfied the eligibility provisions of the Plan.

Employee Any person who is employed by the Employer, but excludes any person who is employed as an independent contractor. The term Employee shall not include leased employees within the meaning of Code Section 414(n)(2) or employees covered under a collective bargaining agreement..

Employer The Plan Sponsor, any Affiliated Employer that adopts this Plan by completing a Participation Agreement and any successor that maintains this Plan. A list of Affiliated Employers that have adopted this Plan can be found in the Appendix.

Group Medical Plan The plan of benefits sponsored by the Employer which provides medical benefits to Employees under which all or a part of the risk of providing medical benefits is borne by a party other than the Employer.

Insurance Contract The contract issued by the Insurer underwriting, or making benefit payments for, the Employer's group medical plan.

Insurer The insurance company that underwrites, or the company that processes claims for, the Employer's group medical plan.

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4. ELIGIBILITY AND PARTICIPATION REQUIREMENTS

Eligibility You are eligible to participate in the Plan when you have satisfied the eligibility requirements for your Employer's group medical plan. Spouses and other dependents are not eligible unless employed by Plan sponsor.

Participation You will become a participant in the Plan on the date that you first become eligible for coverage under your Employer's group medical plan.

COBRA If this Plan is subject to the continuation coverage requirements of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and your participation or a "Qualifying Beneficiary's" participation in the Plan ceases following the occurrence of certain "Qualifying Events" designated by COBRA then you and your "Qualifying Beneficiaries" have the right

to continue to receive benefits from the Plan, but only if the appropriate premiums are paid. The continuation of coverage requirements of COBRA are hereby incorporated into this Plan for determining continuation coverage benefits of terminated participants and "Qualifying Beneficiaries."

FMLA Notwithstanding anything in the Plan to the contrary, if you go on a qualifying unpaid leave under the Family and Medical Leave Act of 1993 (FMLA), to the extent required by the FMLA, you will continue to be eligible for benefits under the Plan on the same terms and conditions as though you were still an active Employee.

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5. BENEFITS

Benefits Provided The Plan will pay an amount equal to the Allowable Reimbursement, as determined under the Schedule of Benefits found in the Appendix. Only claims that are determined to be Covered Expenses for you by the Insurer under the terms of the Insurance Contract, and which are submitted to and processed by the Insurer, will be eligible for payment by the Plan.

Payments to Third Party Benefit payments under this Plan will be made directly to you. However, in the Administrator's discretion, payments may be made to the service provider or to a representative of a mentally, physically or legally incapacitated individual. The Plan Administrator shall be fully discharged from all future liability with respect to any such payment made in good faith.

Qualified Medical Child Support Order This Plan will also provide benefits as required by any qualified medical child support order, as defined in ERISA §609(a), and provide benefits to dependent children place with an eligible employee for adoption under the same terms and conditions as apply in the case of dependent children who are natural children of eligible employees, in accordance with ERISA §609(a).

Benefits Required By Federal Law This Plan will also provide benefits in accordance with the applicable requirements of Federal laws, such as COBRA, HIPAA and the NMHPA.

Special Rights Upon Childbirth This Plan may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less

than 96 hours following a cesarean section, or require that a provider obtain authorization from the Plan Administrator for prescribing a length of stay not in excess of the above periods.

6. CIRCUMSTANCES WHICH MAY AFFECT BENEFITS

Denial or Loss of Benefits

You will not be eligible to receive benefits from the Plan for expenses that arise at any time when you are not covered under your Employer's group medical plan. You also will not be eligible to receive benefits from the Plan for any expenses that arise after you have separated from service with the Employer, unless you are eligible to, and elect to, continue your coverage under COBRA. If your coverage under your Employer's group medical plan terminates and you elect to continue coverage under COBRA (or under a similar state law), you will not receive continuation coverage under this Plan unless you separately elect coverage under this Plan and pay the required premium.

Your benefits will also cease upon termination of the Plan or upon the non-payment of any required premium.

7. CLAIMS PROCEDURE

Applying for Benefits

When you incur a claim for which you wish to be reimbursed, you must first submit the claim to the Insurer. The Insurer will make a determination under its adjudication procedures as to whether your claim is for an expense that is covered under the Insurance Contract. If the Insurer denies all or part of the claim for any reason, the part of the claim that was denied will not, in any circumstance, be eligible for reimbursement under this Plan. If you do not agree with the Insurer's determination, you must appeal to the Insurer by following the appeal procedures contained in the Insurance Contract.

