Le Mars CSD
FLEXIBLE BENEFITS PLAN
SUMMARY PLAN DESCRIPTION INSERT

PLAN INTENT

The employer named below establishes this plan with the intention that this Summary Plan Description Insert, in addition to any plan booklets, certificates, or product material issued by the companies insuring benefits under this plan, will satisfy the Summary Plan Description requirements of ERISA. If you have any questions, please contact the company contact person listed below.

The employer named below establishes this plan with the intention of maintaining such plan for an indefinite period of time and for the exclusive benefit of its employees.

EMPLOYER - SPONSOR

Employer - Plan Sponsor	Le Mars CSD
Federal Tax ID Number	42-6037691
Mailing Address	940 Lincoln St. SE
City, State, ZIP	Le Mars, IA 51031
Plan Administrator	Sponsoring Employer
Company Contact Person	Sandy Downing
Address:	940 Lincoln St. SE
	Le Mars, IA 51031

Plan Information

Name of Plan:	Le Mars CSD Flexible Benefit Plan
Plan Number:	501
Plan Year End:	June 30th
Plan Service Provider:	Kabel Business Services
Address:	1454 30th Street, Suite 105
	West Des Moines, Iowa 50266
Phone Number:	515-224-9400

The appointed Plan Service Provider in conjunction with the Administrator will perform the functions of accounting, record keeping, changes of participant family status, and any election or reporting requirements of the Internal Revenue Code.

Eligibility Requirements

Existing Employees- If you are in the Employer's employment on the Plan's effective date, you shall be eligible to become a participant on the Plan's effective date, subject to the exclusions noted below.

New Employees- If your employment by the Employer begins after the Plan's effective date, your service period requirements for eligibility are incorporated by reference from the terms of the underlying benefit policies subject to the exclusions noted below.

Re-employment of Former Employees- A re-employed former employee shall be treated the same as a new employee in determining eligibility.

Age requirement- There will be no maximum age requirement for participation in the Plan. Employees excluded from this classification group are those individual employees who fall into one or more of the following categories:

Part-Time Employees Working Less Than 25 Hours Per Week

Termination of Participation- You will automatically cease to be a participant on the earliest of the following dates:

a. Your death;
b. The date you terminate your employment;
c. The date you fail to meet the eligibility requirements;
d. The date the Plan terminates;

Terminated employees have 60 days from their termination date to turn in clai ms with a date of service prior to their termination date.

When participant ceases to make contributions to the Plan because of layoff:

a. Unless a Participant has made total payments required for coverage during the entire Plan Year, participant may only submit claims for medical expenses incurred prior to the date contributions cease and no additional Flexible Dollars will accumulate in the Medical Expense Reimbursement Account after contributions cease.
b. When salary is discontinued, but you later return to work in a new Plan Year, you will be treated as a new employee.
c. When salary is continued, you are treated the same as an active employee.

Service period requirements for eligibility are incorporated by reference from the terms of the underlying benefit policies.

The entry date is the date when an employee meeting the eligibility requirements will be able to begin participation in the Plan. This will mean the date eligibility requirements are met.

Benefit Plans

Medical or Medical - Related Premiums - This benefit allows you to contribute your portion of medical or medical-related premiums for employer-provided group coverage on a pre-tax basis.

Each year each participant may choose not to participate in pre-tax group health benefits by notifying the employer in writing on or before the first day of any plan year. Unless notified of a change prior to the start of a new plan year, the prior year election will be continued.

For purposes of this Plan, medical or medical-related premiums include those related to the cost of medical and hospitalization insurance or coverage, major medical insurance, dental insurance, and/or vision insurance. Medical insurance premiums include you, your spouse, and any eligible dependent children.

The terms, conditions, and limitations of the core health benefits offered will be as set forth in and controlled by the group medical and medical-related policies. (Eligible employees become eligible to participate First of the Month After Date of Hire.)

Medical or Medical - Related Expense Reimbursement Benefit - This benefit provides payments by the Employer to reimburse you for medical or medical-related expenses as defined in IRS Section 213(e) for you, your spouse, and dependents.

1. Reimbursement or payment of these benefits shall be made by the Employer only in the event and to the extent that such reimbursement or payment is not provided for under any insurance policy, whether the premium on such policy is paid by the Employer or you.

2. The maximum medical expense reimbursement available to you at any time during the Plan Year shall not be greater than the annual benefit you elected on your enrollment form less benefits paid to date on your behalf during the Plan Year.

