



**IMA Group Health and Flexible
Spending Account Plan
Summary Plan Description**

Health Care Spending Account

January 1, 2020

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1. Introduction and Important Notices

This Summary Plan Description is designed to explain some of the more important terms and provisions of the health care spending account option available under the IMA Group Health and Flexible Spending Account Plan (the "Plan") and the operation of certain pre-tax elections under the Plan Sponsor's Code Section 125 cafeteria plan (the "Cafeteria Plan"). This is only a summary of the Plan and the health care spending account option available under the Plan. It may omit details which may be of importance to you in a given situation. If there is any conflict between the Summary Plan Description and the formal plan documents, the terms and conditions of the plan documents will control. The Plan Administrator has full power to administer the coverage described herein, including without limitation, the power to make discretionary interpretations regarding the terms and provisions of any plan and to make factual findings with respect to any issue arising under any plan, its interpretation to be final and conclusive on all persons.

1.1 Benefit Descriptions. This document should be attached to the benefit summaries, certificates of coverage, benefit description booklets, summary plan descriptions, and other similar descriptions (hereinafter "Benefit Descriptions") that have been provided to you to describe the health care spending account option available under the Plan. If you have lost or misplaced one or more of your Benefit Descriptions, a replacement will be furnished without cost to you upon request to the Plan Administrator. This document, along with such Benefit Descriptions for the health care spending account option available under the Plan, constitutes the Summary Plan Description for the health care spending account option available under the Plan. If there is any conflict between the terms of the Benefit Descriptions and this document, the terms of this document will control.

If you have any questions or wish to see the formal Plan documents, please contact the Plan Administrator.

1.2 Notice Under Newborns' and Mothers' Health Protection Act of 1996. Group health plans and health insurance issuers offering group insurance coverage generally 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 caesarian section, or require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of the above periods.

1.3 Notice Under Women's Health and Cancer Rights Act of 1998. Federal law provides that group health plans and health insurance issuers providing health insurance coverage in connection with group health plans must provide certain medical and surgical benefits with respect to a mastectomy. If you are a participant in the plan, or a beneficiary of the plan, and you receive benefits in connection with a mastectomy and you elect breast reconstruction in connection with that mastectomy, the plan must provide coverage for: reconstruction of the breast on which the mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; prostheses; and,

physical complications of all stages of mastectomy including lymphedemas. The above coverage is subject to any deductibles and co-insurance provisions contained within the plan.

- 1.4 No Right to Employment.** No plan maintained by The IMA Financial Group, Inc. or any affiliate is intended to create any contractual right of employment, and nothing contained therein or in this summary plan description shall be construed as a guarantee of employment for any specific period of time or for any specific type of work.
- 1.5 Reservation of Rights.** The IMA Financial Group, Inc. reserves all rights to make changes at any time in the benefits, costs, and other provisions relative to any benefit plan, including, but not limited to, retiree medical provisions (if any). Those changes could include the complete termination of benefits for all individuals or certain groups of individuals. No employee, spouse, or dependent will acquire any vested (nonforfeitable) right to have benefits or other provisions of the plan remain unmodified or in effect. In addition, your employer reserves all rights to make changes at any time in the costs or contributions relative to any benefit plan or option, notwithstanding any actual or alleged agreement, document, or other communication to the contrary.

2. Plan Administration

2.1 Name of Plan and Plan Number.

IMA Group Health and Flexible Spending Account Plan – Plan Number 501

The health care spending account option described in this Summary Plan Description is offered as part of the IMA Group Health and Flexible Spending Account Plan.

2.2 Name and Address of Plan Sponsor.

The IMA Financial Group, Inc.
8200 E. 32nd Street North
Wichita, Kansas 67226

A complete list of other employers sponsoring the plan (if any) may be obtained by participants and beneficiaries upon written request to the Plan Administrator.

2.3 Employer Identification Number.

48-0805634

2.4 Plan Administrator.

The IMA Financial Group, Inc.
8200 E. 32nd Street North
Wichita, Kansas 67226
(316) 267-9221

2.5 Plan Administration. The Plan is administered by The IMA Financial Group, Inc., which is the “plan administrator” for the Plan. The following organizations also provide

administrative services to the Plan, including review and payment of claims:

NueSynergy
4601 College Blvd., Suite 280
Leawood, KS 66211
(913) 653-8381

- 2.6 COBRA Administration.** The Consolidated Omnibus Budget Reconciliation Act of 1985 (“COBRA”) and the Uniformed Services Employment and Reemployment Rights Act of 1994 (“USERRA”) enable employees to continue group health plan coverage for certain periods of time. In order to preserve certain important rights under COBRA and/or USERRA, you may be required to provide certain notices to the Plan Administrator or COBRA Administrator(s) within specified times as provided by applicable law and Plan rules. (See the “Continuation Coverage” section of this Summary Plan Description).

The COBRA Administrator for health FSA coverage under the Plan is:

NueSynergy
4601 College Blvd., Suite 280
Leawood, KS 66211
(913) 653-8381

2.7 Agent for Service of Legal Process.

The IMA Financial Group, Inc.
Attn: Eric M. Pauly, General Counsel
8200 E. 32nd Street North
Wichita, Kansas 67226

Service of legal process may also be made upon the Plan Administrator.

- 2.8 Plan Year.** The Plan operates on a 12-month period commencing January 1. In general, accounting is done as of the last day of the plan year.

3. Eligibility and Enrollment

- 3.1 Eligibility.** Generally, all employees who are regularly scheduled to work 20 or more hours per week, who normally work 12 months each plan year, who have been employed for at least 30 days, and who satisfy all other conditions established by the Plan and the Benefit Description are eligible to participate in health care spending account coverage under the Plan’s health care spending account option on the first day of the month following or coincident with their eligibility date, provided they enroll within the time limitations established by the Plan Administrator.

- 3.2 Continuing Eligibility.** Generally, participation in health care spending account coverage under the Plan will continue until the earliest of: (i) the date the health care spending account coverage described in this Summary Plan Description is no longer offered under this Plan; (ii) the date on which the Plan terminates; (iii) the day you no longer satisfy the eligibility requirements for health care spending account coverage; (iv) the end of the period for which any required contribution was last paid; or (v) the date coverage terminates under the Benefit Description.

3.3 Eligibility When Re-Employed. Generally, if you quit working after becoming eligible to participate and return to work during the same plan year the following rules will apply:

- (a) If re-employment occurs within 30 days and during the same plan year, you will not be allowed to make a new election but will be required to continue the same election in place at the time you terminated employment, subject to recognized changes in status occurring during your absence. If re-employment occurs within 30 days but during the following plan year, you will be permitted to make a different election than was in place at the time you terminated employment and will be immediately eligible for coverages offered under the Plan (no waiting period will apply). If you elect to resume or commence coverage, or if coverage resumes automatically, coverage will resume or commence as of the first day of the calendar month immediately following the return to service.
- (b) If re-employment occurs after 30 days but within 91 days, you will be permitted to make a different election than was in place at the time you terminated employment and will be immediately eligible for coverages offered under the Plan (no waiting period will apply). If you elect to resume or commence coverage, coverage will resume or commence as of the first day of the calendar month immediately following the return to service.
- (c) If re-employment occurs after 91 days, upon return to active employment you will be treated as a new employee and permitted to enter into a new election after again satisfying the applicable eligibility requirements, including any applicable waiting period.

3.4 Enrollment Procedures. When you become eligible to participate in the health care spending account option under the Plan, you may request that the Plan Administrator provide you with enrollment information. A new participant who fails to make an election for health care spending account coverage on or before the last day of the enrollment period will be deemed to have elected not to participate in such coverage under the Plan. The following rules also apply:

- (a) There may be an annual re-enrollment of all eligible employees during the enrollment period established by the Plan Administrator. During the open-enrollment period, you will have the opportunity to decide to what extent you want to participate in available coverages under the Plan for the upcoming plan year. The election you make during this time period will be effective for the next plan year.
- (b) **If you have previously elected to participate in health care spending account coverage under the Plan but you fail to return a new enrollment form for any subsequent plan year, you will be deemed to have made the same election as was in effect just prior to the end of the preceding plan year.** You will also be deemed to have agreed to a reduction in compensation for the subsequent plan year equal to your share of the cost (as determined by the employer) of providing such coverage. Notwithstanding the foregoing, the Plan Administrator may require you to make a new election with respect to one or more available coverages, if the Plan Administrator deems it necessary or desirable to do so.

3.5 Irrevocability of Election. Any election you make under the Cafeteria Plan cannot be changed by you during the plan year unless such change is permitted under the Cafeteria

Plan. Any revocation or change of election made by you must be made in writing and must be proximate in time to the occurrence of the circumstances giving rise to the revocation or change. Except as required by law, a revocation or change generally will not be accepted more than 30 days after the occurrence giving rise to the revocation or change. Any new election generally will be prospectively effective as of the first day of the month following receipt of timely notice.

3.6 Certain Changes in Elections. Notwithstanding the general rule that elections under the Cafeteria Plan are irrevocable, changes under the Cafeteria Plan generally are permitted in accordance with the following:

- (a) You may be allowed to revoke your election and make a new election if you have a change in status and your election change is consistent with your change in status. Permissible status changes include the following:
 - (1) Events that change your legal marital status including marriage, death of a spouse, divorce, legal separation, or annulment.
 - (2) Events that change the number of your dependents including birth, death, adoption, or placement for adoption.
 - (3) Any of the following events that change your employment status or that of your spouse or dependent: termination or commencement of employment, a strike or lockout, a commencement or return from an unpaid leave of absence, a change in worksite or a change in employment status with the consequence that the individual becomes or ceases to be eligible to participate in a cafeteria plan or other employee plan benefit of such person.
 - (4) Events that cause your dependent to satisfy or cease to satisfy the requirements for coverage including attainment of a specified age, changes in student status, or other similar circumstance.
 - (5) A change in the place of residence or worksite of you or your spouse or dependent.
 - (6) Any other change or revocation which the Plan Administrator determines will allow a change or revocation of an election during the plan year under the regulations or rulings of the Internal Revenue Service.
- (b) In addition to the foregoing status changes, the following changes will also be allowed:
 - (1) In the case of a plan subject to the Health Insurance Portability and Accountability Act of 1996 you may be allowed to revoke an election for coverage under a group health insurance plan during a period of coverage and make a new election that corresponds with the special enrollment rights provided in Code Section 9801(f).
 - (2) A conforming election under a judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order) that requires accident or health

insurance coverage for your child or for a foster child who is your dependent (the foregoing includes an election to provide coverage for the child if the order requires coverage for the child under your plan and cancellation of coverage for the child if the order requires the spouse or former spouse or other individual to provide coverage for the child and that coverage is in fact provided).