Approved Claims

If the Insurer determines that your claim is for an expense that is covered under the Insurance Contract, the amount of benefit which you are to receive from this Plan will be determined exclusively from the Explanation of Benefits report prepared by the Insurer. You will not be required to file a claim or other request with the Plan Administrator of this Plan to receive your benefit.

8. BENEFIT DENIALS AND APPEALS PROCEDURE

Benefit Denials The Plan Administrator is responsible for evaluating claims for benefits under the Plan that have been approved by the Insurer. The Plan Administrator will decide your claim after the Explanation of Benefits report is received from the Insurer according to the following timetable:

Notification of whether claim is accepted or denied	30 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information on the Claim:	
Notification of	15 days
Response by Participant	45 days
Review of claim denial	60 days

If the Plan Administrator denies your claim, in whole or in part, after it has been approved by the Insurer, you will receive a written or electronic notification stating:

a. The specific reason or reasons for the denial.

b. Reference to the specific Plan provisions on which the denial was based.

c. A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary.

d. A description of the Planôs review procedures and the time limits applicable to such procedures. This will include a statement of the right to bring a civil action following a denial on review.

e. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claim.

f. If the denial was based on an internal rule, guideline, protocol or other similar criterion, the specific rule, guideline, protocol or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol or criterion was relied upon in making the denial and a copy will be provided free of charge to the claimant upon request.

Appealing a Denied Claim

If your claim is denied by the Plan Administrator, (not the Insurer) you have 180 days following receipt of the notification in which to appeal the decision. Your written appeal should state the reasons that you feel your claim should not have been denied. It should include any additional facts and/or documents that you feel support your claim. You may also ask additional questions or make comments, and you will be provided, free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim. A document, record or other information will be considered relevant to a claim if it:

1. was relied upon in making the claim determination;

2. was submitted, considered or generated in the course of making the claim determination without regard to whether it was relied upon in making the claim determination;

3. demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that claim determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or

4. constituted a statement of policy or guidance with respect to the Plan concerning the denied claim.

Review of Appeal

The Plan Administrator will review and decide your appeal within 60 days after it is submitted (without regard to whether all the necessary information accompanies the filing) and will notify you of its decision in writing. The review will take into account all comments, documents, records and other information submitted by the claimant relating to the Claim without regard to whether such information was submitted or considered in the initial claim determination. The review will not afford deference to the initial denial and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

If the decision on appeal affirms the initial denial of your claim, this notice will set forth:

a. The specific reason(s) for the denial; and

b. The specific Plan provision(s) on which the denial is based.

9. PLAN ADMINISTRATION

Plan Administration

The administration of the Plan is under the supervision of the Plan Administrator. The principal duty of the Plan Administrator is to see that the Plan is carried out in accordance with its terms, and for the exclusive benefit of persons entitled to participate in the Plan.

Plan Costs

Your Employer bears all costs of administering the Plan.

Power and Authority of Plan Administrator

The Plan Administrator shall have, but shall not be limited to, the following authority:

Å To make and enforce such rules and regulations as the Plan administrator deems necessary or proper for the efficient administration of the Plan;

Å To decide all questions concerning the Plan and the eligibility of any person to participate in the Plan and to receive benefits provided under the Plan;

Å To approve reimbursement requests and to authorize the payment of benefits; and

Å To appoint such agents, counsel, accountants, consultants, and actuaries as the Plan Administrator deems advisable to assist in administering the Plan.

Discretionary Authority

The Plan Administrator has the discretionary authority to interpret the Plan and to resolve any ambiguities under the Plan. The Plan Administrator's interpretations made in good faith are final and conclusive on all persons claiming benefits under the Plan.

10. AMENDMENT OR TERMINATION OF PLAN

Amendment or Termination

Your Employer, at any time or from time to time, may amend or terminate any or all of the provisions of the Plan without the consent of any Employee.

Authority to Amend or Terminate

The Plan may be amended or terminated by a written instrument signed by any officer of the Plan Sponsor without further authorization or approval by a Board of Directors or other similar governing body.

The Third Party Administrator, R. D. Drenkow & Co., Inc., is authorized to adopt amendments to the Plan that are clarifying in nature or advisable to comply with applicable law.

11. MISCELLANEOUS

Plan Interpretation

All provisions of this Plan will be interpreted and applied in a uniform, nondiscriminatory manner. This Plan shall be read in its entirety and not severed except as provided below.

