Appendix 3

Medical Reimbursement Benefits*

Adopting Employer:

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(*To be used in conjunction with the
IBA Group Insurance Trust Cafeteria Plan Base Document
and Adoption Agreement)

Revised March 2011

MEDICAL REIMBURSEMENT BENEFITS

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ARTICLE 1

INTRODUCTION

The IBA Group Insurance Trust ("Trust") provides these Medical Reimbursement Benefits as a component of the IBA Group Insurance Trust Cafeteria Plan for employers participating in the Trust. This Appendix shall be interpreted and administered under the provisions of the Cafeteria Plan Base Document, as supplemented by this Appendix.

These Medical Reimbursement Benefits enable Participants to receive reimbursements of Qualifying Medical Care Expenses that are excludable from their gross income under Code § 105(b). These Medical Reimbursement Benefits are intended to qualify as a medical reimbursement plan under Code § 105(b) and are to be interpreted consistent with the requirements of Code § 105(b).

ARTICLE 2

DEFINITIONS

Whenever used in this Appendix the following words, when the initial letter is capitalized, shall have the meaning set forth in this Article. Other capitalized words are defined in the Cafeteria Plan Base Document.

Section 2.01. "Dependent" means an individual who is:

(a) a dependent under Code § 152, without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof,

(b) a dependent pursuant to IRS Revenue Procedure 2008-48, and

(c) a (i) son, daughter, stepson, stepdaughter or adopted child of Participant, or (ii) a foster child who is placed with a Participant by an authorized placement agency or by a judgment, decree, or order of a court, if the individual as of the end of the year has not attained age 27 (without regard to Code § 152(c)(3)).

Section 2.02. "Grace Period" means the period after the end of a Plan Year, as specified by the Adopting Employer in the Adoption Agreement, during which Qualifying Medical Care Expenses incurred by a Participant, Spouse or Dependent will be treated as if they had been incurred during the Plan Year.

Section 2.03. "Limited Medical Reimbursement Account" means the account described in Article 5 of this Appendix that provides reimbursement for dental care, vision care, or preventive care expenses that are compatible with an HSA, and consistent with IRS Notice 2004-23 and IRS Revenue Ruling 2004-45.

Section 2.04. "Medical Reimbursement Account" means the account described in Article 5 of this Appendix in order to provide reimbursement of Qualifying Medical Care Expenses.

Section 2.05. "Qualifying Medical Care Expense" means an expense incurred by a Participant, or by the Spouse or Dependent of a Participant, for medical care as defined in Code § 213, including without limitation, amounts paid for hospital bills, doctor bills, dental bills, drugs that are prescribed (whether or not the drug is available without a prescription) and insulin, but only to the extent that the Participant, Spouse or Dependent is not reimbursed for the expense through insurance or otherwise.

However, for purposes of Limited Medical Reimbursement Benefits, only a Qualifying Medical Care Expense for dental, vision or preventive care shall be considered a Qualifying Medical Care Expense, consistent with IRS Notice 2004-23 and IRS Revenue Ruling 2004-45.

ARTICLE 3

PARTICIPATION

Section 3.01. Eligibility for Participation. Employees of the Employer who satisfy the eligibility requirements selected by the Employer in its Adoption Agreement for Medical Reimbursement Benefits shall be eligible to participate in the Medical Reimbursement Benefits. If the Adopting Employer does not select eligibility requirements specific to the Medical Reimbursement Benefits, each employee who is eligible to participate in the Adopting Employer's Medical Benefits, is automatically eligible to participate in the Medical Reimbursement Benefits.

Notwithstanding the foregoing, an employee who elects to contribute to an HSA under the Cafeteria Plan may not elect to receive Medical Reimbursement Benefits unless:

(a) the employee's Employer has adopted Limited Medical Reimbursement Benefits; and

(b) the employee elects to participate in the Limited Medical Reimbursement Benefits.

Section 3.02. Commencement of Participation. Participation in these Medical Reimbursement Benefits shall commence on the first day of a month, as soon as administratively feasible after an Eligible Employee elects to receive Medical Reimbursement Benefits under Article 4 of this Appendix.

ARTICLE 4

ELECTION TO RECEIVE MEDICAL REIMBURSEMENT

Election Procedure. A Participant may elect to receive Medical Reimbursement Benefits or Limited Medical Reimbursement Benefits by filing a Benefit Election Form in accordance with the procedures established under Article 5 of the Cafeteria Plan Base Document. The election shall be irrevocable during the Period of Coverage unless the revocation and any new election are on account of and consistent with a change in status or other permitted events under Article 5 of the Cafeteria Plan Base Document and are consistent with the rules and regulations of the Department of the Treasury.