- (3) If you or your spouse or dependent is enrolled in an accident or health plan of the employer and become enrolled under Medicare Part A or Part B of Title XVIII of the Social Security Act or Title XIX of the Social Security Act (other than coverage consisting solely of benefits described in Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines)) you may make a prospective election to cancel or reduce coverage for that individual.
 - (4) If you or your spouse or dependent loses coverage under Medicare or Medicaid, a prospective election may be made to commence or increase coverage of that individual.
- (c) You may also be allowed to revoke a benefit election agreement for the balance of a plan year and make a new prospective election change if both the revocation and new election change is on account of and corresponds to an election change made under another employer's plan if (i) the other cafeteria plan or qualified benefit plan permits participants to make an election change under applicable IRS rules, or (ii) the plan year of this plan is different from the period of coverage under the other cafeteria plan or other qualified benefits plan.
- (d) Also, if the cost of qualified benefits significantly increase or decrease during the plan year, the Plan Administrator may allow you to make a corresponding change in your election. Further, if you or your spouse or dependent experience a significant curtailment of coverage, the Plan Administrator may allow you to make certain prospective changes in your election.
- Caution: Your ability to obtain or otherwise modify coverages under some of the above rules may be limited by the rules and requirements of the applicable plan and/or any insurance carrier or HMO providing underwriting and/or benefits under such plan. You should refer to such rules and requirements prior to choosing to eliminate or otherwise modify any coverages for yourself and/or an affected spouse or dependent.**
- (e) To insure that special nondiscrimination rules governing the Cafeteria Plan are satisfied, the Plan Administrator may take whatever action is necessary to assure compliance with these rules. This action may include modifying or reducing your salary reduction election.
 - (f) Special rules applicable to leaves under the Family and Medical Leave Act of 1993 ("FMLA") are set forth in the plan documents.

4. Continuation Coverage

The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") enables employees that experience a "qualifying event" to continue group health plan coverage for 18, 29, or 36

months depending upon the nature of the “qualifying event.”

COBRA continuation coverage can become available to you and to other members of your family who are covered under a group health plan when you or your covered family members would otherwise lose your group health coverage. This section of your Summary Plan Description explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.

Description of COBRA Continuation Coverage

COBRA continuation coverage is a continuation of group health insurance coverage when coverage would otherwise end because of an event known as a “qualifying event.” Specific qualifying events are listed below. COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” A qualified beneficiary is someone who will lose coverage under a group health plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

Qualifying Events

If you are an employee, you will become a qualified beneficiary if you lose group health plan coverage because either one of the following qualifying events happens:

- (a) Your hours of employment are reduced, or
- (b) Your employment ends for any reason other than your gross misconduct.

If you are a spouse of an employee, you will become a qualified beneficiary if you lose group health plan coverage because any of the following qualifying events happens:

- (a) Your spouse dies;
- (b) Your spouse’s hours of employment are reduced;
- (c) Your spouse’s employment ends for any reason other than his or her gross misconduct;
- (d) Your spouse becomes enrolled in Medicare (under Part A, Part B, or both); or
- (e) You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose group health plan coverage because any of the following qualifying events happens:

- (a) The parent-employee dies;
- (b) The parent-employee’s hours of employment are reduced;
- (c) The parent-employee’s employment ends for any reason other than his or her gross misconduct;

- (d) The parent-employee becomes enrolled in Medicare (under Part A, Part B, or both);
- (e) The parents become divorced or legally separated; or
- (f) The child stops being eligible for coverage under the plan as a “dependent child.”

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Employer and that bankruptcy results in the loss of coverage of any retired employee covered under a group health plan, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee’s spouse, surviving spouse, and dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under a group health plan.

When COBRA Continuation Coverage is Available

COBRA continuation coverage will be offered to qualified beneficiaries only after the Administrator has been timely notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the Employer, or the employee’s becoming enrolled in Medicare (under Part A, Part B, or both), the Employer must notify the Administrator of the qualifying event within 30 days of any of these events.

A Qualified Beneficiary Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child’s losing eligibility for coverage as a dependent child), a qualified beneficiary must provide written notice of the qualifying event to the Administrator within 60 days after the qualifying event occurs (or, if later, the date coverage is lost as a result of the qualifying event), using the group health plan’s notice procedures. If written notice of the qualifying event is not provided to the Administrator within this 60-day period, a spouse or dependent child that would otherwise lose group health plan coverage will not be given the opportunity to continue coverage.

How COBRA Continuation Coverage is Provided

Once the Administrator receives a timely notice that a qualifying event has occurred, COBRA continuation coverage will be offered to the qualified beneficiaries who are recognized by the group health plan as being entitled to elect COBRA continuation coverage with respect to the qualifying event. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. A covered employee or a qualified beneficiary that is (or was) the spouse of the covered employee may elect COBRA continuation coverage on behalf of all other qualified beneficiaries with respect to the qualifying event. In addition, a parent or legal guardian may elect COBRA continuation coverage on behalf of a minor child.

A qualified beneficiary must elect COBRA continuation coverage within 60 days after the date notice of the right to elect COBRA continuation coverage is provided to the qualified beneficiary. If a qualified beneficiary does not elect continuation coverage within the 60-day election period, the qualified beneficiary will lose his or her right to elect continuation coverage.

Length of COBRA Continuation Coverage

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying

event is the death of the employee, the employee's becoming enrolled in Medicare (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child under the group health plan, COBRA continuation coverage may last for up to a total of 36 months after the date of the qualifying event.

When the qualifying event is the end of employment or reduction of the employee's hours of employment and the employee became enrolled in Medicare less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee may last for up to 36 months after the date of enrollment in Medicare. For example, if a covered employee becomes enrolled in Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare enrollment, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months after the date of the qualifying event. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability Extension of 18-Month Period of Continuation Coverage

If any qualified beneficiary is determined by the Social Security Administration (SSA) to be disabled and a qualified beneficiary provides timely written notice of the disability to the COBRA Administrator, all qualified beneficiaries receiving COBRA continuation coverage with respect to the same covered employee may be entitled to get up to 11 additional months of COBRA continuation coverage, for a total maximum of up to 29 months after the date of the qualifying event. The SSA's determination of disability must occur either before or during the first 60 days after the date of the qualifying event, and the disability must last at least until the end of the first 18 months after the date of the qualifying event. In general, a qualified beneficiary giving notice of a disability must provide written notice of the SSA's determination to the COBRA Administrator within 60 days after the latest of (i) the date of the SSA's determination, (ii) the date of the qualifying event, or (iii) the date the qualified beneficiary loses (or would lose) coverage under the Plan as a result of the qualifying event. In all events, a qualified beneficiary must give notice of a disability before the end of the first 18 months after the date of the qualifying event. The qualified beneficiary must follow the notice procedures specified below (see "Notice Procedures"). Notice must be given to the COBRA Administrator. If the notice procedures are not followed or timely written notice is not provided, there will be no extension of COBRA continuation coverage.

Each qualified beneficiary who has elected continuation coverage with respect to the same covered employee will be entitled to the 11-month disability extension if one of them qualifies. If the disabled qualified beneficiary is determined by the SSA to no longer be disabled, written notice of that fact must be given within 30 days after the SSA's determination using the notice procedures specified below (see "Notice Procedures"). Notice must be given to the COBRA Administrator. Continuation coverage will cease for all qualified beneficiaries on the first day of the month that is 30 days after the date the SSA determines that the qualified beneficiary is no longer disabled. If timely written notice is not given that the qualified beneficiary is no longer disabled, coverage for all qualified beneficiaries may be retroactively cancelled and restitution to the group health plan may be required.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If, while receiving 18 months of COBRA continuation coverage, a qualified beneficiary

experiences another qualifying event that would have caused the qualified beneficiary to lose group health plan coverage if the first qualifying event had not occurred, the qualified beneficiary may get up to 18 additional months of COBRA continuation coverage, for a maximum of up to 36 months, if timely written notice of the second qualifying event is properly given to the COBRA Administrator. This extension may be available to the spouse and any dependent children getting COBRA if the employee or former employee dies, becomes enrolled in Medicare (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the group health plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the group health plan had the first qualifying event not occurred. In all of these cases, timely written notice of the second qualifying event must be given within 60 days after the date of the second qualifying event. The qualified beneficiary must follow the notice procedures specified below (see "Notice Procedures"). Notice must be given to the COBRA Administrator. If the notice procedures are not followed or timely written notice is not provided, there will be no extension of COBRA continuation coverage.

Notwithstanding the foregoing provisions, COBRA continuation coverage will not be made available to any qualified beneficiary under a plan constituting a health care spending account plan for any plan year after the end of the plan year in which a qualifying event occurs if the following conditions are satisfied: (i) the plan is a health care spending account plan and excepted from compliance under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and (ii) the annual premium payment for COBRA continuation coverage equals or exceeds the maximum benefit available under the plan for the plan year.

Notice Procedures

Any notice you provide must be in writing. Oral notice, including notice by telephone, is not acceptable. You must deliver your written notice to the Administrator or COBRA Administrator, as applicable, at the addresses listed at the beginning of this Summary Plan Description. If you mail your notice, it must be postmarked not later than the last day of the required notice period.

Any notice you provide must include the following:

- (a) The name of the group health plan.
- (b) The name and address of the employee covered under the group health plan.
- (c) The name(s) and address(es) of the qualified beneficiary(ies).
- (d) If the notice is a notice of a qualifying event or second qualifying event, the name of the qualifying event and the date it happened.

If the qualifying event is divorce or legal separation, the notice also must include a copy of the divorce decree or decree of legal separation. A notice of disability also must include the name of the disabled qualified beneficiary and a copy of the SSA's determination. If a qualified beneficiary is determined by the SSA to no longer be disabled, the notice of such determination also should include a copy of the SSA's determination.

Notice of a qualifying event or disability determination must be given using the group health plan's form. A copy of the necessary form may be obtained without charge by contacting the Administrator or COBRA Administrator.

Electing Continuation Coverage

To elect continuation coverage, you must complete the group health plan's election form and furnish it according to the directions of the form and the notice procedures specified above (see "Notice Procedures"). A copy of the required election form may be obtained from the Administrator or COBRA Administrator at no charge. Failure to make a timely written election will result in loss of the right to elect continuation coverage under the group health plan.

Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee's spouse may elect continuation coverage even if the employee does not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A covered employee or a qualified beneficiary that is (or was) the spouse of the covered employee may elect COBRA continuation coverage on behalf of all other qualified beneficiaries with respect to the qualifying event. In addition, a parent or legal guardian may elect COBRA continuation coverage on behalf of a minor child.

In considering whether to elect continuation coverage, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

Additional information about whether to elect COBRA continuation coverage is available in Notice 98-12, which was prepared by the Internal Revenue Service and the Department of Labor and is available on the internet at www.dol.gov/ebsa. You also may contact the Administrator to obtain a copy of Notice 98-12.

Cost of Continuation Coverage

Generally, each qualified beneficiary is required to pay the entire cost of continuation coverage. The amount a qualified beneficiary will be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. You should contact the Administrator or COBRA Administrator for the required payment for continuation coverage.

Payment For Continuation Coverage

If you elect continuation coverage, you do not have to send any payment with the election form, but you will not be covered under the group health plan until you make timely payment. You must make your first payment for continuation coverage not later than 45 days after the date of your election. (The date of your election is the date the election form is postmarked, if mailed.) If you do not make your first payment for continuation coverage in full within this 45-day period, you will lose all COBRA continuation coverage rights under the group health plan.