Gender and Number

Whenever any words are used in the masculine, feminine or neuter gender, they are to be construed as though they were also used in another gender in all cases where they would so apply. And whenever any words are used in the singular or plural form, they are to be construed as though they were also used in the other form in all cases where they would so apply.

Non-Alienation of Benefits

No benefit, right or interest of any person is to be subject to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, seizure, attachment or legal, equitable or other process or be liable for, or subject to, the debts, liabilities or other obligations of such person, except as otherwise required by law.

No Contract of Employment

This Plan shall not be deemed to constitute a contract between the Employer and any Employee or to be a consideration or an inducement for the employment of any Employee. Nothing contained in this Plan shall be deemed to give any Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Employee at any time regardless of the effect which such discharge shall have upon him as a participant of this Plan.

Governing Law

This Plan is governed by the Internal Revenue Code of 1986 and the Treasury regulations issued thereunder (as they might be amended from time to time). To the extent not preempted by Federal law, the provisions of this Plan shall be construed, enforced and administered according to the laws of the State of Iowa.

Severability If any provision of this Plan is held invalid or unenforceable, its invalidity 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.

Failure to Enforce Failure to enforce any provision of this Plan does not constitute a waiver or otherwise affect the Plan Administrator's right to enforce such a provision at another time, nor will such failure affect the right to enforce any other Plan provision.

Captions Captions contained 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 of the Plan.

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12. PRIVACY PROVISIONS

Protected Health Information Protected Health Information (PHI) means information that is created or received by the Plan and relates to the past, present, or future physical or mental health or condition of a participant; the provision of health care to a participant; or the past, present, or future payment for the provision of health care to a participant; and that identifies the participant or for which there is a reasonable basis to believe the information can be used to identify the participant. Protected Health Information includes information of persons living or deceased.

Permitted and Required Uses and Disclosures Employer shall:

- not use or further disclose PHI other than as permitted by this Plan document or as required by law;
- ensure that any agents or subcontractors to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Employer;
- not use or disclose PHI for employment-related actions or in connection with any other employee benefit plan;
- report to the duly appointed Privacy Officer any use or disclosure of the information that is inconsistent with the permitted uses or disclosures;
- make PHI available to Plan participants, consider their amendments and, upon request, provide them with an accounting of PHI disclosures;
- make the Employer's internal practices and records relating to the use and disclosure of PHI received from the Plan available to the Department of Health and Human Services upon request; and

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

Certifications The Employer must certify to the duly appointed Privacy Officer that the Plan documents have been amended to include the above restrictions and that the Employer agrees to those restrictions. The Employer must also provide adequate safeguards to protect PHI.

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13. STATEMENT OF PARTICIPANT RIGHTS

Your Rights All Plan participants shall be entitled to:

Å examine, without charge, at the Plan Administrator's office, all Plan documents, and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions; and

Å obtain copies of all Plan documents and other Plan information upon request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

Fiduciary Obligations The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the best interest of you and other Plan participants.

No Discrimination No one, including your Employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights.

Right to Review If your claim for a benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have your claim reviewed and reconsidered.

Filing Suit There are steps you can take to enforce the above rights. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a

Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

Questions If you have any questions about this statement or your rights, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

APPENDIX A

Schedule of Benefits
OPTION 1
Collins-Maxwell Community Schools Medical Expense Reimbursement Plan