3. The maximum annual contribution amount any employee may have for the medical and medical related expense reimbursement benefit is $2,550.00.

4. Each year each participant may elect in writing on a form filed with the plan administrator on or before the first day of any plan year. (Eligible employees become eligible to participate First of the Month After Date of Hire.)

Dependent Care Reimbursement Benefit - This benefit provides payment by the Employer to reimburse you for Dependent Care Assistance as defined in IRS Section 129.

1. The maximum amount of Dependent Care Assistance which you may elect to receive in a Plan Year shall be as set forth on your Flexible Compensation Enrollment Form.

2. The Employer shall not be required to pay any Dependent Care Assistance in excess of amounts contributed and not previously paid out on your behalf during the Plan Year.

3. Payment of Dependent Care Assistance shall be made by the Employer only to the extent that such amounts have not been previously claimed as a credit by you on your personal income tax return.

4. The maximum amount of dependent care assistance benefits provided for any participant during any plan year may not exceed the amount specified in Code Section 129 which currently is five thousand dollars ($5,000) or, if the Participant is married and files a separate federal income tax return, two thousand five hundred dollars ($2,500).

5. Each year each participant may elect in writing on a form filed with the plan administrator on or before the first day of any plan year. (Eligible employees become eligible to participate First of the Month After Date of Hire.)

Expense Reimbursements and Forfeitures

A closing or "runout" period is the period of time that begins after the plan year ends or Grace Period (if applicable) ends to allow Participants sufficient time to submit claims for payment of Qualified Expenses incurred during the plan year not yet reimbursed. The runout period generally terminates 60 days after the plan year ends,or, if applicable, 60 days after the Grace Period ends.

Prohibited Deposits- Extra Deposits are prohibited. All accounts are accumulated through voluntary salary reduction.

Forfeitures- If you fail or are unable to fully utilize a reimbursement benefit during the Plan Year (including the runout period and any Grace Period, and no carryover applies), your unused benefit election dollars will be forfeited.

Medical Expense Reimbursement Carryover

The Plan includes an exception to the forfeiture rule, permitting the carryover of up to $500 of unused medical expense reimbursement contributions into the next Plan Year. The carryover amount is determined after the expiration of the 60-day runout period for the applicable Plan Year. Any carryover of unused amounts does not affect your ability to contribute up to the maximum allowed in the next Plan Year. As an example, suppose a participant contributed $2,000 to the medical expense reimbursement account during the Plan Year, but only submitted reimbursement claims for $1,650 in eligible medical expenses incurred during the Plan Year. The unused $350 will carry over and be available to reimburse the participant during the next Plan Year. If instead the participant had $550 in unused contributions, $500 would carry over to the next Plan Year and $50 would be forfeited.

Grace Period for Unused Flexible Dollars

With respect to a Participant, expenses for qualified benefits under the Dependent Care Expense Reimbursement Account incurred during the Grace Period (as defined below) may be paid or reimbursed from benefits or contributions remaining unused in the applicable account at the end of the immediately preceding Plan Year as if the expenses had been incurred in such immediately preceding Plan Year.

The "Grace Period" shall be a period beginning with the first day following the end of the immediately preceding Plan Year and ending with the 15th day of the third calendar month after the end of the immediately preceding Plan Year. The runout period will last for 60 days from the end of the Grace Period.

During the Grace Period, the Plan may not permit unused benefits or contributions to be cashed-out or converted to any other taxable or nontaxable benefit. Unused benefits or contributions relating to a particular qualified benefit may only be used to pay or reimburse expenses incurred with respect to that particular qualified benefit (e.g., qualified dependent care expenses incurred during the Grace Period can only be paid from unused credits in the Dependent Care Expense Reimbursement Account).

To the extent any unused benefits or contributions from the immediately preceding Plan Year exceed the expenses for the qualified benefit incurred during the Grace Period, those remaining unused benefits or contributions may not be carried forward to any subsequent period and are forfeited.

During the Grace Period, any unused benefits or contributions from the immediately preceding Plan Year shall first be used for qualified reimbursements before using any benefits or contributions in the applicable account for the Plan Year which includes the Grace Period.