After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent month of coverage. Although periodic payments are due on the applicable due date, you will be given a grace period of 30 days to make each periodic payment. Your continuation coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that payment. If you do not make your payment on

the applicable due date, however, the group health plan may elect to suspend your coverage until payment is made, with coverage reinstated retroactively if payment is made within the grace period. If your coverage is suspended, any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated. If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to COBRA continuation coverage under the group health plan.

You are responsible for making sure your payment amounts are correct. You may contact the Administrator or COBRA Administrator to confirm the correct amount of your payments. Your payments for continuation coverage must be sent to the COBRA Administrator listed at the beginning of this Summary Plan Description.

Conversion Rights

If a qualified beneficiary's COBRA continuation coverage ends because the qualified beneficiary has reached the end of the maximum coverage period described above (see "Length of COBRA Continuation Coverage"), a conversion insurance option may be available. In general, a qualified beneficiary may have the right to convert group health plan coverage to an individual policy of group health insurance if the qualified beneficiary applies promptly under the terms and conditions of the conversion provisions (if any) contained in the group health plan. For more information concerning conversion policies, please contact the COBRA Administrator.

Early Cessation of COBRA Continuation Coverage

COBRA continuation coverage will be terminated prior to the expiration date of the continuation period otherwise applicable (see "Length of COBRA Continuation Coverage" above) under the following circumstances:

- (a) The employer (including any affiliate of the employer) ceases to provide any group health plan to any employee;
- (b) Any required premium is not paid in full on time;
- (c) A qualified beneficiary becomes covered, after electing COBRA continuation coverage, under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition (other than an exclusion or limitation that does not apply to, or is satisfied by, such beneficiary by reason of chapter 100 of title 26, part 7 of subtitle B of ERISA);
- (d) A qualified beneficiary becomes enrolled in Medicare (under Part A, Part B, or both) after electing COBRA continuation coverage; or
- (e) If a qualified beneficiary is receiving extended disability coverage, upon a final determination under Title II or XVI of the Social Security Act that the disabled qualified beneficiary is no longer disabled, in which case coverage will end the month that begins more than 30 days following the date of such determination.

Continuation coverage may also be terminated for any reason the group health plan would terminate coverage of a participant or dependent not receiving continuation coverage (such as fraud).

Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the COBRA Administrator (or Plan Administrator, if there is no separate COBRA Administrator). For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.healthcare.gov.

Address Changes and Records

You should let the Administrator and COBRA Administrator, as applicable, know about any changes in the addresses of participants or beneficiaries under the group health plan that are, or may become, qualified beneficiaries under the group health plan. You should also keep a copy, for your records, of any notices you provide.

5. Claims

5.1 Claims for Benefits. To obtain benefits from an insurance contract or self-funded arrangement you must follow the claims procedures under the applicable insurance contract or self-funded arrangement. Such procedures may require you to complete, sign, and submit a written claim on the insurance carrier's or Plan Administrator's claim form. Forms are available from the insurance carrier or Plan Administrator, as applicable. The insurance carrier or Plan Administrator will decide your claim in accordance with its reasonable claims procedures, as required by ERISA. If the insurance carrier or Plan Administrator denies your claim, in whole or in part, you will receive a written notification setting forth the reasons(s) for the denial.

5.2 Denial of Claim. If your claim is denied, you may appeal to the insurance carrier or Plan Administrator for a review of the denied claim. The insurance carrier or Plan Administrator will decide the claim appeal in accordance with its reasonable claim procedures, as required by ERISA. If you fail to appeal on time, you may lose the right to file suit in a state or federal court, as you will not have exhausted your internal administrative appeal rights (which is generally a prerequisite to bringing a suit in state or federal court). For more information and details regarding claims procedures for the various coverages available under the Plan, you should refer to the applicable claims procedures in the attached Benefit Descriptions.

6. General Information

6.1 Plan Amendment. The IMA Financial Group, Inc. reserves the right to amend any plan, or any coverage available under any plan, in any manner, at will, and at any time, including, but not limited to, retiree medical coverage (if any) offered under any plan. No one will acquire any vested (nonforfeitable) right to have benefits, costs, or other plan provisions remain unmodified or in effect.

6.2 Plan Termination. The IMA Financial Group, Inc. specifically reserves the right to terminate any plan, or any coverage available under any plan, in whole or in part, at will, and at any time.

- 6.3 Erroneous Payments.** If you, or your dependent or any other person, receives any amount of benefits that the Plan Administrator in its sole discretion later determines that you were not entitled to receive under the terms of any plan, you are required to make reimbursement to the plan. In addition, the Plan Administrator has the right to offset any future claims for benefits against amounts that you were not otherwise entitled to receive.
- 6.4 Fraud or Misrepresentation.** If any person obtains coverage and/or benefits or other payments under the Plan by reason of any direct or indirect act of fraud or misrepresentation (including fraud or misrepresentation by omission), as determined by the Plan Administrator in its sole discretion, such individual will be required to make restitution to, and/or pay any direct or indirect fees, expenses, costs, losses, or other damages suffered by, the Plan and/or the employer by reason of such act of fraud or misrepresentation in such amount or amounts as may be determined by the Plan Administrator, in its sole discretion. The Plan Administrator also may take such other and further action with respect to such individual as it deems necessary or appropriate, including, but not limited to, retroactively terminating such individual's participation in the Plan (in whole or in part).
- 6.5 Additional Questions.** This Summary Plan Description is a summary of provisions and cannot answer all questions which might arise. Please contact the Plan Administrator about any questions you might have.
- 6.6 Additional Information.** Copies of the following items may be obtained from the Plan Administrator or the insurance carrier:
- (a) The plan procedures governing qualified medical child support orders (there is no charge for this document);
 - (b) A list of any provider networks; and
 - (c) The current premium cost.
- 6.7 Compliance with Law.** The Plan and its component benefits are intended to comply with, and will be interpreted, construed, and administered in a manner that complies with, the requirements of all applicable laws, including (to the extent applicable) ERISA, HIPAA, COBRA, USERRA, the Newborns' and Mothers' Health Protection Act, the Women's Health and Cancer Rights Act, the Family and Medical Leave Act, the Mental Health Parity Act, the Mental Health Parity and Addiction Equity Act, the Health Information Technology for Economic and Clinical Health Act, Michelle's Law, the Genetic Information Nondiscrimination Act, the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act, and the Internal Revenue Code.

7. Statement of ERISA Rights

As a participant in the Plan, you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine without charge at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts

and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under such plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of an 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 you and other 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 welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from a 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 the materials and pay you up to \$110 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. If it should happen that plan fiduciaries misuse a 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. In all cases, however, you may not file suit in federal court unless and until you have exhausted any and all administrative remedies and review procedures available to you by law or under the terms of the Plan. 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.

Assistance With Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have

any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C., 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

8. Benefit Descriptions

The Benefit Descriptions provide additional information regarding the specific terms and provisions of the coverages available to you under the Plan. You are encouraged to carefully review the Benefit Description in its entirety. **You should pay particular attention to the limitations and exclusions described in the Benefit Descriptions, and any required conditions precedent to receiving benefits (e.g., prior authorization), before incurring any claim for benefits.** In addition, coverage may be reduced or unavailable for goods or services obtained out of network.



**IMA GROUP HEALTH AND
FLEXIBLE SPENDING ACCOUNT
PLAN
SUMMARY PLAN DESCRIPTION**

**HEALTH CARE SPENDING
ACCOUNT**

JANUARY 1, 2015

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**THE IMA FINANCIAL GROUP, INC.
IMA GROUP HEALTH AND FLEXIBLE SPENDING ACCOUNT PLAN
SUMMARY PLAN DESCRIPTION
HEALTH CARE SPENDING ACCOUNT**

INTRODUCTION

This Summary Plan Description is designed to explain some of the more important terms and provisions of the health care spending account option available under the IMA Group Health and Flexible Spending Account Plan (the "Plan"). This is only a summary of the Plan and the health care spending account option available under the Plan, and it may omit details which may be of importance to you in a given situation. If there is any conflict between the Summary Plan Description and the formal Plan documents, the terms and conditions of the Plan documents will control. The Plan Administrator has full power to administer the coverage described herein, including without limitation, the power to make discretionary interpretations regarding the terms and provisions of any plan and to make factual findings with respect to any issue arising under any plan, its interpretation to be final and conclusive on all persons.

This document should be attached to the Benefit Description for the health care spending account option that has been provided to you. If you have lost or misplaced your Benefit Description, a replacement will be furnished without cost to you upon request to the Plan Administrator. This document, along with such Benefit Description, constitutes the Summary Plan Description for the health care spending account option available under the IMA Group Health and Flexible Spending Account Plan. If there is any conflict between the terms of the Benefit Description and this document, the terms of this document will control.

If you have any questions or wish to see the formal Plan documents, please contact the Plan Administrator.

Notice Under Newborns' and Mothers' Health Protection Act of 1996

Group health plans and health insurance issuers offering group insurance coverage generally 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 caesarian section, or require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of the above periods.

Notice Under Women's Health and Cancer Rights Act of 1998

Federal law provides that group health plans and health insurance issuers providing health insurance coverage in connection with group health plans must provide certain medical and surgical benefits with respect to a mastectomy. If you are a participant in the plan, or a beneficiary of the plan, and you receive benefits in connection with a mastectomy and you elect breast reconstruction in connection with that mastectomy, the plan must provide coverage for: reconstruction of the breast on which the mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; prostheses; and, physical complications of all stages of mastectomy including lymphedemas. The above coverage is subject to any deductibles and co-insurance provisions contained within the plan.

Grandfathered Plan Notice

The IMA Group Health and Flexible Spending Account Plan believes it is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the “Affordable Care Act”). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the Plan may not include certain provisions of the Affordable Care Act that apply to nongrandfathered plans. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at (316) 267-9221. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Limitations and Reservation of Rights

NO PLAN MAINTAINED BY THE IMA FINANCIAL GROUP, INC. OR ANY AFFILIATE IS INTENDED TO CREATE ANY CONTRACTUAL RIGHT OF EMPLOYMENT, AND NOTHING CONTAINED THEREIN OR IN THIS SUMMARY PLAN DESCRIPTION SHALL BE CONSTRUED AS A GUARANTEE OF EMPLOYMENT FOR ANY SPECIFIC PERIOD OF TIME OR FOR ANY SPECIFIC TYPE OF WORK.

THE IMA FINANCIAL GROUP, INC. RESERVES ALL RIGHTS TO MAKE CHANGES AT ANY TIME IN THE BENEFITS, COSTS, AND OTHER PROVISIONS RELATIVE TO ANY BENEFIT PLAN, INCLUDING, BUT NOT LIMITED TO, RETIREE MEDICAL PROVISIONS (IF ANY). THOSE CHANGES COULD INCLUDE THE COMPLETE TERMINATION OF BENEFITS FOR ALL INDIVIDUALS OR CERTAIN GROUPS OF INDIVIDUALS. NO EMPLOYEE, SPOUSE, OR DEPENDENT WILL ACQUIRE ANY VESTED (NONFORFEITABLE) RIGHT TO HAVE BENEFITS OR OTHER PROVISIONS OF THE PLAN REMAIN UNMODIFIED OR IN EFFECT. IN ADDITION, YOUR EMPLOYER RESERVES ALL RIGHTS TO MAKE CHANGES AT ANY TIME IN THE COSTS OR CONTRIBUTIONS RELATIVE TO ANY BENEFIT PLAN OR OPTION, NOTWITHSTANDING ANY ACTUAL OR ALLEGED AGREEMENT, DOCUMENT, OR OTHER COMMUNICATION TO THE CONTRARY.