BENEFIT	INDIVIDUAL LIMITS (Embedded Deductibles)	ADDITIONAL FAMILY LIMITS
DEDUCTIBLES	**The Plan will pay 80% of any additional non-prescription In-Network deductibles and 70% of any additional non-prescription Out-of-Network deductibles incurred by an individual once that individual has incurred a combined total of $500 of non-prescription In-Network and Out-of-Network deductibles.** **See below for a separate schedule of benefits for prescription deductibles**	**The plan will pay 80% of any additional non-prescription In-Network deductibles and 70% of any additional non-prescription Out-of-Network deductibles incurred by an Eligible Employee or any family member of that Eligible Employee once the Eligible Employee and family members of that Employee have collectively incurred a combined total of $1,000 of non-prescription In-Network and Out-of-Network deductibles.** **See below for a separate schedule of benefits for prescription deductibles**
CO-INSURANCE	**The Plan will pay 33.33% of all In-Network co-insurance charges and 25% of all Out-of-Network co-insurance charges.**	
OUT OF POCKET MAXIMUM	**The Plan will pay 100% of all additional non-prescription In-Network and Out-of-Network deductible and co-insurance charges incurred by an individual after the individual has incurred $1,000 of non-prescription In-Network and Out-of-Network deductibles and co-insurance.** **Co-payments an Prescription deductibles are not included in the $1,000 Out-of-Pocket maximum.**	**The Plan will pay 100% of all additional non-prescription In-Network and Out-of-Network deductible and co-insurance charges incurred for any Eligible Employee or family member of an Eligible Employee after the Eligible Employee and family members of that Employee have incurred a combined total of $2,000.00 of non-prescription In-Network and Out-of-Network deductibles and co-insurance.** **Co-payments and Prescription deductibles are not included in the $2,000 Out-of-Pocket maximum.**
OFFICE VISIT CO-PAYMENT	**The Plan will pay the amount by which an In-Network Office Visit Co-payment (including Chiropractic Office Visits) exceeds $20. This payment will be limited to the lesser of 100% of the excess amount or $10.** **No payment is made on Out-of-Network Office Visit Co-payments.**	
Rx CO-PAYMENT	**No payments are made for Tier 1 Prescription Co-Payments.** **The Plan will pay the amount by which a Tier 2 Prescription Co-Payment exceeds $25. This payment will be limited to the lesser of 100% of the excess amount or $10.** **The Plan will pay the amount by which a Tier 3 Prescription Co-Payment exceeds $40. This payment will be limited to the lesser of 100% of the excess amount or $10.**	
Rx DEDUCTIBLE	**The Plan will pay up to $100 of Prescription deductible expenses for single coverage.**	**The Plan will pay up to $200 of Prescription deductible expenses for family coverage.**

APPENDIX B

Schedule of Benefits
OPTION 2
Collins-Maxwell Community Schools Medical Expense Reimbursement Plan

BENEFIT	INDIVIDUAL LIMITS (Embedded Deductibles)	ADDITIONAL FAMILY LIMITS
DEDUCTIBLES	**The Plan will pay 80% of any additional non-prescription In-Network deductibles and 70% of any additional non-prescription Out-of-Network deductibles incurred by an individual once that individual has incurred a combined total of $1,000 of non-prescription In-Network and Out-of-Network deductibles.** **See below for a separate schedule of benefits for prescription deductibles**	**The plan will pay 80% of any additional non-prescription In-Network deductibles and 70% of any additional non-prescription Out-of-Network deductibles incurred by an Eligible Employee or any family member of that Eligible Employee once the Eligible Employee and family members of that Employee have collectively incurred a combined total of $2,000 of non-prescription In-Network and Out-of-Network deductibles.** **See below for a separate schedule of benefits for prescription deductibles**
CO-INSURANCE	**The Plan will pay 33.33% of all In-Network co-insurance charges and 25% of all Out-of-Network co-insurance charges.**	
OUT OF POCKET MAXIMUM	**The Plan will pay 100% of all additional non-prescription In-Network and Out-of-Network deductible and co-insurance charges incurred by an individual after the individual has incurred $2,000 of non-prescription In-Network and Out-of-Network deductibles and co-insurance.** **Co-payments an Prescription deductibles are not included in the $2,000 Out-of-Pocket maximum.**	**The Plan will pay 100% of all additional non-prescription In-Network and Out-of-Network deductible and co-insurance charges incurred for any Eligible Employee or family member of an Eligible Employee after the Eligible Employee and family members of that Employee have incurred a combined total of $4,000.00 of non-prescription In-Network and Out-of-Network deductibles and co-insurance.** **Co-payments and Prescription deductibles are not included in the $4,000 Out-of-Pocket maximum.**
OFFICE VISIT CO-PAYMENT	**The Plan will pay the amount by which an In-Network Office Visit Co-payment (including Chiropractic Office Visits) exceeds $20. This payment will be limited to the lesser of 100% of the excess amount or $10.** **No payment is made on Out-of-Network Office Visit Co-payments.**	
Rx CO-PAYMENT	**No payments are made for Tier 1 Prescription Co-Payments.** **The Plan will pay the amount by which a Tier 2 Prescription Co-Payment exceeds $25. This payment will be limited to the lesser of 100% of the excess amount or $10.** **The Plan will pay the amount by which a Tier 3 Prescription Co-Payment exceeds $40. This payment will be limited to the lesser of 100% of the excess amount or $10.**	
Rx DEDUCTIBLE	**The Plan will pay up to $100 of Prescription deductible expenses for single coverage.**	**The Plan will pay up to $200 of Prescription deductible expenses for family coverage.**

APPENDIX C

List of Affiliated Employers

NONE