The ability to submit claims for qualified expenses incurred during the Grace Period shall apply to all individuals who are Participants with respect to the applicable reimbursement account as of the last day of the immediately preceding Plan Year. A person who was a Participant as of the last day of the immediately preceding Plan Year shall be permitted to submit claims for qualified expenses incurred during the Grace Period (to the extent of unused credits from the prior Plan Year) even if such Participant terminates employment prior to the end of the Grace Period.

The deadline for submitting claims incurred during the Plan Year or during the Grace Period shall be the "runout" period as described above.

Irrevocability of Elections

Irrevocability of Elections- Elections made by you under the Plan shall be irrevocable during the Plan Year subject to a change in family status. You may revoke a benefit election for the balance of the Plan Year and file a new election only if both the revocation and the new election are based on and consistent with a change in family status. Any new election shall be effective at such time as the administrator shall prescribe but not earlier than the first pay period beginning after the election form is signed.

Change in Family Status- You may not change a benefit election after the start of the Plan Year unless the change and new election are based on and consistent with the following:

The following changes in status apply to health and term life insurance as well as to the dependent care and medical flexible spending accounts:

1. Change in an employee's legal marital status – this includes marriage, divorce, death of a spouse, legal separation, and annulment.
2. Change in number of dependents – this includes birth, adoption, placement for Adoption, and death.
3. Change in employment status – if any of the following events change: the employment status of the employee, the employee's spouse, or the employee's dependent would qualify: a termination or commencement of employment; a strike or lockout; a commencement of or return from an unpaid leave of absence; and a change in work-site. In addition, if the eligibility conditions of the Cafeteria Plan or other employee benefit plan of the employer or the employee, spouse or dependent depend on the employment status of that individual and there is a change in that individual's employment status with the consequence that the individual becomes (or ceases to be) eligible under the Plan, then that change constitutes a change in employment under this paragraph. For example, if a Plan applies only to salaried employees and an employee switches from salaried to hourly paid, with the consequence that the employee ceases to be eligible for the Plan, then that change constitutes a change in employment status.
4. Dependent satisfies or ceases to satisfy eligibility requirements for coverage on account of attainment of age, student status, or any similar circumstances.
5. HIPAA Special Enrollment Rights – a change may be made if an employee has a right to enroll in an employer's group health plan; or to add coverage for a family member under HIPAA, the employee can make a conforming election under the Cafeteria Plan.
6. Judgment, Decree or Order – a change may be made as a result of a judgment, decree or order resulting from a divorce, annulment or legal separation, including a qualified medical child support order (QMCSO).
7. Entitlement to Medicare or Medicaid – a change may be made as a result of Medicaid and Medicare entitlement.
8. COBRA – a change may be made if a COBRA event (or similar state law continuation coverage event) occurs with respect to the employee, the employee's spouse or a dependent.
9. A leave of absence under the Family Medical Leave Act.

The following events relating to a change in cost or change in coverage allow a change in plan election for all benefits under the Cafeteria Plan, **with the exception of the medical flexible spending account.**

1. Residence – a change in the place of residence of the employee, spouse or dependent.

[The following events permit a participant to revoke his or her medical benefit premium election (but not his or her medical expense reimbursement account election):

1. A reduction of average hours of employment to less than 30 per week, but the employee remains eligible for medical benefits under the employer medical coverage. The employee may revoke his or her election in order to enroll in another medical plan providing minimum essential coverage, which could include a plan offered through an Affordable Care Act (ACA) exchange or marketplace. The new coverage must begin no later than the first day of the second month following the month in which coverage is revoked under the Employer's medical coverage.
2. The employee desires to enroll in an ACA exchange or marketplace plan due to a "special enrollment period" provided under the ACA rules or to change to an ACA exchange or marketplace plan during ACA open enrollment (for a non-calendar Plan Year). The new coverage must begin no later than the day after the coverage is revoked under the Employer's medical coverage.

In either case, the employee must enroll his or her spouse and/or dependents who were enrolled in the Employer's medical coverage in the new medical coverage. The Employer may require the employee to certify or represent that he or she and any applicable dependents will enroll in the new coverage.]

Changes in Cost

The plan allows for an automatic election change that corresponds to an increase or decrease in the cost of the coverage. Moreover, if there is a significant cost increase, a Plan may allow participants either to make a corresponding election increase or elect alternative coverage.