NOTE: The information contained in the following IMA pages supersede any conflicting or inconsistent information found in the attached plan description.

PLAN ADMINISTRATION

Name of Plan and Plan Number

Plan Name

Plan Number

IMA Group Health and Flexible Spending Account Plan

501

The health care spending account option described in this Summary Plan Description is offered as part of the IMA Group Health and Flexible Spending Account Plan.

Employer (Plan Sponsor) and Address

The IMA Financial Group, Inc.
8200 E. 32nd Street North
Wichita, KS 67226

A complete list of other employers sponsoring the plan (if any) may be obtained by participants and beneficiaries upon written request to the Plan Administrator.

Employer Identification Number

48-0805634

Plan Administrator

The IMA Financial Group, Inc.
8200 E. 32nd Street North
Wichita, KS 67226
(316) 267-9221

Plan Administration

The Plan is administered by The IMA Financial Group, Inc.

Claims Administration

For Plan Year 2015: PayFlex Systems USA, Inc., P.O. Box 3039, Omaha, NE, 68103-3039, provides certain administrative services to the Plan, including review and payment of claims for health care spending account benefits and COBRA Administration.

For Plan Year 2016: NueSynergy, 10901 Granada Lane, Leawood, KS, 66211, provides certain administrative services to the Plan, including review and payment of claims for health care spending account benefits and COBRA Administration.

COBRA Administration

The Consolidated Omnibus Budget Reconciliation Act of 1985 (“COBRA”) and the Uniformed Services Employment and Reemployment Rights Act of 1994 (“USERRA”) enable employees to continue group health plan coverage for certain periods of time. In order to preserve certain important rights under COBRA and/or USERRA, you may be required to provide certain notices to the Plan Administrator or COBRA Administrator(s) within specified times as provided by applicable law and Plan rules. (See the “Continuation Coverage” section of this Summary Plan Description). The Plan Administrator is the COBRA Administrator for group health coverage under the Plan. All notices or information regarding COBRA coverage required to be given to the COBRA Administrator must be given to the Plan Administrator.

Agent for Service of Legal Process

Ms. SueAnn V. Schultz
The IMA Financial Group, Inc.
8200 E. 32nd Street North
Wichita, KS 67226

Service of legal process may also be made upon the Plan Administrator.

Plan Year

The Plan operates on a 12-month period commencing January 1. In general, accounting is done as of the last day of the plan year.

ELIGIBILITY AND ENROLLMENT

Eligibility

Generally, all employees who are regularly scheduled to work 20 or more hours per week, who normally work 12 months each plan year, who have been employed for at least 30 days, and who satisfy all other conditions established by the Plan and the Benefit Description are eligible to participate in health care spending account coverage under the Plan's health care spending account option on the first day of the month following or coincident with their eligibility date, provided they enroll within the time limitations established by the Plan Administrator.

Continuing Eligibility

Generally, your participation in health care spending account coverage under the Plan's health care spending account option will continue until the earliest of: (i) the date the health care spending account coverage described in this Summary Plan Description is no longer offered under this Plan; (ii) the date on which the Plan terminates; (iii) the day you no longer satisfy the eligibility requirements for health care spending account coverage; (iv) the end of the period for which any required contribution was last paid; or (v) the date coverage terminates under the Benefit Description.

Eligibility When Re-Employed

Generally, if you quit working after becoming eligible to participate and return to work during the same plan year the following rules will apply:

- If re-employment occurs within 30 days and during the same plan year, you will not be allowed to make a new election but will be required to continue the same election in place at the time you terminated employment, subject to recognized changes in status occurring during your absence. If re-employment occurs within 30 days but during the following plan year, you will be permitted to make a different election than was in place at the time you terminated employment and will be immediately eligible for coverages offered under the Plan (no waiting period will apply). If you elect to resume or commence coverage, or if coverage resumes automatically, coverage will resume or commence as of the first day of the calendar month immediately following the return to service.

- If re-employment occurs after 30 days but within 91 days, you will be permitted to make a different election than was in place at the time you terminated employment and will be immediately eligible for coverages offered under the Plan (no waiting period will apply). If you elect to resume or commence coverage, coverage will resume or commence as of the first day of the calendar month immediately following the return to service.
- If re-employment occurs after 91 days, upon return to active employment you will be treated as a new employee and permitted to enter into a new election after again satisfying the applicable eligibility requirements, including any applicable waiting period.

Enrollment Procedures

When you become eligible to participate in health care spending account coverage under the Plan, you may request that the Plan Administrator provide you with enrollment information. A new participant who fails to make an election for health care spending account coverage will be deemed to have elected not to participate in health care spending account coverage under the Plan. The following rules also apply:

- There will be an annual re-enrollment of all eligible employees during the enrollment period established by the Plan Administrator. Subject to the Plan Administrator's discretion in holding open enrollment, you will have the opportunity to decide each year to what extent you want to participate in health care spending account coverage under the Plan. The election you make during this time period will be effective for the next plan year.
- **An employee who has previously elected to participate in health care spending account coverage under the Plan but fails to return a new enrollment form for any subsequent plan year will be deemed to have made the same election as was in effect just prior to the end of the preceding plan year.** Such participant will also be deemed to have agreed to a reduction in compensation for the subsequent plan year equal to the participant's share of the cost (as determined by the employer) of providing such coverage.

Irrevocability of Election

Any pre-tax election you make under the IMA Flexible Benefits Plan cannot be changed by you during the plan year unless such change is permitted under such plan. Any revocation or change of election made by you must be made in writing and must be proximate in time to the occurrence of the circumstances giving rise to the revocation or change. No revocation or change will be accepted more than 30 days after the occurrence giving rise to the revocation or change. Any new election generally will be prospectively effective as of the first day of the month following receipt of timely notice.

Generally, changes under the IMA Flexible Benefits Plan are permitted in accordance with the following:

- You may be allowed to revoke your election and make a new election if you have a change in status and your election change is consistent with your change in status. Permissible status changes include the following:

- ❖ Events that change your legal marital status including marriage, death of a spouse, divorce, legal separation, or annulment.
 - ❖ Events that change the number of your dependents including birth, death, adoption, or placement for adoption.
 - ❖ Any of the following events that change your employment status or that of your spouse or dependent: termination or commencement of employment, a strike or lockout, a commencement or return from an unpaid leave of absence, a change in worksite or a change in employment status with the consequence that the individual becomes or ceases to be eligible to participate in a cafeteria plan or other employee plan benefit of such person.
 - ❖ Events that cause your dependent to satisfy or cease to satisfy the requirements for coverage including attainment of a specified age, changes in student status, or other similar circumstance.
 - ❖ A change in the place of residence or worksite of you or your spouse or dependent.
 - ❖ Any other change or revocation which the Plan Administrator determines will allow a change or revocation of an election during the plan year under the regulations or rulings of the Internal Revenue Service.
- In addition to the foregoing status changes, the following changes will also be allowed:
- ❖ In the case of a plan subject to the Health Insurance Portability and Accountability Act of 1996 you may be allowed to revoke an election for coverage under a group health insurance plan during a period of coverage and make a new election that corresponds with the special enrollment rights provided in Code Section 9801(f).
 - ❖ A conforming election under a judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order) that requires accident or health insurance coverage for your child or for a foster child who is your dependent (the foregoing includes an election to provide coverage for the child if the order requires coverage for the child under your plan and cancellation of coverage for the child if the order requires the spouse or former spouse or other individual to provide coverage for the child and that coverage is in fact provided).
 - ❖ If you or your spouse or dependent is enrolled in an accident or health plan of the employer and become enrolled under Medicare Part A or Part B of Title XVIII of the Social Security Act or Title XIX of the Social Security Act (other than coverage consisting solely of benefits described in Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines)) you may make a prospective election to cancel or reduce coverage for that individual.
 - ❖ If you or your spouse or dependent loses coverage under Medicare or Medicaid,

a prospective election may be made to commence or increase coverage of that individual.

- You may also be allowed to revoke a benefit election agreement for the balance of a plan year and make a new prospective election change if both the revocation and new election change is on account of and corresponds to an election change made under another employer's plan if (i) the other cafeteria plan or qualified benefit plan permits participants to make an election change under applicable IRS rules, or (ii) the plan year of this plan is different from the period of coverage under the other cafeteria plan or other qualified benefits plan.
- Also, if the cost of qualified benefits significantly increase or decrease during the plan year, the Plan Administrator may allow you to make a corresponding change in your election. Further, if you or your spouse or dependent experience a significant curtailment of coverage, the Plan Administrator may allow you to make certain prospective changes in your election.

Special rules applicable to leaves under the Family and Medical Leave Act of 1993 ("FMLA") are set forth in the plan documents.

Caution: Your ability to obtain or otherwise modify coverages under some of the above rules may be limited by the rules and requirements of the applicable plan and/or any insurance carrier or HMO providing underwriting and/or benefits under such plan. You should refer to such rules and requirements prior to choosing to eliminate or otherwise modify any coverages for yourself and/or an affected spouse or dependent.

To insure that special nondiscrimination rules governing the IMA Flexible Benefits Plan are satisfied, the Plan Administrator may take whatever action is necessary to assure compliance with these rules. This action may include modifying or reducing your salary reduction election.

CONTINUATION COVERAGE

The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") enables employees that experience a "qualifying event" to continue group health plan coverage for 18, 29, or 36 months depending upon the nature of the "qualifying event."

COBRA continuation coverage can become available to you and to other members of your family who are covered under a group health plan when you or your covered family members would otherwise lose your group health coverage. This section of your Summary Plan Description explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

Description of COBRA Continuation Coverage

COBRA continuation coverage is a continuation of group health insurance coverage when coverage would otherwise end because of an event known as a "qualifying event." Specific qualifying events are listed below. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under a group health plan because of a qualifying event. Depending on the type of

qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

Qualifying Events

If you are an employee, you will become a qualified beneficiary if you lose group health plan coverage because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are a spouse of an employee, you will become a qualified beneficiary if you lose group health plan coverage because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes enrolled in Medicare (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose group health plan coverage because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes enrolled in Medicare (under Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

When COBRA Continuation Coverage is Available

COBRA continuation coverage will be offered to qualified beneficiaries only after the Administrator has been timely notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming enrolled in Medicare (under Part A, Part B, or both), the Employer must notify the Administrator of the qualifying event within 30 days of any of these events.

A Qualified Beneficiary Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), a qualified beneficiary must provide written notice of the qualifying event to the Administrator within 60 days after the qualifying event occurs, using the group health plan's notice procedures. If written notice of the qualifying event is not provided to the Administrator within this 60-day period, a spouse or dependent child that would otherwise lose group health plan coverage will not be given the opportunity to continue coverage.