ARTICLE 5

MEDICAL REIMBURSEMENT ACCOUNTS

Section 5.01. Establishment of Accounts. The Employer will establish a Medical Reimbursement Account for each Participant who has elected to receive Medical Reimbursement Benefits for the Plan Year, or a Limited Medical Reimbursement Account for each Participant who has elected to receive Limited Medical Reimbursement Benefits for the Plan Year. A Participant's Account for a Plan Year is the amount elected by the Participant for the Plan Year, not the amount credited to the Participant's Account at any particular time under Section 5.03.

Section 5.02. Maximum Account. The maximum amount which a Participant may elect to contribute to the Participant's Medical Reimbursement Account or Limited Medical Reimbursement Account for reimbursement of Qualifying Medical Care Expenses incurred during the Plan Year (and Grace Period, if applicable) shall be the dollar amount selected by the Employer in its Adoption Agreement; provided, however, that, in 2013 and subsequent years, the maximum amount a Participant may contribute to a Medical Reimbursement Account or Limited Medical Reimbursement Account is $2,500.

Section 5.03. Crediting of Accounts. On each pay day, the Employer shall credit to a Participant's Medical Reimbursement Account or Limited Medical Reimbursement Account the amount withheld from the Participant's pay in accordance with the Participant's Benefit Election Form under the Cafeteria Plan. All amounts credited to the Medical Reimbursement Account or Limited Medical Reimbursement Account shall be the property of the Employer until paid out pursuant to Article 6.

Section 5.04. Debiting of Accounts. A Participant's Medical Reimbursement Account or Limited Medical Reimbursement Account shall be debited from time to time in the amount of payments under Article 6 to or for the benefit of the Participant for Qualifying Medical Care Expenses incurred during the Plan Year (and, if applicable, the Grace Period).

Section 5.05. Forfeiture of Accounts. If any balance remains in a Participant's Medical Reimbursement Account or Limited Medical Reimbursement Account after the end of a Plan Year (and, if applicable, the Grace Period) after all reimbursements of Qualifying Medical Care Expenses, the balance shall not be carried over to reimburse the Participant for Qualifying Medical Care Expenses incurred during a subsequent Plan Year, and shall not be available to the Participant in any other form or manner, but shall remain the property of the Employer, and the Participant shall forfeit all rights with respect to the balance.

ARTICLE 6

PAYMENT OF MEDICAL CARE EXPENSE REIMBURSEMENT

Section 6.01. Claims for Reimbursement. A Participant who has elected to contribute to a Medical Care Reimbursement Account or Limited Medical Reimbursement Account for a Plan Year may apply to the Administrator for reimbursement of Qualifying Medical Care Expenses incurred by the Participant during the Plan Year (and, if applicable, the Grace Period) by submitting an application in writing to the Administrator, in the form the Administrator prescribes, setting forth:

(a) the amount, date and nature of the expense with respect to which reimbursement is requested;

(b) the name of the person, to whom the expense was or is to be paid; and

(c) the name of the person for whom the expense was incurred, and if the person is not the Participant, the relationship of the person to the Participant.

The application must be submitted on or before the 90th day following the close of the Plan Year (or, if applicable, the 90th day following the last day of the Grace Period). It shall include a written statement from an independent third party stating that the expense has been incurred and the amount of the expense. Furthermore, the Participant shall provide a written statement that the expense has not been reimbursed and will not be reimbursed under any other health plan coverage and, if reimbursed from the Medical Reimbursement Account or Limited Medical Reimbursement Account, the amount will not be claimed as a tax deduction. The application shall also be accompanied by any bills, invoices, receipts, canceled checks or other statements showing the amount of the expenses, together with any additional document which the Administrator may request. The Administrator shall retain a file of all the applications.

Section 6.02. Reimbursement or Payment of Expenses. The Employer shall reimburse the Participant from the Participant's Medical Reimbursement Account or Limited Medical Reimbursement Account for Qualifying Medical Care Expenses incurred during the Plan Year (and, if applicable, the Grace Period) for which the Participant submits documentation in accordance with Section 6.01. The Employer may, at its option, pay the Qualifying Medical Care Expenses directly to the person providing or supplying medical care in lieu of reimbursing the Participant.

No reimbursement or payment under this Section 6.02 of expenses incurred during a Plan Year (and, if applicable, the Grace Period) shall at any time exceed the amount the Participant elects to contribute to the Medical Care Reimbursement Account or Limited Medical Reimbursement Account for the Plan Year under Section 4.01. Reimbursements shall, however, be made available to the Participant throughout the Plan Year without regard to the amount credited to the Participant's Medical Reimbursement Account or Limited Medical Reimbursement Account at any given point in time.

A Participant shall not be entitled to reimbursement for Qualifying Medical Care Expenses that are paid by insurance or by another health plan covering the Participant and/or his Spouse or Dependents.

ARTICLE 7

TERMINATION OF PARTICIPATION

In the event that a Participant ceases to participate in the Medical Reimbursement Benefits for any reason, any related compensation reduction under the Cafeteria Plan shall terminate. The Participant (or the Participant's estate) shall be entitled to reimbursement only for Qualifying Medical Care Expenses incurred on and prior to the date the Participant ceases to participate (and if applicable, the Grace Period), and only if the Participant (or the Participant's estate) applies for the reimbursement in accordance with Article 6 on or before the earlier of:

(a) the 180th day following the date participation is terminated, or

(b) the 90th day after the close of the Plan Year.

No reimbursement shall exceed the remaining balance, if any, of the amount the Participant elected to contribute to the Medical Reimbursement Account or Limited Medical Reimbursement Account for the Plan Year.

ARTICLE 8

ADMINISTRATION

Section 8.01. Plan Administrator. Administration of the Medical Reimbursement Benefits shall be under the supervision of the Administrator, as set out in Article 6 of the Cafeteria Plan Base Document. The Trust shall have no responsibility for administration of the Medical Reimbursement Benefits (including, but not limited to determining eligibility or benefits, testing for compliance or discrimination, reporting, disclosure or review of claims).

Section 8.02. Named Fiduciary. The Administrator shall be a "named fiduciary" for purposes of ERISA § 402(a)(1) with authority to control and manage the operation and administration of the Medical Reimbursement Benefits, and shall be responsible for complying with all of the reporting and disclosure requirements of ERISA which apply to the Medical Reimbursement Benefits.

Section 8.03. Claims and Review Procedures.

(a) Claims Procedure. If any person believes he or she is being denied any rights or benefits under the Medical Reimbursement Benefits, the person may file a claim in writing with the Administrator. If the claim is wholly or partially denied, the Administrator shall notify the person of its decision in writing. The notification will be written in a manner calculated to be understood by the person and will contain (i) specific reasons for the denial, (ii) specific reference to pertinent Medical Reimbursement Benefit provisions, (iii) a description of any additional material or information necessary for the person to perfect the claim and an explanation of why the material or information is necessary, and (iv) the steps to be taken if the person wishes to submit a request for review. The notification shall be given within 30 days after the claim is received by the Administrator (or within 45 days if special circumstances beyond the control of the Administrator require an extension of time for processing the claim and if written notice of the extension and circumstances is given to the person within the initial 30-day period). If a claim is incomplete, the Administrator will allow the Participant 45 days to complete the claim.

(b) Review Procedure. Within 180 days after the date on which a person receives a written notice of a denied claim the person (or his duly authorized representative) may (i) file a written request with the Administrator for a review of his denied claim and pertinent documents and (ii) submit written issues and comments to the Administrator. The Administrator shall notify the person of its decision in writing. The notification will be written in a manner calculated to be understood by the person and shall contain specific reasons for the decision, as well as specific references to pertinent Medical Reimbursement Benefit provisions, a description of any additional criteria used in making the decision, a statement of the person's right to review (upon request and at no charge), relevant documents and other information, copies of any additional criteria used, and the person's right to bring suit under ERISA § 502(a). The decision on review shall be made within 60 days after the request for review is received by the Administrator.

ARTICLE 9

MISCELLANEOUS

Section 9.01. Benefits Solely from General Assets. Nothing herein shall be construed to require the Employer or the Administrator to maintain any fund or segregate any amount for the benefit of a Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account or asset of the Employer from which

any payment of Medical Reimbursement Benefits may be made. Credits to Medical Reimbursement Accounts or Limited Medical Reimbursement Accounts will not be segregated, or placed in trust or dedicated to a specific benefit, but will be general assets of the Employer. The Medical Reimbursement Benefits will be paid solely from the general assets of the Employer.

Section 9.02. Nonassignability of Rights. The right of any Participant to receive Medical Reimbursement Benefits shall not be alienable by the Participant by assignment or any other method, and shall not be subject to the Participant's creditors by any process whatsoever, and any attempt to alienate, assign or attach the Medical Reimbursement Benefits shall not be recognized.

Section 9.03. Indemnification of Employer by Participants. If a Participant receives a payment or reimbursement under Article 6 that is not for Qualifying Medical Care Expenses, the Participant shall refund the payment or reimbursement to the Employer and shall indemnify and reimburse the Employer for any liability, loss or damage which it may incur for failure to withhold federal, state or local income taxes or payroll taxes from the payments or reimbursements.

Section 9.04. Continuation of Coverage. Notwithstanding anything in this Appendix to the contrary, Participants in the Medical Reimbursement Benefits are entitled to elect continuation coverage under Code Section 4980B until the end of the Plan Year if they have a balance remaining in their Medical Reimbursement Account or Limited Medical Reimbursement Account when they terminate employment.