Change in Coverage

1. Significant Curtailment – if the coverage under a Plan is significantly curtailed or ceases during a period of coverage, the Cafeteria Plan may permit affected employees to revoke their elections under the Plan and make a new election for coverage under another benefit package option providing similar coverage. Coverage under a Plan is significantly curtailed only if there is an overall reduction in coverage provided to participants under the Plan so as to constitute reduced coverage to participants.
2. Addition to or elimination of benefit package – if during a period of coverage a Plan adds a new benefit package option or other coverage option (or eliminates an existing benefit package option or other coverage option), the Cafeteria Plan may permit affected employees to elect the newly added option (or elect another option if an option has been eliminated) prospectively on a pre-tax basis and make corresponding election changes with respect to other benefit package options providing similar coverage.
3. Change in coverage of spouse or dependent under other employer's plan – a Cafeteria Plan may permit an employee to make a prospective election change that is on account of and corresponds with a change made under the plan of the spouse's former or dependent's employer if (1) a Cafeteria Plan or qualified benefits plan of the spouse's, former spouse's or dependent's employer permits participants to make an election change that would be permitted under the proposed and final regulation; or (2) the Cafeteria Plan permits participants to make an election for a period of coverage that is different from the period of coverage under the Cafeteria Plan or qualified benefits plan of the spouse's, former spouse's, or dependent's employer.

Consistency Rule (applicable to all events except 6-9 above) – The election change must be on account of and correspond to a change in the status that affects eligibility for coverage under an employer's plan. An exception to this rule is that an impact on eligibility is not required for marital status or employment status events to support election changes for group term life insurance or long-term disability coverage.

Under most circumstances the change must be made within 30 days of the event.

Termination

Employee Right to Terminate- Once the Plan Year commences, your election is irrevocable except when:
a. Legislation required termination of or substantial amendment to the Plan.
b. The company terminates the Plan and/or coverages.

Plan Termination- The Plan or any portion of the Plan shall be subject to termination at any time by the Employer. Upon termination of the Plan, the Administrator may continue the Plan in order to pay balances or distribute balances.

Claims

When to File- Claims should be filed as soon as you or your dependents incur eligible expenses.
How to File- The "Request for Reimbursement" form should be completed and signed. This form must be completed for all claims submitted. The completed forms should then be sent to the Administrator for processing.
Notice of Claim- You should file a claim only on forms provided for such purpose.
Forms- Upon request, the Administrator will provide you with the necessary forms.
Processing the Request- Your "Request for Reimbursement" form will be processed by the Plan Administrator. Determination of expense and eligibility and fund's availability based on your account balances, will then be made.
Information for Claim- Prior to making any payment of benefits hereunder, the Plan Administrator may require you to provide information and complete the appropriate documents or forms necessary for the proper administration of a claim.
Claims Procedure- The Plan Administrator shall make all determination as to the right of any person to benefit under the Plan.
Payment- After reviewing the request, the Administrator shall issue a benefit check, if appropriate, to you.
Failure to File- If you fail to file a claim for benefits, the Employer may take whatever steps are necessary and proper to dispose of your potential benefits under the Plan.
Coordination of Benefits- It is your responsibility to make certain that claimed expenses have not been previously reimbursed by another benefit plan and will not be claimed as a tax deduction.

Your Rights

As a participant in the Company's Medical and Dental Expense Reimbursement Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act ("ERISA"). ERISA provides that all Plan participants shall be entitled to:

Examine, without charge, at the Plan Administrator's office and at other specified locations such as work-sites and union halls, all plan documents including insurance contract, collective bargaining agreements and copies of all documents filed by the Plan with the U.S. Department of Labor such as detailed annual reports and plan descriptions.

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

Receive a summary of the Plan's annual financial report when such a report is required by law.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of the plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit from the plan or from exercising your rights under ERISA.

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 the Plan Administrator review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide materials and pay you up to $100 a day until you receive the materials unless the materials were not sent because of reasons beyond the control of the Administrator. 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 as above. 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 or if it finds your claim is frivolous. If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this part of

the Summary Plan Description or about your rights under ERISA, you should contact the nearest office of the U.S. Labor-Management Services Administration, Department of Labor.

Incorporation By Reference

The actual terms and the conditions of the separate benefits offered under this Plan are contained in separate, written documents governing each respective benefit, and will govern in the event of a conflict between the individual plan document and the Employer's Flexible Benefits Plan.

The Employer has established this Plan with the intention that it will be continued indefinitely, but the Employer reserves the right to amend or terminate this Plan and the separate, related benefits at any time.