How COBRA Continuation Coverage is Provided

Once the Administrator receives a timely notice that a qualifying event has occurred, COBRA continuation coverage will be offered to the qualified beneficiaries who are recognized by the group health plan as being entitled to elect COBRA continuation coverage with respect to the qualifying event. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. A covered employee or a qualified beneficiary that is (or was) the spouse of the covered employee may elect COBRA continuation coverage on behalf of all other qualified beneficiaries with respect to the qualifying event. In addition, a parent or legal guardian may elect COBRA continuation coverage on behalf of a minor child.

A qualified beneficiary must elect COBRA continuation coverage within 60 days after the date notice of the right to elect COBRA continuation coverage is provided to the qualified beneficiary. If a qualified beneficiary does not elect continuation coverage within the 60-day election period, the qualified beneficiary will lose his or her right to elect continuation coverage.

Length of COBRA Continuation Coverage

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming enrolled in Medicare (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child under the group health plan, COBRA continuation coverage may last for up to a total of 36 months after the date of the qualifying event.

When the qualifying event is the end of employment or reduction of the employee's hours of employment and the employee became enrolled in Medicare less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee may last for up to 36 months after the date of enrollment in Medicare. For example, if a covered employee becomes enrolled in Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare enrollment, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months after the date of the qualifying event. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability Extension of 18-Month Period of Continuation Coverage

If any qualified beneficiary is determined by the Social Security Administration (SSA) to be disabled and a qualified beneficiary provides timely written notice of the disability to the COBRA Administrator, all qualified beneficiaries receiving COBRA continuation coverage with respect to the same covered employee may be entitled to receive up to 11 additional months of COBRA continuation coverage, for a total maximum of up to 29 months after the date of the qualifying event. The SSA's determination of disability must occur either before or during the first 60 days after the date of the qualifying event, and the disability must last at least until the end of the first 18 months after the date of the qualifying event. In general, a qualified beneficiary giving notice of a disability must provide written notice of the SSA's determination to the COBRA Administrator within 60 days after the latest of (i) the date of the SSA's determination, (ii) the date of the qualifying event, or (iii) the date the qualified beneficiary loses (or would lose) coverage under the Plan as a result of the qualifying event. In all events, a qualified beneficiary must give notice of a disability before the end of the first 18 months after the date of the qualifying event. The qualified beneficiary must follow the notice procedures specified below (see "Notice Procedures"). Notice must be given to the COBRA Administrator. If the notice procedures are not followed or timely written notice is not provided, there will be no extension of COBRA continuation coverage.

Each qualified beneficiary who has elected continuation coverage with respect to the same covered employee will be entitled to the 11-month disability extension if one of them qualifies. If the disabled qualified beneficiary is determined by the SSA to no longer be disabled, written notice of that fact must be given within 30 days after the SSA's determination using the notice procedures specified below (see "Notice Procedures"). Notice must be given to the COBRA Administrator. Continuation coverage will cease for all qualified beneficiaries on the first day of the month that is 30 days after the date the SSA determines that the qualified beneficiary is no longer disabled. If timely written notice is not given that the qualified beneficiary is no longer disabled, coverage for all qualified beneficiaries may be retroactively cancelled and restitution to the group health plan may be required.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If, while receiving 18 months of COBRA continuation coverage, a qualified beneficiary experiences another qualifying event that would have caused the qualified beneficiary to lose group health plan coverage if the first qualifying event had not occurred, the qualified beneficiary may get up to 18 additional months of COBRA continuation coverage, for a maximum of up to 36 months, if timely written notice of the second qualifying event is properly given to the COBRA Administrator. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes enrolled in Medicare (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the group health plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the group health plan had the first qualifying event not occurred. In all of these cases, timely written notice of the second qualifying event must be given within 60 days after the date of the second qualifying event. The qualified beneficiary must follow the notice procedures specified below (see "Notice Procedures"). Notice must be given to the COBRA Administrator. If the notice procedures are not followed or timely written notice is not provided, there will be no extension of COBRA continuation coverage.

Notwithstanding the foregoing provisions, COBRA continuation coverage will not be made available to any qualified beneficiary under a plan constituting a health care spending account plan for any plan year after the end of the plan year in which a qualifying event occurs if the following conditions are satisfied: (i) the plan is a health care spending account plan and excepted from compliance under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and (ii) the annual premium payment for COBRA continuation coverage equals or exceeds the maximum benefit available under the plan for the plan year.

Notice Procedures

Any notice you provide must be in writing. Oral notice, including notice by telephone, is not acceptable. You must deliver your written notice to the Administrator at the addresses listed at the beginning of this Summary Plan Description. If you mail your notice, it must be postmarked not later than the last day of the required notice period.

Any notice you provide must include the following:

- The name of the group health plan.
- The name and address of the employee covered under the group health plan.
- The name(s) and address(es) of the qualified beneficiary(ies).
- If the notice is a notice of a qualifying event or second qualifying event, the name of the qualifying event and the date it happened.

If the qualifying event is divorce or legal separation, the notice also must include a copy of the divorce decree or decree of legal separation. A notice of disability also must include the name of the disabled qualified beneficiary and a copy of the SSA's determination. If a qualified beneficiary is determined by the SSA to no longer be disabled, the notice of such determination also should include a copy of the SSA's determination.

Notice of a qualifying event or disability determination must be given using the group health plan's form. A copy of the necessary form may be obtained without charge by contacting the Administrator.

Electing Continuation Coverage

To elect continuation coverage, you must complete the group health plan's election form and furnish it according to the directions of the form and the notice procedures specified above (see "Notice Procedures"). A copy of the required election form may be obtained from the Administrator at no charge. Failure to make a timely written election will result in loss of the right to elect continuation coverage under the group health plan.

Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee's spouse may elect continuation coverage even if the employee does not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A covered employee or a qualified beneficiary that is (or was) the spouse of the covered employee may elect COBRA continuation coverage on behalf of all other qualified beneficiaries with respect to the qualifying event. In addition, a parent or legal guardian may elect COBRA continuation coverage on behalf of a minor child.

In considering whether to elect continuation coverage, you should take into account that you

have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

Additional information about whether to elect COBRA continuation coverage is available in Notice 98-12, which was prepared by the Internal Revenue Service and the Department of Labor and is available on the internet at www.dol.gov/ebsa. You also may contact the Administrator to obtain a copy of Notice 98-12.

Cost of Continuation Coverage

Generally, each qualified beneficiary is required to pay the entire cost of continuation coverage. The amount a qualified beneficiary will be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. You should contact the Administrator for the required payment for continuation coverage.

Payment For Continuation Coverage

If you elect continuation coverage, you do not have to send any payment with the election form, but you will not be covered under the group health plan until you make timely payment. You must make your first payment for continuation coverage not later than 45 days after the date of your election. (The date of your election is the date the election form is postmarked, if mailed.) If you do not make your first payment for continuation coverage in full within this 45-day period, you will lose all COBRA continuation coverage rights under the group health plan.

After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent month of coverage. Although periodic payments are due on the applicable due date, you will be given a grace period of 30 days to make each periodic payment. Your continuation coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that payment. If you do not make your payment on the applicable due date, however, the group health plan may elect to suspend your coverage until payment is made, with coverage reinstated retroactively if payment is made within the grace period. If your coverage is suspended, any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated. If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to COBRA continuation coverage under the group health plan.

You are responsible for making sure your payment amounts are correct. You may contact the Administrator to confirm the correct amount of your payments. Your payments for continuation coverage must be sent to the Administrator listed at the beginning of this Summary Plan Description.

Conversion Rights

If a qualified beneficiary's COBRA continuation coverage ends because the qualified beneficiary has reached the end of the maximum coverage period described above (see "Length of COBRA Continuation Coverage"), a conversion insurance option may be available. In general, a qualified beneficiary may have the right to convert group health plan coverage to an individual policy of group health insurance if the qualified beneficiary applies promptly under the terms and conditions of the conversion provisions (if any) contained in the group health plan. For more information concerning conversion policies, please contact the Administrator.

Early Cessation of COBRA Continuation Coverage

COBRA continuation coverage will be terminated prior to the expiration date of the continuation period otherwise applicable (see "Length of COBRA Continuation Coverage" above) under the following circumstances:

- The employer (including any affiliate of the employer) ceases to provide any group health plan to any employee;
- Any required premium is not paid in full on time;
- A qualified beneficiary becomes covered, after electing COBRA continuation coverage, under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition (other than an exclusion or limitation that does not apply to, or is satisfied by, such beneficiary by reason of chapter 100 of title 26, part 7 of subtitle B of ERISA);
- A qualified beneficiary becomes enrolled in Medicare (under Part A, Part B, or both) after electing COBRA continuation coverage; or
- If a qualified beneficiary is receiving extended disability coverage, upon a final determination under Title II or XVI of the Social Security Act that the disabled qualified beneficiary is no longer disabled, in which case coverage will end the month that begins more than 30 days following the date of such determination.

Continuation coverage may also be terminated for any reason the group health plan would terminate coverage of a participant or dependent not receiving continuation coverage (such as fraud).

Address Changes and Records

You should keep the Administrator informed of any changes in the addresses of participants or beneficiaries under the group health plan that are, or may become, qualified beneficiaries under the group health plan. You should also keep a copy, for your records, of any notices you provide.

CLAIMS

Claims for Benefits

To obtain benefits from a self-funded arrangement you must follow the claims procedures under the applicable self-funded arrangement. Such procedures may require you to complete, sign, and submit a written claim on the Plan Administrator's claim form. Forms are available from the Plan Administrator.

The Plan Administrator will decide your claim in accordance with its reasonable claims procedures, as required by ERISA. If the Plan Administrator denies your claim, in whole or in part, you will receive a written notification setting forth the reasons(s) for the denial.

Denial of Claim

If your claim is denied, you may appeal to the Plan Administrator for a review of the denied claim. The Plan Administrator will decide the claim appeal in accordance with its reasonable claim procedures, as required by ERISA. If you fail to appeal on time, you may lose the right to file suit in a state or federal court, as you will not have exhausted your internal administrative appeal rights (which is generally a prerequisite to bringing a suit in state or federal court).

GENERAL INFORMATION

Plan Amendment

The IMA Financial Group, Inc. reserves the right to amend any plan in any manner, at will, and at any time, including, but not limited to, retiree medical coverage (if any) offered under any plan. No one will acquire any vested (nonforfeitable) right to have benefits, costs, or other plan provisions remain unmodified or in effect.

Plan Termination

The IMA Financial Group, Inc. specifically reserves the right to terminate any plan, in whole or in part, at will, and at any time.

Erroneous Payments

If you, or your dependent or any other person, receives any amount of benefits that the Plan Administrator in its sole discretion later determines that you were not entitled to receive under the terms of any plan, you are required to make reimbursement to the plan. In addition, the Plan Administrator has the right to offset any future claims for benefits against amounts that you were not otherwise entitled to receive.

Fraud or Misrepresentation

If any person obtains coverage and/or benefits or other payments under the Plan by reason of any direct or indirect act of fraud or misrepresentation (including fraud or misrepresentation by omission), as determined by the Plan Administrator in its sole discretion, such individual will be required to make restitution to, and/or pay any direct or indirect fees, expenses, costs, losses, or

other damages suffered by, the Plan and/or the employer by reason of such act of fraud or misrepresentation in such amount or amounts as may be determined by the Plan Administrator, in its sole discretion. The Plan Administrator also may take such other and further action with respect to such individual as it deems necessary or appropriate, including, but not limited to, retroactively terminating such individual's participation in the Plan (in whole or in part).

Additional Questions

This Summary Plan Description is a summary of provisions and cannot answer all questions which might arise. Please contact the Plan Administrator about any questions you might have.

Additional Information

Copies of the following items may be obtained from the Plan Administrator or the insurance carrier:

- The plan procedures governing qualified medical child support orders (there is no charge for this document);
- A list of any provider networks; and
- The current premium cost.

STATEMENT OF ERISA RIGHTS

As a participant in the Plan, you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine without charge at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under such plan as a result of a qualifying event. You or your dependents may have to pay for

such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of an 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 you and other 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 welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from a 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 the materials and pay you up to \$110 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. If it should happen that plan fiduciaries misuse a 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. In all cases, however, you may not file suit in federal court unless and until you have exhausted any and all administrative remedies and review procedures available to you by law or under the terms of the Plan. 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.

Assistance With Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits

Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C., 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

BENEFIT DESCRIPTION

The attached Benefit Description provides additional information regarding the specific terms and provisions of health care spending account coverage available to you under the Plan's health care spending account option. You are encouraged to carefully review the Benefit Description in its entirety.



**IMA
HEALTH CARE SPENDING
ACCOUNT OPTION**

BENEFIT DESCRIPTION

JANUARY 1, 2015

**IMA
HEALTH CARE SPENDING ACCOUNT OPTION
BENEFIT DESCRIPTION**

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**IMA
HEALTH CARE SPENDING ACCOUNT OPTION
BENEFIT DESCRIPTION**

ARTICLE I – INTRODUCTION

Section 1.01. Introduction. This Benefit Description sets forth the terms and provisions of the Health Care Spending Account Option (the “Option”) under the IMA Group Health and Flexible Spending Account Plan (the “Plan”). If there is any conflict between this document and the Plan document, the terms and conditions of the Plan document will control. The Plan Administrator has full power to administer the Option and the Plan, including, without limitation, the power to make discretionary interpretations regarding the terms and provisions of any plan or arrangement and to make factual findings with respect to any issue arising under any plan or arrangement, its interpretation to be final and conclusive on all persons. If you have any questions or wish to see the Plan document, please contact the Plan Administrator.

Section 1.02. Separate Plan/Option. This Option is one of several benefit coverages available pursuant to the Plan. Coverage pursuant to this Option shall not entitle an individual to coverage pursuant to any other benefit coverages available under the Plan.

ARTICLE II – DEFINITIONS

Where the following words and phrases appear in this Description, they shall have the respective meaning as set forth in this Article unless the context clearly indicates to the contrary.

Section 2.01. Administrator or Plan Administrator means the Company or one or more person(s) or entities designated by the Company to carry out the various administrative duties with respect to this Option and the Plan in a manner consistent with the terms of the Plan and ERISA.

Section 2.02. Benefit Description or Description means this document describing the benefits available under the Option.

Section 2.03. Cafeteria Plan means the IMA Flexible Benefits Cafeteria Plan. The terms “Cafeteria Plan” and “Flexible Benefits Plan” are used interchangeably herein.

Section 2.04. Calendar Year means the 12-month period commencing January 1.

Section 2.05. Claims Administrator means the person(s) or entities duly authorized by the Company and/or the Plan Administrator to administer all or part of the Option or Plan.

Section 2.06. Code means the Internal Revenue Code of 1986, as amended from time to time, and corresponding provisions of future United States revenue laws along with any applicable proposed, temporary or final regulations issued by the United States Treasury.

Section 2.07. Company means The IMA Financial Group, Inc. and any successor thereto.

Section 2.08. Dependent means, for purposes of this Option, a Participant's spouse and any dependent within the meaning of Code Section 105(b), including a child of the Participant (as defined in Code Section 152(f)(1)) who has not attained age 27 by the end of the taxable year, who is eligible for reimbursement of Qualifying Medical Care Expenses.

Section 2.09. Eligible Employee means a full-time Employee of the Employer. In no event shall the term "Eligible Employee" include any individual classified, treated or otherwise characterized by the Employer as an independent contractor, consultant, leased employee, temporary agency employee or otherwise not treated by the Employer as an "Eligible Employee" for purposes of this Option. The term "Eligible Employee" shall not include any individual who is self-employed within the meaning of Code Section 401(c)(1) or who is treated as a partner under Code Section 1372, and no such deemed partner, actual partner, or other self-employed person may participate in this Option. In addition, the term "Eligible Employee" shall not include any individual covered under the provisions of a collective bargaining agreement unless such collective bargaining agreement specifically provides for participation in this Option. The foregoing determination of whether an individual constitutes an "Eligible Employee" for purposes of this Option shall be made by the Employer subject to the approval and consent of the Plan Administrator in its sole discretion. Said determination shall apply for all purposes of this Option and regardless of whether such individual is later classified by any governmental agency, court, tribunal, governing body or any other person or entity as a common law employee of the Employer. It is the intent hereof that the Employer, subject to the approval and consent of the Plan Administrator in its sole discretion, shall decide which individuals are classified as Eligible Employees for purposes of this Option.

Section 2.10. Employee means an individual who is employed and compensated (by (i) a payroll check issued directly from the Employer or Employer agent to the individual, (ii) direct payroll deposit made to the individual's account by the Employer or Employer agent, or (iii) other similar means of direct payment by the Employer or Employer agent, such as electronic pay card or debit card) by the Employer.

Section 2.11. Employer means the Company and any affiliated employer within the meaning of Code Section 414(b), (c) or (m) which adopts the Plan for the benefit of its Employees, provided the Employer has not specifically excluded this Option.

Section 2.12. Enrollment Period means the time period established by the Plan Administrator in which benefit elections must be made.

Section 2.13. Entry Date means the first day of the month following or coincident with an Eligible Employee's satisfaction of this Option's eligibility requirements.

Section 2.14. ERISA means the Employee Retirement Income Security Act of 1974, as amended from time to time, and corresponding provisions of similar, future United States laws dealing with employee benefit plans.

Section 2.15. Health Care Spending Account means the account described in Article V.

Section 2.16. Health Insurance Portability and Accountability Act ("HIPAA") means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time.

Section 2.17. Highly Compensated Employee means an individual defined by Code Section 105(h) and/or Code Section 125. For purposes of the determination whether an individual is a Highly Compensated Employee within the meaning of Code Section 125, the “top-paid group rule” of Code Section 414(q) will apply.

Section 2.18. Key Employee means an individual defined by Code Section 416(i)(1).

Section 2.19. Membership Costs means the Employee’s contribution for the Employee’s share of the cost of selected coverages under this Option.

Section 2.20. Option means this Health Care Spending Account Option offered pursuant to the Plan.

Section 2.21. Participant means any Eligible Employee who is qualified in accordance with Article III, and who remains as such under this Option. Where the context requires, the term “Participant” shall also include a former Participant.

Section 2.22. Plan means the IMA Group Health and Flexible Spending Account Plan, together with any and all amendments and supplements thereto.

Section 2.23. Qualified Beneficiary has the meaning set forth in the Plan.

Section 2.24. Qualifying Event has the meaning set forth in the Plan.

Section 2.25. Qualifying Medical Care Expenses means expenses incurred by a Participant, or Dependent of such Participant, for medical care (excluding insurance premiums) as defined in Code Section 213. Reimbursement for qualifying over-the-counter drugs and medicines will be made only for drugs or medicines that (1) are designated by the Plan Administrator as eligible for reimbursement, and (2) are prescribed or are insulin.

ARTICLE III – ELIGIBILITY

Section 3.01. Eligibility. Each Eligible Employee is eligible to participate in this Option on the first Entry Date after his or her date of hire (subject to the limitations set forth in the Company’s Flexible Benefits Plan), provided such Eligible Employee has satisfied all of the eligibility requirements set forth below and provided such Eligible Employee is still employed on such date. To be eligible to participate in this Option, an Eligible Employee must meet all of the following requirements:

- A. Agree and elect in the manner established by the Plan Administrator to reduce his or her compensation for purposes of payment of Membership Costs under this Option;
- B. Be regularly scheduled to work 20 or more hours per week;
- C. Normally work 12 months each Plan Year; and

- D. Have been employed for at least 30 days.

Section 3.02. Cessation of Participation. In general, a Participant will cease to participate in this Option as of the earliest of the following dates:

- A. The date this Option terminates; or
- B. The date on which the Participant ceases to be an Eligible Employee or otherwise ceases to be eligible under the requirements set forth in Section 3.01.

In the event a Participant ceases to be a Participant as provided for above, any balance in his or her Health Care Spending Account actually deducted or deductible from compensation as of the end of the pay period in which he or she ceases to participate shall remain in such account and the former Participant may continue to submit claims for a 90 day period after the end of the Calendar Year under Article VI for expenses incurred during the Calendar Year prior to the date of such cessation of participation. Any funds remaining in a former Participant's Health Care Spending Account at the end of this period shall be forfeited and made available for purposes of defraying reasonable administrative costs of the Plan. Except as set forth in the "Rehire" provisions of the Flexible Benefits Plan (and except as otherwise provided herein or as otherwise allowed in situations involving change of status), any Employee ceasing participation shall be prohibited from making any new benefit election for the remaining portion of the Calendar Year.

ARTICLE IV – ELECTION TO REDIRECT SALARY

Section 4.01. Election Procedure and Enrollment. For each Calendar Year, each Participant may elect to have such Participant's compensation reduced throughout the Calendar Year and applied by the Employer toward reimbursement of Qualifying Medical Care Expenses under this Option. The maximum amount of any such salary reduction under this Option for a Calendar Year will be \$2,500, as adjusted for inflation under Code Section 125(i)(2), but not to exceed \$5,000. The minimum amount of any such salary reduction will be \$120 per Calendar Year.

Prior to the first pay day in a new Calendar Year, and any other required time of enrollment, the Plan Administrator may provide new enrollment information to each Participant and to each other Eligible Employee who is expected to become eligible for participation. Enrollment must be completed in the manner established by the Plan Administrator during the Enrollment Period which shall terminate prior to the beginning of the first pay period for which the Participant's new election will apply.

A new Participant or Eligible Employee who fails to make an election with respect to this Option on or before the last day of the Enrollment Period shall be deemed to have elected not to participate in this Option.

A Participant who has previously elected (or is deemed to have elected) to participate in this Option but who fails to make an election or re-enroll on or before the last day of the Enrollment Period for any subsequent Calendar Year shall be deemed to have elected not to participate in this Option for the subsequent Calendar Year.

Section 4.02. Irrevocability of Election. Elections made under this Option (or deemed made) shall be irrevocable by the Participant during the Calendar Year subject only to certain changes as provided in Sections 4.04 and 4.05. Any new election allowed hereunder shall be effective at such time as the Plan Administrator shall prescribe and the Claims Administrator can accommodate (e.g., changes generally will be effective as of the first day of the month following receipt of timely notice). In addition, except as otherwise required by law, all elections will be prospective only and must be made in accordance with rules and procedures prescribed by the Plan Administrator. All benefit election changes under this Option must be proximate in time to the occurrence of the event giving rise to the change. Except as otherwise required by law, no revocation or change will be accepted more than 30 days after the occurrence giving rise to the revocation or change.

Section 4.03. Changes by Plan Administrator. The Plan Administrator may take such actions as the Plan Administrator, in its sole discretion, deems appropriate for the operation and maintenance of this Option and/or to assure compliance with all applicable laws and regulations, including, without limitation, modifying elections by Highly Compensated Employees and/or Key Employees without the consent of such individuals and electing to treat this Option as a separate benefit plan.

Section 4.04. Change of Status. A Participant may be allowed to revoke a benefit election agreement for the balance of a Calendar Year and make a new election if both the revocation and the new election are on account of and consistent with a change in status. For purposes of this Option, a change in status includes events that change the Participant's legal marital status including marriage, death of a spouse, divorce, legal separation or annulment; events that change the Participant's number of dependents including birth, death, adoption or placement for adoption; any of the following events that change the employment status of the Participant, the Participant's spouse or dependent: termination or commencement of employment, a strike or lockout, a commencement or return from an unpaid leave of absence, a change in worksite or a change in the employment status of the Participant, or the Participant's spouse or dependent with the consequence that the individual becomes or ceases to be eligible to participate in the cafeteria plan or other employee plan benefit of such person; events that cause the Participant's dependent to satisfy or cease to satisfy the requirements for coverage including attainment of a specified age, changes in student status or any other similar circumstance; a change in the place of residence of the Participant, or the Participant's spouse or dependent; and any other change or revocation which the Plan Administrator determines will allow a change or revocation of an election during the Calendar Year under the regulations or rulings of the Internal Revenue Service.

In addition to the foregoing changes in benefit elections, the following changes will also be allowed: if this Option is subject to HIPAA, a Participant may be allowed to revoke an election for coverage under a group health insurance plan during a period of coverage and make a new election that corresponds with the special enrollment rights provided in Code Section 9801(f); a conforming election under a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody (including a qualified medical child support order) that requires accident or health insurance coverage for the Participant's child or for a foster child who is a dependent of the Participant (the foregoing includes an election to provide coverage for the child if the order requires coverage for the child under the Participant's plan and cancellation of coverage for the child if the order requires the spouse or

former spouse or other individual to provide coverage for the child and that coverage is in fact provided); if a Participant, or the Participant's spouse or dependent who is enrolled in an accident or health plan of the Employer becomes enrolled under Medicare Part A or Part B of Title XVIII of the Social Security Act or Title XIX of the Social Security Act (other than coverage consisting solely of benefits described in Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines)) the Participant may make a prospective election to cancel or reduce coverage for that individual, or if the Participant, or the Participant's spouse, or dependent loses coverage under Medicare or Medicaid, a prospective election may be made to commence or increase coverage of that individual.

Section 4.05. Family Leave. The taking of a leave of absence pursuant to the Family and Medical Leave Act of 1993 ("FMLA") will constitute a change in status for purposes of this Option. Upon the taking of a leave of absence pursuant to the FMLA, Participants will be allowed to completely opt out of coverage. Upon return from an FMLA leave, Participants will be required to continue their election under this Option subject to recognized changes in status occurring during the Participant's absence and either resume coverage at the level in effect before the FMLA leave and make up the unpaid Membership Costs or resume coverage at a level that is reduced and resume Membership Costs at the appropriate level. A Participant continuing coverage under this Option during an FMLA leave will be required to continue paying Membership Costs.

Section 4.06. Timing of Election. All elections, including permitted changes in elections, will be effective at such time as the Plan Administrator will prescribe and the Claims Administrator can accommodate (e.g., elections will be effective as of the first pay period following receipt of timely notice but not earlier than the first day of a month). Under no circumstances will an election to reduce compensation made with respect to this Option be accepted after the beginning of a pay period for which it is to be effective. All elections to reduce compensation must be completed prior to the beginning of the first pay period for which such election is to take effect and compensation is earned.

Section 4.07. Automatic Termination of Election. Except as otherwise provided in Article VII (with respect to COBRA and USERRA continuation), elections made by a Participant under this Option (or deemed made) shall automatically terminate as of the date the Participant ceases to participate in this Option.

ARTICLE V – HEALTH CARE SPENDING ACCOUNTS

Section 5.01. Establishment of Accounts. The Company, or its designated Claims Administrator, will establish and maintain on its books a Health Care Spending Account for each Calendar Year with respect to each Participant who has elected to have his or her compensation reduced, in order to receive reimbursement of Qualifying Medical Care Expenses. The Health Care Spending Account shall be maintained for record keeping purposes only.

Section 5.02. Crediting of Accounts. There shall be credited to a Participant's Health Care Spending Account at the beginning of each Calendar Year an amount equal to the total reduction, with respect to this Option, if any, to be made in the Participant's compensation for

the entire Calendar Year in accordance with the Participant's election and compensation reduction agreement under the Flexible Benefits Plan.

Section 5.03. Debiting of Accounts. A Participant's Health Care Spending Account for each Calendar Year shall be debited from time to time in the amount of any reimbursement pursuant to this Option of Qualifying Medical Care Expenses incurred during such Calendar Year. A Participant's annual contribution to his or her Health Care Spending Account shall be available at all times during the applicable Calendar Year, reduced by prior reimbursements for the same Calendar Year, without regard to Participant contributions actually contributed on the date reimbursement is made.

Section 5.04. Forfeiture of Benefits. The Company's Flexible Benefits Plan absolutely prohibits the carry over from one Calendar Year to the next Calendar Year of amounts dedicated to the payment or reimbursement of amounts under this Option. This Option also provides that no such amounts be used to pay for coverage extending beyond the end of the year. Any such amounts held under this Option after the end of a Calendar Year and not utilized to reimburse Qualifying Medical Care expenses incurred in such Calendar Year on or before 90 days after the end of the Calendar Year will be made available for purposes of defraying reasonable administrative costs of the Plan.

The Flexible Benefits Plan and any corresponding elections made under this Option are intended to comply with applicable provisions of ERISA and the Code, including applicable Treasury Regulations promulgated pursuant to Code Section 125. In that regard, any amount directed or contributed by a Participant under this Option, remaining unexpended or unapplied at the end of any Calendar Year shall be forfeited and not returned to the Participant directly or indirectly in any form, including cash, taxable salary, or any other form of benefits, nor shall this Option or any trust used in conjunction with this Option operate in any manner which would enable any Participant to carry over unused benefits beyond the end of the Calendar Year or which would allow the Participant to otherwise defer the receipt of compensation.

ARTICLE VI – REIMBURSEMENT OF MEDICAL CARE EXPENSES

Section 6.01. Claims for Reimbursement. If offered by the Plan Administrator, a Participant may automatically be reimbursed through electronic means (e.g., debit card) from the Participant's Health Care Spending Account for Qualifying Medical Care Expenses, so long as (1) the Participant has elected such treatment, if applicable, in the manner specified by the Plan Administrator, and (2) the Participant has satisfied all substantiation requirements imposed by the Plan Administrator or Claims Administrator or required by law. All other reimbursements of Qualifying Medical Care Expenses for a Calendar Year may be made by applying to the Administrator for reimbursement of such expenses incurred (an expense is incurred on the date the medical care giving rise to the expense is actually provided) by the Participant during the Calendar Year by submitting an application in writing to the Administrator or its designated Claims Administrator, in such form as the Administrator may prescribe, which application shall include the following information, to the extent relevant:

- A. The amount incurred, date, provider, and nature of the expense with respect to which a benefit is requested;

- B. A written statement from an independent third-party stating that the expense has been incurred and the amount of such expense;
- C. The name of the person, organization, or entity to which the expense was paid or incurred;
- D. The name of the person for whom the expense was incurred and the relationship of such person to the Participant; and
- E. The amount recovered or expected to be recovered, under any insurance arrangement or other plan (including both private and government arrangements and plans) with respect to the expense, or any amount for which the Participant has no obligation to pay, including a written statement that the expense for which payment or reimbursement is sought has not been reimbursed or is not reimbursable under any other plan.

Such application shall be accompanied by such additional documentation as the Plan Administrator (or its designated Claims Administrator) may request, including, but not limited to, bills, vouchers, invoices, receipts or canceled checks. Under no circumstances shall the Plan Administrator (or its designated Claims Administrator) make advance reimbursements of future or projected expenses.

The Plan Administrator (or its designated Claims Administrator) shall deny reimbursement for any Participant's expense that is not sufficiently documented.

Section 6.02. Reimbursement or Payment of Expenses. Upon approval of a claim for reimbursement, the Plan Administrator (or its designated Claims Administrator) shall reimburse to the Participant, from the Participant's Health Care Spending Account for Qualifying Medical Care Expenses incurred during the Calendar Year for which the Participant submits a written application and documentation in accordance with Section 6.01. At the option of the Plan Administrator, the Plan Administrator (or its designated Claims Administrator) may pay any Qualifying Medical Care Expenses directly to the person providing or supplying the medical care in lieu of reimbursing the Participant.

Section 6.03. No Grace Period. This Option does not offer a grace period. Thus, in no case will Participants be allowed to seek reimbursement from unused amounts remaining in their Health Care Spending Account at the end of the Calendar Year for Qualifying Medical Care Expenses incurred after the end of the Calendar Year.

ARTICLE VII – CONTINUATION COVERAGE

Section 7.01. Termination of Employment. Except where the Participant elects to continue coverage for a longer period in accordance with the terms and provisions of the Plan and this Article VII, upon a Participant's termination of employment, or where a Participant otherwise becomes ineligible to participate in this Option, his prior election under this Option and/or the Flexible Benefits Plan to have his compensation reduced toward payment or reimbursement of Qualifying Medical Care Expenses shall terminate in accordance with the Automatic Termination Sections of this Benefit Description and the Flexible Benefits Plan.

Section 7.02. Election to Continue Coverage. Each Qualified Beneficiary who would otherwise lose health coverage benefits under this Option as a result of a Qualifying Event shall be entitled to elect continuation of such coverage if, and to the extent, such election is permitted under the applicable terms and provisions of the Plan and this Article VII. Any such coverage shall be provided in accordance with, and shall be subject to, all applicable provisions of the Plan and this Article VII.

Section 7.03. Health Care Flexible Spending Account Plan. Except for coverage mandated by USERRA, continuation coverage under this Option shall not be made available to any Qualified Beneficiary for any Calendar Year after the end of the Calendar Year in which a Qualifying Event occurs if the following conditions are satisfied: (i) this Option is a health care flexible spending account plan and excepted from compliance under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and (ii) the annual premium payment for COBRA continuation coverage equals or exceeds the maximum benefit available under this Option for the Calendar Year.

ARTICLE VIII – COMPANY

Section 8.01. Company Duties. The Company shall have the authority and responsibility for:

- A. Determining the design of this Option, including the right to amend or terminate this Option;
- B. The qualification of this Option under applicable law;
- C. The crediting of amounts to Health Care Spending Accounts under this Option and the disbursement of reimbursements from such accounts;
- D. The exercise of all functions and powers as may be necessary to the operation of this Option, except such functions as are assigned to others pursuant to this Option.

Section 8.02. Delegation of Duties. The Company may delegate its duties and responsibilities under this Option to other persons.

Section 8.03. Action by Company. Whenever the Company under the terms of this Option is permitted or required to do or perform any act or matter or thing, it shall be authorized by the Company's governing board or body or shall be performed by an officer or other delegate thereunto duly authorized by such board or body.

Section 8.04. Funding Policy and Method. The cost of benefits are provided exclusively by Participant salary reduction elections. Salary reduction amounts paid pursuant to this Option are made during the Calendar Year based upon elections made by the Participant.

ARTICLE IX – ADMINISTRATION

Section 9.01. Administration. This Option and the benefits available pursuant to this Option shall be administered by the Plan Administrator (and/or its designated Claims Administrator) in accordance with, and subject to, the terms and provisions of the Plan. Benefits under this Option will be paid only if the Plan Administrator (and/or its designated Claims Administrator) decides in its discretion that the applicant is entitled to them. The Plan Administrator (and/or its designated Claims Administrator) shall have the discretionary authority to interpret this Benefit Description and shall have full power and authority to administer this Option, and the benefits available pursuant to this Option, in all of its details. However, the Plan Administrator's authority under this Section 9.01 shall not extend to any matter as to which an administrator under any other plan or benefit coverage option is empowered to make determinations.

ARTICLE X – CLAIMS

Section 10.01. Claims. Claims for benefits will be administered in accordance with the applicable provisions of the Plan.

ARTICLE XI – AMENDMENT

Section 11.01. Right to Amend. The Company reserves the right, at will, at any time and from time to time, to modify, alter, or amend this Benefit Description or any other terms and provisions of this Option (including, without limitation, a retroactive modification, alteration, or amendment), in whole or in part, and any such modification, alteration, or amendment shall be binding upon the Plan Administrator, the Claims Administrator, any adopting Employers, the Eligible Employees, the Participants, and all other persons; provided, however, that the duties, powers and liabilities of the Plan Administrator (and/or any Claims Administrator) shall not be substantially increased without the Plan Administrator's (and/or Claims Administrator's) written consent. All amendments to this Benefit Description or any other terms or provisions of this Option shall be in writing.

ARTICLE XII – TERMINATION

Section 12.01. Termination. The Company has established this Option with the bona fide intention and expectation that it will be continued indefinitely, but the Company will have no obligation whatsoever to maintain this Option, or any part of this Option, for any given length of time and may at will, and at any time, discontinue or terminate this Option in whole or in part without liability. In addition, an adopting Employer shall have the right to discontinue or terminate its participation in this Option as to its Employees.

Section 12.02. Termination Procedures. Upon termination of this Option, the Company shall give notice of the same to all Participants, all individuals then receiving benefits under this Option, the Plan Administrator, any Claims Administrator, and any other affected person. Further, upon termination of this Option, all elections and reductions in compensation related to this Option shall terminate.

ARTICLE XIII – HIPAA PRIVACY AND SECURITY

Section 13.01. HIPAA Privacy and Security. If mandated by HIPAA and its accompanying regulations, compliance with 45 C.F.R. Parts 160 and 164, Subparts A and E (the “HIPAA Privacy Rule”) and 45 C.F.R. Parts 160 and 164, Subparts A and C (the “HIPAA Security Rule”) will be governed by the applicable provisions of the Plan.

ARTICLE XIV – MISCELLANEOUS

Section 14.01. Communication to Participants. The Company will notify all Participants of the availability and terms of this Option.

Section 14.02. Limitation of Rights. Neither the establishment of this Option nor any amendment thereof will be construed as giving to any Employee or other person any legal or equitable right against the Plan Administrator, Claims Administrator, Company, Employer, or any other person, except as expressly provided herein, and in no event will the terms of employment or service of any Employee be modified or in any way be affected hereby.

Section 14.03. Nonassignability of Rights. The right of any person to receive any benefit pursuant to this Option shall not be alienable by such person by assignment or any other method (except as otherwise provided in this Benefit Description), and will not be subject to be taken by such person’s creditors by any process whatsoever, and any attempt to cause such right to be so subjected will not be recognized.

Section 14.04. No Guarantee of Tax Consequences. Neither the Plan Administrator, Claims Administrator, Employer, nor the Company makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant will be excludible 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 with respect to salary reduction amounts or otherwise. It shall be the obligation of each Participant to determine whether each payment is excludible from the Participant’s gross income for federal and state income tax purposes, and to notify the Employer if the Participant has reason to believe that any such payment is not so excludible.

Section 14.05. Indemnification of Employer by Participants. Each Participant shall indemnify and reimburse the Employer for any liability the Employer may incur for failure to withhold federal or state income tax, social security tax, unemployment tax, or other required amounts from any payment or reimbursement. However, such indemnification and reimbursement shall not exceed the amount of additional federal and state income tax that the Participant would have owed if the payment or reimbursement had been made to the Participant as regular cash compensation, plus the Participant’s share of any Social Security tax, unemployment tax, or other required amounts that would have been paid on such compensation, less any such additional income tax, Social Security tax, unemployment tax, or other required amounts actually paid by the Participant.

Section 14.06. Information to be Furnished. Each Eligible Employee and Participant shall provide the Company, Employer, Plan Administrator, and any duly authorized Claims Administrator with such information and evidence, and shall sign such documents, as may reasonably be requested from time to time for the purpose of administration of this Option.

Section 14.07. Binding on Successors. This Benefit Description shall be binding upon all persons entitled to benefits under this Option, their respective heirs and personal representatives, upon the Employer, its successors and assigns, and upon the Plan Administrator and its successors.

Section 14.08. State Law. This Benefit Description shall be governed, construed, administered, and regulated in all respects under the laws of the State of Kansas to the extent such laws are not preempted by the laws of the United States of America.

Section 14.09. Headings. The headings used in this Benefit Description are inserted for reference purposes only and shall not be deemed to limit or affect in any way the meaning or interpretation of any of the terms or provisions herein.

Section 14.10. Notices. Except as otherwise provided in this Benefit Description or in the Plan, any notices or communications required to be given herein by any Participant, Employer, the Company, the Plan Administrator, or duly authorized Claims Administrator, shall be deemed given when delivered or when placed in the United States mail in an envelope addressed to the last communicated address of the person to whom the notice is being given, with adequate postage thereon prepaid.

Section 14.11. Separate Liability. Except to the extent imposed by law, no fiduciary shall have the duty to question whether any other fiduciary is fulfilling all the responsibilities imposed upon such other fiduciary by this Option, by ERISA, the Code, or by any regulations or rulings issued under ERISA or the Code. No fiduciary shall have any liability for a breach of fiduciary responsibility of another fiduciary with respect to this Option unless it participates knowingly in such breach, knowingly undertakes to conceal such breach, has actual knowledge of such breach and fails to take reasonable remedial action to remedy such breach, or, through its negligence in performing its own specific fiduciary responsibilities, it has enabled such other fiduciary to commit a breach of the latter's fiduciary responsibilities.

Section 14.12. Word Usage. Wherever any words are used herein in the masculine or neuter gender, they shall be construed as though they were used in the feminine, masculine or neuter gender, as the context may require, and vice versa, and wherever any words are used herein in the singular form they shall be construed as though they were also used in the plural form, as the context may require, and vice versa.

Section 14.13. Severability. If any provision of this Benefit Description shall be held invalid or unenforceable, such invalidity or unenforceability shall not affect any other provisions thereof, and this Benefit Description shall be construed and enforced as if such provisions had not been included.

Section 14.14. Adoption by Other Employers. Any employer, corporation, or other entity with employees now in existence or hereafter formed or acquired, which is not already an Employer under this Option, and which is otherwise legally eligible, may in the future, with the

consent and approval of the Company adopt this Option for all or any classifications of persons in its employment, and thereby, from and after the specified effective date, become an Employer under this Option. However, the sole and absolute right to amend this Benefit Description and the terms and provisions of this Option is reserved to the Company. The adoption shall become, as to the adopting corporation or entity and its employees, a part of this Option, and may contain such specific changes or variations in the provisions hereof as may be acceptable to the Company. It shall not be necessary for the adopting corporation or entity to sign or execute the original or the amended plan documents. The administrative powers and control of the Company as provided in the Plan and/or this Benefit Description, including the sole right of amendment and of appointment and removal of the Plan Administrator, shall not be diminished by reason of the participation of any such adopting entity in this Option.

Section 14.15. Erroneous Payments/Fraud or Misrepresentation. If any person receives any payment that the Plan Administrator in its sole discretion later determines the person was not entitled to receive, such person shall be required to make reimbursement of such amounts. The Plan Administrator shall have the right to offset any future payment against amounts that the person was not otherwise entitled to receive. In addition, if any person obtains coverage and/or benefits or other payments under this Option by reason of any direct or indirect act of fraud or misrepresentation (including fraud or misrepresentation by omission), as determined by the Plan Administrator in its sole discretion, such individual shall be required to make restitution to, and/or pay any direct or indirect fees, expenses, costs, losses, or other damages suffered by, the Plan and/or the Employer by reason of such act of fraud or misrepresentation in such amount or amounts as may be determined by the Plan Administrator, in its sole discretion. The Plan Administrator also may take such other and further action with respect to such individual as it deems necessary or appropriate, including, but not limited to, retroactively terminating such individual's participation in this Option.

Section 14.16. No Contract of Employment. Nothing contained herein shall be construed to constitute a contract of employment between an Employer and any Employee. Nothing herein contained shall be deemed to give any Employee the right to be retained in the employ of an Employer or to interfere with the right of the Employer to discharge any Employee at any time without regard to the effect such discharge might have on the Employee as a Participant under this Option.

Section 14.17. Indemnification by Employer. Each Employer shall indemnify and save harmless each member of its governing body and any Employee of the Company (or any Employer), from and against losses resulting from liability to which they may be subjected by reason of any act or conduct (except willful or wanton misconduct) in their official capacities in the administration of this Option. Expenses shall include the amount of any settlement or judgment, costs, counsel fees, and related charges reasonably incurred in connection with a claim asserted, or a proceeding brought in settlement thereof. The foregoing right of indemnification shall be in addition to any other rights to which any such person may be entitled as a matter of law. The indemnification provision of this Section shall not relieve such person of any liability he may have under ERISA for breach of a fiduciary duty.

ADOPTION OF BENEFIT DESCRIPTION

This Benefit Description is hereby adopted by the Company, effective as of the 1st day of January, 2015.

THE IMA FINANCIAL GROUP, INC.

By:

Name:

Title:

ATTEST:
