OLD NATIONAL BANCORP
EMPLOYEE WELFARE BENEFITS PLAN

Summary Plan Description

January 2016

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PURPOSE OF THIS SUMMARY

The purpose of this Summary Plan Description ("**Summary**") is to help you understand the Benefit Features offered under the Old National Bancorp Employee Welfare Benefits Plan (the "**Plan**") maintained by Old National Bancorp (the "**Company**") for the benefit of Eligible Employees employed by an Employer. This Summary generally discusses certain laws that apply to most of the Benefit Features – such as continuation of benefit coverage under COBRA, USERRA, FMLA, and your privacy protection under HIPAA. This Summary addresses only the major aspects of the Plan – meaning not every detail or circumstance that might arise under the Plan or each Benefit Feature is addressed in this Summary. Separate summaries will be provided for certain Benefit Features.

The "Plan" is the document that legally governs the Plan's terms and operations and creates any rights for you or your dependents. If there are any differences between this Summary and the Plan, the provisions in the Plan will control. Copies of the Plan are on file at the Human Resources Department of Old National Bancorp (the "**Company**") at One Main Street, P.O. Box 328, Evansville, IN 47708. Also, if you have Internet access, you may find other information concerning the Benefit Features available under the Plan by accessing the websites listed in the chart beginning on page 7.

You should not rely on this Summary or the various insurance certificates, booklets and other summaries as creating any legal rights, including any right to employment with an Employer. Any rights you may have under the Plan are created solely by the terms of the Plan, insurance certificates, booklets and summaries relating to the Benefit Features, which you may examine upon request. Any differences between this Summary, the various summaries, booklets, insurance certificates and the Plan will be decided in accordance with the terms of the Plan. .

DEFINITIONS

Certain words and phrases used in this Summary have those meanings described in this Section.

Administrator means the Company or its designee.

Affiliate means any corporation, trade or business within the Company's controlled group as defined in ERISA Section 3(40)(B).

Benefit Features mean those welfare benefits listed in the chart beginning on page 7.

Board means the Board of Directors of the Company.

Claim Reviewer means the insurance company or benefit provider who provides technical or administrative services, including processing and payment of claims.

Committee means the Health and Welfare Administrative Committee.

Company means Old National Bancorp.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Covered Employee means any Eligible Employee covered under a Benefit Feature.

Covered Person means any person other than an Eligible Employee covered under a Benefit Feature.

Denial means a denial, reduction, termination, or failure to provide or make payment for a benefit. This includes determinations based on eligibility. Relating to Medical Benefits, a Denial also includes a denial, reduction, termination or failure to provide or make payment for a benefit based on utilization review, or a failure to cover a benefit because it is determined to be experimental or investigational or not medically necessary, or failure to provide coverage due to Rescission.

Domestic Partner means the domestic partner of an Eligible Employee eligible for coverage under any Benefit Feature.

Eligible Employee means any employee or retiree eligible under a Benefit Feature, excluding an independent contractor, a non-resident alien, a leased employee, a temporary or seasonal employee, an intern, a member of the Board or a committee appointed by the Board who is not an Eligible Employee or an employee who is not entitled to benefits per his or her employment contract.

Employer means the Company and any Affiliate that adopts this Plan. See WHAT GENERAL INFORMATION ABOUT THE PLAN SHOULD I KNOW? for a list of participating Employers participating.

ERISA means the Employee Retirement Income Security Act of 1974, as amended.

Health Coverage means, for purposes of offering COBRA continuation coverage, any Benefit Feature providing Medical Benefits, vision or dental benefits or benefits under the Plan's employee assistance program.

Health Care Professional means a physician or other health care professional licensed, accredited, or certified to perform health services consistent with state law.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended.

Medical Benefits means medical care provided under the Plan's group medical and pharmacy drug coverages.

Post-Service Claim means any claim for Medical Benefits that is not an Urgent Care Claim or a Pre-Service Claim.

PPACA means the Patient Protection and Affordable Care Act of 2010, as amended.

Pre-Service Claim means any claim for Medical Benefits that requires approval, in whole or in part, before obtaining such medical care.

Rescission means a cancellation or discontinuance of coverage for any Medical Benefits that has retroactive effect. A Rescission does not include the cancellation or discontinuance of any Benefit Feature providing Medical Benefits that: (i) has only a prospective effect; or (ii) is effective retroactively to the extent such Rescission is due to the failure to timely pay required premiums or contributions toward the cost of such coverage.

Spouse means the spouse to whom a Covered Employee is considered legally married under any state law, including marriage to a person of the same sex if they were legally married in a state that recognizes such marriages, even if the Covered Employee resides in a state that does not recognize such marriages; but not including any relationship with a person of the same or opposite sex if the formal relationship is recognized by a state but is not deemed a marriage under state law. For this purpose, the term "state" includes any domestic or foreign jurisdiction.

Urgent Care Claim means any claim for Medical Benefits or treatment where the failure to make a non-urgent care determination quickly (i) could seriously jeopardize your life, health or your ability to regain maximum function, or (ii) in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without such care or treatment.

BENEFIT FEATURES

The "Benefit Features" available under the Plan are listed below and described in the insurance certificates, booklets and benefit summaries you received separately from the Company.

BENEFIT FEATURE	INSURER/COMPANY/ CLAIMS ADMINISTRATOR	POLICY/ CONTRACT	BENEFIT SUMMARY	PARTICIPANT CONTRIBUTIONS	COMPANY CONTRIBUTIONS
Medical and Prescription Drug Benefits (Self-Insured) • ***[4 PPO Options]*** • ***[3 HDHP Options]***	Anthem Blue Cross and Blue Shield (866) 270-3714 www.anthem.com	003322200	See Booklet	✓	✓
Dental Benefits (Insured)	Health Resources, Inc. (800) 727-1444 www.insuringsmiles.com	606020670333 606030970333	See Insurance Booklet	✓	
Dental Benefits (Insured)	Delta Dental of Indiana (800)524-0149) www.deltadentalin.com	0789	See Insurance Booklet	✓	
Vision Benefits (Insured)	Vision Service Plan (800) 877-7195 www.vsp.com	GL141754	See Insurance Booklet	✓	
Group Life and Accidental Death and Dismemberment Benefits (Insured)	Reliance Standard Life Insurance Company (800) 644-1103	GL141754	See Insurance Certificate		✓
Dependent Life Benefits (Insured)	Reliance Standard Life Insurance Company (See above for contact information)	GL141701	See Insurance Certificate	✓	
Supplemental Life Benefits (Insured)	Reliance Standard Life Insurance Company (See above for contact information)	GL141701	See Insurance Certificate	✓	
Accidental Death & Dismemberment (Insured)	Reliance Standard Life Insurance Company (800) 644-1103	VAR203834	See Insurance Certificate		
Long-Term Disability Benefits (Insured)	Reliance Standard Life Insurance Company (See above for contact information)	LTD115702	See Insurance Certificate		✓

Supplemental Accident Plan (Insured)	Reliance Standard Life Insurance Company (See above for contact information)	VAI 825591	See Insurance Certificate	✓	
Critical Illness Benefits (Insured)	Reliance Standard Life Insurance Company (See above for contact information)	VCI800033	See Insurance Certificate	✓	
Tax-Saver Benefit Plan (including Health and Dependent Care Flexible Spending Accounts)	Employee Plans, LLC (800) 305-1740	N/A	See Tax Saver Plan/SPD	✓	
Severance Pay Plan (Self-Insured)	N/A	N/A	See Benefit Summary		✓
Supplemental Severance Pay Plan (Self-Insured)	N/A	N/A	See Benefit Summary		✓
Employee Assistance Program (Self-Insured)	ACI Specialty Benefits 1-855-775-4357 http://rsli.acieap.com	N/A	See Benefit Summary		✓
Employer Sponsored Wellness Center (Self-Insured)	Activate Healthcare (812) 602-3300 activatehealthcare.com/onb	N/A	See Benefit Summary	✓	✓
Medical Benefits– Retirees Smart Value Plan	Anthem Blue CrossBlue Shield 1-877-326-2201 www.anthem.com	00218702	See Insurance Booklet		✓

ELIGIBILITY AND ENROLLMENT

Review the insurance certificates, booklets and benefit summary to determine who is eligible for coverage under the various Benefit Features. On your date of hire and during any annual open enrollment period, you will receive materials describing the Benefit Features available under the Plan.

Notwithstanding the foregoing, only Full-Time Employees (defined below), their Spouses, dependents and Domestic Partners, will be eligible for benefits under the Health Coverages (without regard to the EAP for such purposes). The following rules will apply in determining if an Eligible Employee qualifies as a Full-Time Employee for purposes of the Health Coverages:

- If an Eligible Employee hired on or after January 1, 2016 is scheduled to work a consistent schedule through his Initial Measurement Period (defined below) which schedule is anticipated to result in the employee working, on average, 30 or more hours per week, such Eligible Employee will be treated as a Full-Time Employee on his date of hire and will be offered coverage under the Health Coverages as of the date specified in the applicable Benefit Feature, but not later than 90 days after his date of hire.

- If an Eligible Employee hired on or after January 1, 2016 is not scheduled to work a consistent schedule through his Initial Measurement Period, his actual hours of service will be determined by averaging his hours worked each week during his Initial Measurement Period. If the Eligible Employee works, on average, at least 30 hours of service per week during his Initial Measurement Period, he will be offered coverage under the Health Coverages which coverage will be effective no later than the first day of the month beginning on or after the 13-month anniversary of his date of hire and will continue for the following 12-month period, regardless of his actual hours of service during such 12-month period, so long as he remains is employed as an Eligible Employee.

- If an Ongoing Employee works, on average, 30 or more hours per week during the Standard Measurement Period, he will be offered coverage under the Health Coverages during the following Administrative Period which coverage will be effective as of the first day of the Plan Year immediately following the Standard Measurement Period and will continue in effect for such Plan Year, regardless of his actual hours of service during such Plan Year, so long as he remains employed as an Eligible Employee during such Plan Year.

For purposes of determining eligibility under the Health Coverages, certain terms have the meanings set forth below:

Full-Time Employee means an Eligible Employee who completes, on average, at least 30 or more hours of service per week.

Initial Measurement Period means the 12-month period beginning on an Eligible Employee's date of hire.

Ongoing Employee means an Eligible Employee who has completed at least one Standard Measurement Period.

Standard Measurement Period means, the period beginning each October 15 and ending the following October 14 preceding the Plan Year for which eligibility for Health Coverage(s) is being determined. For example, for purposes of determining whether an Eligible Employee is a Full-Time Employee for the Plan Year beginning January 1, 2017, the Standard Measurement Period will begin on October 4, 2015 and end on October 3, 2016.

Administrative Period means the 90-day period ending December 31 of each Plan Year.

It is the intention of the Employers that eligibility under the Health Coverages will be administered to allow all Full-Time Employees to be eligible under the Health Coverages so as to avoid any penalty under PPACA for the failure to provide such coverage. To the extent permitted by PPACA, the Administrator may make such rules and decisions with respect to the complying with the requirements of PPACA as may be necessary to avoid such penalties.

COBRA CONTINUATION COVERAGE

COBRA is a federal law that allows certain persons to continue health coverage under certain circumstances.

A. Qualified Beneficiaries.

Qualified Beneficiaries may elect to continue coverage with respect to any Health Coverage under which the Qualified Beneficiary was covered on the day before a Qualifying Event (defined below). For this purpose, a **Qualified Beneficiary** means any Covered Employee or Spouse, Domestic Partner or dependent child of the Covered Employee or Domestic Partner (including any dependents born to or placed for adoption during the continuation coverage). A Qualified Beneficiary may separately elect to continue coverage under each Health Coverage.

Each Health Coverage also provides "COBRA-like" continuation coverage to Domestic Partners; however, coverage is not offered pursuant to COBRA.

B. Qualifying Events.

If one of the Qualifying Events described below cause you to lose benefits under a Health Coverage, you may elect to continue receiving benefits under the Health Coverage through COBRA. These **Qualifying Events** include:

- **death**;
- **termination of employment** (other than by reason of gross misconduct) or **reduction of hours** that results in a termination of coverage under the applicable Health Coverage;
- **divorce** or **legal separation**;
- becoming **entitled** to **Medicare** benefits;
- any child or the child of a Domestic Partner **ceases** to be considered a **dependent child** under the applicable Health Coverage. (In this instance, your child would be eligible for COBRA, but your coverage under the applicable Health Coverage would not change); or
- termination of the relationship with a Domestic Partner relationship.

C. Electing COBRA Coverage.

To elect COBRA continuation coverage, a Qualified Beneficiary must elect to continue coverage on a form provided by the Administrator within the period ending **60 days** after the later of (i) the date the Qualified Beneficiary would lose coverage due to the Qualifying Event; or (ii) the date the COBRA notice is sent by the Administrator. The election form explains the terms and payments for coverage. Any election to continue coverage under COBRA will be deemed effective as of the date you send the election form to the Administrator.

D. Paying for COBRA Coverage.

Qualified Beneficiaries must pay any monthly premiums required to maintain COBRA continuation coverage. After a Qualifying Event, Qualified Beneficiaries will receive a notice specifying (i) the amount of such monthly premiums, (ii) to whom the premium must be paid, and (iii) the date each monthly premium is due.

Failure to pay premiums on a timely basis will result in termination of any applicable Health Coverage as of the date the premium is due. Payment of any premium (other than the initial one – see below) will be considered "timely" only if made ***within 30 days*** after the due date.

The *initial* premium payment for the period between the Qualifying Event and the date a Qualified Beneficiary elects COBRA coverage must be made ***within 45 days*** following such election. Failure to timely pay this initial premium will result in cancellation of coverage retroactive to the initial date coverage would have terminated.

E. Length of COBRA Coverage.

18 Months. If a Qualifying Event is caused by termination of employment or reduction in hours, a Qualified Beneficiary may elect continuation coverage for up to *18 months* following the Qualifying Event.

29 Months. If a Qualifying Event is caused by termination of employment or reduction in hours and Qualified Beneficiary is determined to be disabled under the Social Security Act within 60 days of the initial COBRA coverage period, then Qualified Beneficiaries may elect to extend coverage for up to *29 months* from the date of the Qualifying Event. To obtain this extended coverage, the Qualified Beneficiary must notify the Administrator of the disability determination within 18 months of the Qualifying Event *and* within 60 days following the latest of: (i) the disability determination, (ii) the Qualifying Event, (iii) the date the Qualified Beneficiary loses or would lose coverage due to the Qualifying Event, or (iv) the date the Qualified Beneficiary is notified of his or her obligation to notify the Administrator.

In addition, a Qualified Beneficiary must notify the Administrator within 30 days of the later of the date: (i) the Qualified Beneficiary is no longer disabled, or (ii) the date the Qualified Beneficiary is notified of his or her obligation to notify the Administrator.

36 Months. If a Qualifying Event is caused by death, divorce or legal separation, entitlement to Medicare or a child ceasing to be a dependent child, a Qualified Beneficiary may elect continuation coverage for up to 36 months from the Qualifying Event.

Second Qualifying Event. If a second Qualifying Event (e.g., death or divorce) occurs during the initial 18-month continuation coverage period or, in the case of disability, the 29-month continuation coverage period) all individuals who were Qualified Beneficiaries in connection with the initial Qualifying Event and who are still Qualified

Beneficiaries at the time of the second Qualifying Event may elect continuation coverage for up to *36 months* from the *original* Qualifying Event.

Also, if a Covered Employee becomes entitled to Medicare within 18 months prior to a Qualifying Event caused by a termination of employment or reduction in hours, any Qualified Beneficiary *other than* the Covered Employee may elect continuation coverage for up to *36 months* from the date the Covered Employee became entitled to Medicare.

F. When COBRA Continuation Coverage Ends.

Notwithstanding the periods described above, COBRA continuation coverage will terminate upon the occurrence of any of the following:

- COBRA premiums are not timely paid (subject to any grace period);
- a Qualified Beneficiary is eligible for coverage under any other group health plan *after* electing COBRA coverage;
- the Qualified Beneficiary becomes entitled to Medicare benefits *after* electing COBRA coverage;
- the Qualified Beneficiary ceases to be disabled (if such continuation coverage is due to disability); or
- the Employers cease to provide any group health plan its employees.

G. Notification Requirements.

Notice to Qualified Beneficiaries. The Administrator will notify Qualified Beneficiaries regarding their rights to COBRA continuation coverage no later than the earlier of: (i) 90 days after coverage begins, or (ii) the date the Qualified Beneficiary would otherwise receive an election form due to a Qualifying Event (see below).

Employer Notice to Administrator. In addition, the Employers will notify the Administrator in the event of your death, termination of employment (other than gross misconduct), reduction in hours, or entitlement to Medicare benefits within 30 days following a Qualifying Event.

Covered Employee/Qualified Beneficiary Notice to Administrator. A Covered Employee or Qualified Beneficiary (or any representative of such individuals) must notify the Administrator if/upon (i) the Covered Employee divorces or legally separates from his Spouse or terminates a Domestic Partner relationship, (ii) a child ceases to be a dependent child, (iii) a second Qualifying Event occurs, or (iv) notice of disability entitlement or cessation of disability. Notice must be provided as soon as possible, but no later than *60 days* after the *later* of the date: (i) of the Qualifying Event, (ii) a Qualified Beneficiary would lose coverage due to such Qualifying Event, or (iii) the Covered Employee is notified of his obligation to notify the Administrator. Failure to provide notice within this time frame will result in the loss of the right to elect COBRA continuation coverage.

Notice to Administrator. The notice provided to the Administrator must be submitted in writing on an election form provided by the Administrator ("**Notice Form**"). Oral notice, including notice by telephone, is *not* acceptable. You must request (either in person, via telephone or e-mail) a copy of **Notice Form** from the Administrator. You must complete Notice Form (including any attachments described below) and then return **Notice Form** and attachments (either by hand-delivery or mail) to the Administrator by the time period set forth in **Covered Employee/Qualified Beneficiary Notification to Administrator** above. If mailed, the **Notice Form** must be postmarked no later than the last day of the required notice period. If you do not complete and return the **Notice Form** within this required time period, no continuation coverage will be provided to you.

Required Information. On the **Notice Form** you must indicate the name of the Plan, the name and address of the Covered Employee under the Plan, the name and address of any Qualified Beneficiary, the Qualifying Event or disability information (if applicable), and the date of the Qualifying Event or necessary disability information (if applicable). If the Qualifying Event is a divorce, you must attach a copy of the divorce decree to the **Notice Form**. Any notice of disability determination (or cessation) must attach a copy of the Social Security Administration's determination.

If any Covered Person is not entitled to receive COBRA continuation coverage, such Covered Person will be notified and provided with an explanation as to why continuation coverage was not available.

For COBRA continuation purposes, notice to a Qualified Beneficiary who is a Spouse or Domestic Partner of a Covered Employee will be treated as notice to all other Qualified Beneficiaries residing with the Spouse or Domestic Partner .

H. About COBRA Continuation Coverage.

COBRA coverage under any Health Coverage will be identical to the coverage provided under such Health Coverage to any similarly-situated person who has not experienced a Qualifying Event. If such coverage is modified for any group of similarly-situated persons, such coverage will be modified in the same manner for all Qualified Beneficiaries.

I. Other Continuation Coverage.

In addition to COBRA continuation coverage, Covered Persons may be eligible for continuation coverage pursuant to the terms of the underlying Benefit Features. Please consult the insurance certificate, booklet or summary describing the Benefit Features to determine whether additional coverage may be available.

PROTECTED HEALTH INFORMATION

The Plan must comply with certain of the requirements under the Standards for Privacy of Individually Identifiable Health Information (the "**Privacy Regulations**") and the Security Standards for the Protection of Electronic Protected Health Information (the "**Security Regulations**"), 45 CFR 160 and 164. The Plan will only receive "summary health information" (as defined at 45 CFR 164.504(a)) for the purpose of obtaining premium bids from health insurers for providing health insurance coverage under the Plan; or (b) modifying, amending or terminating a an insurance policy or benefit arrangement. In addition, the Plan may receive and disclose to the Employers information on whether the individual is participating in a Benefit Feature. The Plan will also safeguard electronic protected health information in accordance with the Security Regulations, including implementing or addressing the administrative, technical and physical safeguards found in the Security Regulations (as is reasonable in light of the limited electronic protected health information received by the Plan). You have certain other rights that must be provided to you regarding the Health Benefits offered under the Plan. Please contact each health insurer directly regarding your HIPAA rights.

OTHER IMPORTANT INFORMATION REGARDING BENEFIT FEATURES

A. Uniformed Services Employment and Reemployment Rights Act (USERRA).

You may be entitled to reemployment and other rights during and following any period of **Uniformed Service** (as defined in USERRA), including certain contributions and service credits under the Plan.

To be *eligible* for USERRA benefits, you are generally required to give the advance written notice to your Employer prior to reporting to any required Uniformed Service. When you return from military service, you must timely apply for reemployment with an Employer. Time limits for returning to work will depend on the length of your military service. Please contact the Human Resources Department to request additional information regarding your reemployment rights under USERRA.

In addition to these rights, your Employer will pay the difference between your regular salary and the amount paid by the government during such period of Uniformed Service for up to 18 months.

As required under USERRA, you may elect continuation coverage under the applicable Benefit Feature for you and your dependents (your dependents do not have an independent right to elect USERRA continuation coverage) for a period of the lesser of: (i) 24 months beginning on your date of your period of Uniformed Service, or (ii) the day following the date you fail to timely apply for re-employment with the Employer. You may elect to discontinue such continuation coverage by submitting forms to the Employer.

Coverage must be elected on an election form provided by the Employer and must be provided during an election period that begins on the date you provide advance notice to your Employer that you are reporting for Uniformed Service and ends 60 days after you would otherwise lose coverage under the applicable Benefit Feature. If providing advance notice is impossible, unreasonable or precluded by military necessity, your election period begins on the date you leave for Uniformed Service and ends the earlier of: (i) the 24 month period beginning on the date such Uniformed Service begins, or (ii) the date you fail to timely apply for re-employment following such Uniformed Service.

If you elect coverage in a timely manner, coverage will be retroactive to the day you lost coverage as a result of your Uniformed Service.

You will be required to pay 102% of the full premium cost require to continue coverage if your Uniformed Service lasts for more than 30 days. Your initial premium is due within 45 days after you elect continuation coverage . Future premiums for such continuation coverage are due on the first day of each month and will be considered late if not received within 30 days of such date. Late payments will result in loss of coverage for you and any covered dependents. USERRA continuation coverage runs concurrently with COBRA continuation coverage. You may discontinue any Health Coverage during your Uniformed Service by submitting certain forms to the Employer.

During your Uniformed Service, you will be entitled to the same level of Health Coverage that is available to similarly-situated Covered Persons.

B. Legally Mandated Coverage.

Certain Benefit Features must comply with the requirements of the Federal laws described below. For additional information, please review the insurance certificate, booklet or summary relating to each Benefit Feature.

- Family and Medical Leave Act of 1993 ("**FMLA**"),
- Health Insurance Portability and Accountability Act of 1996 (including but not limited to any certification requirements) ("**HIPAA**"),
- Mental Health Parity Act of 1996,
- Newborns' and Mothers' Health Protection Act of 1996; and
- Women's Health and Cancer Rights Act of 1998 ("**WHCRA**").

FMLA. Under FMLA, employees have the right to take an unpaid leave or a paid leave (if earned) for a period of up to 12 weeks during a 12-month period because of:

- the birth and care of a child,
- the adoption or foster care placement and care of a child,
- the need to care for a family member (child, spouse, or parent) with a serious health condition, or
- any serious health condition that makes you unable to do your job.

In addition, any Spouse, son, daughter, parent, or nearest blood relative ("next of kin") of a "covered service member" has the right to take leave for up to 26 work weeks during any 12-month period to care for the covered service member. During this 12-month period, you may be granted a combined total of 26 work weeks of leave for any combination of leaves under FMLA. "**Covered service member**" means a member of the Armed Forces, including a member of the National Guard or Reserves, who is:

- undergoing medical treatment, recuperation, or therapy;
- is otherwise in an "outpatient status" (as defined under FMLA); or
- is otherwise temporarily disabled due to a "serious injury or illness" (as defined by regulations).

Under FMLA, you may elect continue coverage for any Health Coverage while on leave, provided you pay any required contributions. The coverage for any Health Coverage is the same as would be provided if you had been employed during the leave period. You may choose not to continue such Health Coverage during FMLA leave, in which case you will be immediately reinstated under the Benefits Features providing Health Benefits when you return from leave. Your right to continue coverage under any Benefit Feature that does not provide Health Coverage will be governed by the terms of such Benefit Feature. See the underlying Benefit Features for details.

Except as provided under **COBRA CONTINUATION COVERAGE**, benefit coverage under FMLA will terminate when you: (i) inform your Employer of your intent not to return from FMLA leave; (ii) fail to return from FMLA leave; or (iii) exhaust your FMLA leave.

If you fail to return to work after exhausting your FMLA leave, you may be required to reimburse your Employer for any premiums paid by the Employer during FMLA leave. This will not apply if you fail to return to work due to a serious health condition (your own or a family member) or other circumstances beyond your control.

HIPAA.

Special Enrollment Rights . If you are an Eligible Employee and decline to participate in the Benefit Feature providing Medical Benefits when initially eligible or at open enrollment, you and/or your dependents may elect such coverage upon occurrence of "special enrollment event" as provided by HIPAA. HIPAA special enrollment events generally occur when you or your dependents lose coverage under another employer's group health plan (unless due to failure to pay premiums), and when you gain a dependent through marriage, birth or adoption. You have 30 days from the occurrence of these events to notify your Employer and enroll in the applicable Benefit Features. You and/or your dependents may also have special enrollment rights if coverage is lost under Medicaid or a state health insurance ("SCHIP") program, or when you and/or your dependents gain eligibility for state premium assistance. You have 60 days from the occurrence of one of these events to notify your Employer and enroll or disenroll in the policies.

Guaranteed Renewability. Guarantees renewability and availability of health coverage to certain employers and individuals.

PPACA.

The Plan must meet the requirements imposed by the PPACA which include, but are not limited to, exclusions based on pre-existing health conditions, extended coverage for young adults, removal of aggregate annual limits, and prohibitions against the Rescission of Medical Benefits (unless a Covered Employee (or dependent) has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact).

Mental Health Parity Act of 1998.

The Plan is required to provide parity in the application of aggregate lifetime and annual dollar limits for mental health benefits as compared with other dollar limits for Medical Benefits.

Newborn Health Coverage.

The Plan 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 vaginal delivery, or less than 96 hours following a caesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, the Plan may not, under Federal law, require that a provider obtain prior authorization for prescribing a length of stay that does not exceed 48 hours (or 96 hours).

WHCRA.

If you receive benefits in connection with a mastectomy and elect breast reconstruction, the Plan will cover (i) reconstruction of the breast on which the mastectomy has been performed, (ii) surgery and reconstruction of the other breast to produce a symmetrical appearance; and (iii) prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

C. Not a Contract of Employment.

This Plan does not constitute a contract between an Employer and any Eligible Employee, and is not a consideration for, or any inducement or condition of, employment. Nothing in the Plan gives any Eligible Employee the right to be retained by an Employer or to interfere with an Employer's right to discharge any Eligible Employee at any time.

D. Nonalienation.

Except when mandated by a qualified medical child support order ("**QMCSO**"), no benefit under the Plan or underlying Benefit Feature will be subject to voluntary or involuntary alienation or other legal or equitable process. However, you and your dependents may assign benefits to a provider or facility, provided the Benefit Feature allows such assignment.

E. QMCSOs.

A QMCSO is an order that provides for the right for your children to receive benefits under certain Benefit Features under the Plan. If the Administrator receives a QMCSO, the Administrator is required to follow the order as required by applicable law. The Administrator will notify you and the individual who has a right to benefits regarding: (i) the receipt of the order, (ii) the procedures for determining if the order is a QMCSO, and (iii) the decision whether the order is a QMCSO.

You may request the Administrator provide,, without charge, a copy of the procedures relating to QMCSO.

F. Eligibility for Medicaid Benefits.

Benefits will be paid in accordance with any assignment rights made by or on your behalf under Medicaid. For purposes of enrollment and eligibility for any Benefit Feature under the Plan, your eligibility for or receipt of Medicaid benefits will not be taken into account.

G. Right of Recovery.

If payment is made under the Plan or any Benefit Feature that should not have been made, the Administrator may recover such payment from the person who received the payment (or any other appropriate party). If the incorrect payment is made directly to you or your dependents, the amount of the incorrect payment may be deducted from future Plan payments to you or your dependents.

H. Disclaimer of Liability.

Nothing gives you or your dependents the right to take action against the Plan, the Administrator, Claim Reviewers, or an Employer for the acts or omissions of any provider from whom you or your dependent receives care, services, or supplies.

I. Misrepresentation.

If you or your dependents make any material misrepresentation when applying for coverage, or reclassification of coverage, or when applying for and/or obtaining benefits, your coverage will be null and void from the date coverage began.

J. Notice.

Any notice given under the Plan will be sufficient if given to the Administrator, when addressed to it at its office; if given to the Claim Reviewer, when addressed to its office; or if given to an Eligible Employee or retiree, when addressed to the Eligible Employee or retiree at his or her address as such appears in the records of the Administrator or Claim Reviewer.

K. Receipt and Release.

Any payments made to an Eligible Employee or retiree will be in full satisfaction of that individual's claim. The Company may condition payments on the delivery by the Eligible Employee or retiree of an executed receipt and release.

L. Reliance.

The Company will not incur any liability in acting on any notice, request, signed letter, telegram, or other paper or document the Company believes to be genuine or to be executed or sent by an authorized person.

M. Protective Clause.

The Employers are not responsible for the validity of any Benefit Feature, including the contract of insurance or other benefit contract or policy by any benefit provider issued to an Employer or for the failure on the part of any insurance company or other benefit provider to make payments.

PROCEDURES FOR FILING CLAIMS FOR BENEFITS

A. Coordination of Claims Procedures.

The procedures below apply only in the event:

- a Benefit Feature has no claims provisions and is subject to the requirements under ERISA Section 503, or
- the claim procedures of a Benefit Feature do not comply with the requirements under ERISA Section 503, but compliance is still legally required.

Generally, all claim notifications to a claimant will be done in writing or electronically.

Whenever we refer to "you" in this Section, this will mean any claimant such as you or your dependents.

B. Claims for Long-Term Disability Benefits.

Claim for Disability Benefit. Generally, any claim for long-term disability benefits must be filed with the Claim Reviewer. The time frame is shown on the claim form. Please contact your local Human Resources Department to find out where to get claim forms. As part of the claim, you must submit a physician's statement proving you are "disabled" (as defined under the long-term disability policy). If the Claim Reviewer disagrees that you are disabled, the terms of the long-term disability policy will be followed in resolving a dispute.

Review of Claim. When the disability claim has been filed properly, it will be reviewed. You will be notified of the approval or Denial within 45 days after the claim is received. If the Claim Reviewer needs additional time to process the claim, the 45-day period may be extended twice, each extension period lasting no more than 30 additional days. You will receive written notice of the extension(s) explaining why the extension(s) is necessary and when a final decision will be made. The notice will also explain: (i) the standards on which eligibility for the benefit is based, (ii) any unresolved issues that prevent a decision on the claim, and (iii) any additional information needed to resolve those issues. You will have 45 days to provide any specified information.

Denial of Claim. If any claim for disability benefits is denied, you will be given a notice. The notice will include: (i) the reasons for the Denial; (ii) appropriate reference to applicable Benefit Feature provisions; (iii) a description of, and reasons for, any requested additional information; (iv) a description of the review procedures and time limits; (v) the specific reason for the Denial (copies of the guidelines are available upon request, free of charge); and (vi) if Denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment or a statement that the explanation will be provided for free, at request. (items (i) through (vi), collectively, the "**Claims Information**").

Appeal. You may appeal a Denial of any claim for disability benefits by filing a written appeal with the Claim Reviewer. You have 180 days after you receive notice of the Denial to file the appeal. If you do not file the appeal within this time period, the Claim Reviewer's decision will be final. You will receive notice of the Claim Reviewer's decision on appeal within 45 days after your appeal request is received, unless special circumstances require additional time to process the appeal. If additional time is needed due to special circumstances, the Claim Reviewer will notify you when a final decision will be made. A decision will be made within 90 days after the appeal is received.

If the disability claim is denied on appeal, you will be given a notice stating that you are entitled to receive, free and upon request, access to and copies of all documents, records, and other information that apply to your claim. The notice will also contain the necessary Claims Information, described above. A decision on review will be final and binding.

C. Claims for Medical Benefits.

Claim for Medical Benefits. To file a claim for Medical Benefits, simply complete and send a claim form to the Claim Reviewer within the time period shown on the claim form. If you fail to follow these claims procedures for filing an *Urgent Care Claim* or a *Pre-Service Claim*, you will be notified orally (unless you request written notice) of the proper procedures to follow – not later than 24 hours for *Urgent Care Claims* and 5 days for *Pre-Service Claims*. This special timing rule applies only to *Urgent Care Claims* and *Pre-Service Claims* that: (i) are received by the person

or unit customarily responsible for handling such claims; and (ii) specify a claimant, a medical condition or symptom, and a specific treatment, service, or product.

You must submit any physician statements, if required. If the Claim Reviewer disagrees with the physician's statement, look to the summary of the applicable Benefit Feature to direct you as to how this issue will be resolved.

Review of Claims. When a claim has been filed properly, you will be notified of the approval or Denial within the time periods shown in the chart beginning on page 19.

Denial of Claims. If a claim for benefits is partially or wholly denied, you will be given a notice. The notice will include the necessary Claims Information. For *Urgent Care Claims*, the notice will also include a description of the expedited review process that applies to those claims. This information may be provided orally if you are given notification within 3 days after the oral notification.

Appeal(s) of Denial. You may appeal a Denial by filing a written appeal(s) with the Claim Reviewer within the time periods shown in the chart in Supplement A. If your request is not timely, the decision of the Claim Reviewer will be final. For *Urgent Care Claims*, you may make a request for an "expedited" appeal orally or in writing.

You will receive notice of the Claim Reviewer's decision on appeal(s) within the time periods shown in the chart in Supplement A. In addition, if your claim is denied on appeal(s), you will be given a notice with a statement that you are entitled to receive, free of charge, access to and copies of all documents, records, and other information that apply to your claim. The notice will also contain the necessary Claims Information.

Depending on who the Claim Reviewer is, the appeal may consists of a single-level or two-level review process with respect to the various Benefit Features. The last decision on review will be final and binding.

Ongoing Treatments. If the Claim Reviewer has approved an ongoing "course of treatment" over a certain period of time or for a certain number of treatments, any reduction or termination of the "course of treatment" will constitute a Denial. You will be notified of the Denial before the reduction or termination occurs.

For an *Urgent Care Claim*, any request you make to extend the ongoing "course of treatment" will be decided as soon as possible but no later than 24 hours after receipt of the *Urgent Care Claim*, provided the claim is filed at least 24 hours before the treatment expires.

Independent External Review. You may appeal the outcome of a denied appeal by requesting an external review of the outcome by an Independent Review Organization pursuant to Federal law. Denials eligible for external review include: (i) Denials which, in the opinion of the external reviewer, are based solely on medical judgment; and (ii) Denials relating to a Rescission. External review of eligible Denials is available after the first level appeal.

You must request an external review to the Claim Reviewer within four months of the notice of Denial. A request for an external review must be submitted in writing unless the Claims Reviewer determines it is not reasonable to require a written statement. You are not required to re-send the information that you submitted for internal appeal; however, you are permitted to submit any additional information that you deem important for review.

For Pre-Service Claims involving urgent/concurrent care, you may proceed with an expedited external review without filing an internal appeal or while simultaneously pursuing an expedited appeal through the Claims Reviewer's internal appeals process. You or your authorized representative may request expedited external review orally or in writing. All necessary information, including the Claims Reviewer's decision, can be submitted by telephone, facsimile or other similar method. To proceed with an expedited external review, you or your authorized representative must contact the Claims Reviewer at the number shown in the applicable Benefit Feature, and provide the following information: (i) your identity; (ii) the date(s) of the medical care; (iii) the specific medical condition or symptom; (iv) the provider's name; (v) the service or supply for which approval was sought; and (vi) any reasons why the appeal should be processed on a more expedited basis.

All other requests for expedited external review should be submitted in writing unless the Claims Reviewer determines that it is not reasonable to require a written statement. Such requests should be submitted by you or your authorized representative to the address shown in the applicable Benefit Feature.

External review is not an additional step that you must take in order to fulfill his appeal procedure obligations described in the Plan, and will not affect a claimants rights to any other benefits under the applicable Benefit Feature. There is no charge to a claimant for initiating the option of an independent external review. The external review decision is final and binding on all parties except for any relief available through applicable state laws or ERISA.

D. Claims for All Other Welfare Benefits.

Claim for Other Welfare Benefits. Any claim to receive other welfare benefits (other than insured disability benefits or health benefits) must be filed with the Claim Reviewer within the time period shown on the claim form.

Review of Claim. When a claim for other welfare benefits has been filed properly, you will be notified of the approval or denial within 90 days after the claim is received, unless special circumstances require an extension of time to process the claim. Written notice of any extension will be furnished to you before the end of the initial 90-day period – telling you the circumstances requiring an extension and when a final decision will be reached (which will be no later than 180 days after the claim was filed).

Denial of Claim. If a claim for other welfare benefits is partially or wholly denied, you will be given a notice containing the necessary Claims Information:

Appeal of Denial. You may appeal a claim denial by filing a written appeal with the Claim Reviewer within 60 days after you receive notice of the denial. If you do not file the appeal within this time period, the Claim Reviewer's decision will be final.

You will receive notice of the Claim Reviewer's decision on appeal within 60 days after receipt of your appeal request, unless special circumstances require an extension of time to process the appeal. If an extension is necessary, the Claim Reviewer will notify you of the extension, and the date a final decision will be made (which will not be later than 120 days after receipt of the appeal).

If your claim for other welfare benefits is denied on appeal, you will be given a notice stating that you are entitled to receive, free of charge, access to and copies of all documents, records, and other information that apply to your claim. The notice will also contain: (i) the reasons for the Denial; and (ii) appropriate reference to applicable provisions of the underlying Benefit Feature.

A decision on review will be final and binding.

E. All Claims for Benefits.

Authorized Representative. You may have an authorized representative act on your behalf in pursuing a benefit claim or appeal. For an *Urgent Care Claim*, a Health Care Professional with knowledge of your medical condition may act as your authorized representative.

Calculating Time Periods. The period of time that applies for determining initial claims or appeals will begin when a claim or appeal is filed, even if the information necessary to make a determination is not with the filing. However, if you fail to provide certain needed information, these time periods may be put on hold. Contact the Claim Reviewer for details.

Full and Fair Review. When you request, you will have reasonable access to, and copies of, all documents, records, and other information relating to your claim, free of charge. In addition, you may submit to the Claim Reviewer written comments, documents, records, and other information relating to your claim.

If your review request is timely, the review of a Denial will take into account all comments and documents you submitted about your claim even if that information was not submitted or considered in the initial benefit determination.

Appeals for claims for disability benefit or Medical Benefits will be reviewed by the Claim Reviewer who will (i) be the named fiduciary of the Plan, (ii) not be the individual or subordinate of the individual who made the initial determination, and (iii) not give any weight to the initial determination.

For instance, in the case of two levels of appeal, the second level reviewer will not defer to the first level reviewer. The second level reviewer will not be the same individual or the subordinate of the first level reviewer. If any appeal is based, in whole or in part, on a medical judgment, the reviewer will consult with an appropriate Health Care Professional who will not be the individual or subordinate of the individual who was consulted in connection with any previous determination (including the initial determination, or the first level of appeal if a two level appeal process is used). The Claim Reviewer will identify any medical or vocational experts it uses regardless of whether the advice was relied upon in making the benefit determination.

Mediation. You and the Plan may have voluntary alternative dispute resolution options, such as mediation. For available options, please contact your local U.S. Department of Labor Office and state insurance regulatory agency.

Exhaustion of Remedies. If you fail to file a request for review of a Denial, in whole or in part, as required by these procedures, you will have no right to review and no right to bring action, at law or in equity, in any court. The Denial will become final and binding for all purposes.

SUBROGATION

The Plan reserves the right to subrogation and reimbursement of amounts paid by the Plan on your behalf. This provision applies if you or your dependents are entitled to receive payment from a third party for an illness or injury. By participating in the Plan, you and your dependents agree that the Plan is subrogated to all rights that you and your dependents may have against any such third party. You may be required to sign a subrogation agreement and provide information before benefits are paid under the Plan.

If payment is made under the Plan, and the person who receives it recovers monies from a third party as a result of settlement, judgment, or otherwise, that person must hold that recovery in trust for the Plan and reimburse the Plan for the payments it has made for you.

You or your dependents are responsible for all expenses of recovery from third parties or other persons, including all attorneys' fees you incur in collecting payments from those third parties. Any attorneys' fees or expenses you or your dependents owe will not reduce the amount of reimbursement due to the Plan.

This is a full and complete right of subrogation; it exists even if you or your dependents do not receive full compensation or recovery for all of your losses, debts, injuries, or damages. This means that the Plan is entitled to be paid first out of any recovery you or your dependents receive, even if you or your dependents are not "made whole".

You are further agreeing to take action, furnish information, and execute and deliver instruments necessary to enforce these rights. If you or your dependents do not pursue your rights against the third party, the Administrator may pursue the third party in your name in order to recover benefits paid by the Plan on your behalf or on behalf of your dependents. The Administrator will give you 30 days written notice before taking action against the third party. You and your dependents may not release any third party from any obligation it allegedly owes you, or take any other action that affects the Plan's rights, without the prior written authorization of the Administrator.

If you or your dependents fail or refuse to comply with these provisions, the Plan has the right to impose a constructive trust over any and all funds you or your dependents receive or have the right to receive. The Administrator is authorized on behalf of the Plan to pursue any and all legal and equitable relief available to enforce these rights against any and all appropriate parties who may be in possession of funds described here. If you or your dependents fail to comply with these requirements, you and your dependents will not be eligible to receive any benefits, services, or payments under the Plan until or unless there is compliance.

If you or your dependent receive any recovery from a third party, the Plan will not have any further obligation to pay benefits for future claims relating to the same or related injuries for which recovery was made from the third party.

PLAN ADMINISTRATION

A. Responsibility of the Administrator.

As Administrator, the Company has full authority to: (i) determine eligibility issues arising under the Plan, (ii) interpret and construe the terms of the Plan, and (iii) resolve any ambiguities, inconsistencies or omissions, and correct any defect.

The Company shall act through its Board or duly authorized officers, who may delegate authority to an appropriate committee. All determinations and interpretations by the Administrator will be final, conclusive, and binding. Benefits under the Benefit Features of the Plan will be paid only if the Administrator decides in its discretion that the Eligible Employee or retiree is entitled to such benefits.

The Company has appointed Claim Reviewers to provide consulting services, including the processing and payment of claims.

B. Amendment and Termination of the Plan.

To the extent the Benefit Features do not address amendment or termination of a Benefit Feature, the following provisions apply. The following provisions also apply to this Plan.

The Plan and any Benefit Features may be changed, added to, amended or modified, at any time and from time to time at the sole discretion of the Company, by action of the Committee. The Plan and any Benefit Feature (or option of any Benefit Feature) may be terminated at any time at the sole discretion of the Board.

PARTICIPATING EMPLOYERS

A. Adoption of Plan.

Any Affiliate may become an Employer under the Plan as of the date set forth in any applicable acquisition/merger documents or, if not addressed in such documents, as of the date approved by the Committee.

B. Withdrawal from the Plan.

An Employer may withdraw from the Plan by delivering written notice of its withdrawal to the Committee or, in the event of a sale of an Employer, as set forth in the sale document between the parties.

GENERAL INFORMATION

A. Administrator and Plan Sponsor.

The Administrator and sponsor for the Plan is Old National Bancorp, One Main Street, P.O. Box 328, Evansville, IN 47708, (812) 468-7895. Service of legal process may be made on the Administrator.

B. Employer Identification Number and Plan Number.

Employer identification number: 35-1539838

Plan Number: 502

C. Plan Year.

The Plan Year is the 12-month period from January 1 to December 31.

D. Health Insurance Issuer Information.

The Claim Reviewers for the Benefit Features under the Plan are shown in the chart beginning on page 2.

E. Sources of Financing.

The Plan is financed through contributions made by the Company and Covered Employees and retirees (if applicable) in amounts determined by the Company in accordance with the Plan. Certain contributions by Covered Employees will be treated as Employer contributions for purposes of the Old National Bancorp Tax Saver Benefit Plan and Summary Plan Description.

F. Effective Date

The original effective date of the Plan was January 1, 2005. The effective date of this Plan is January 1, 2016.

G. Participating Employers

- Old National Bancorp
- Old National Bank

WHAT ARE MY RIGHTS UNDER ERISA?

As a participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants will be entitled to:

Receive Information About Your Plan and Benefits. Examine, without charge, at the Administrator's office, and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, 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 Administrator, copies of documents governing the operation of the Plan, including insurance contracts, 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's annual financial report. The Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Health Coverage. Continue coverage for yourself, spouse or dependents if there is a loss of coverage under any Health Coverage as a result of a Qualifying Event. You or your dependents may have to pay for such coverage. Review this Summary 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 the 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 Plan participants and beneficiaries. No one, including the Company or any other Employer, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights. If your claim for a 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 the Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the 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. However, before you file suit, you must first complete all of the claims procedures described beginning on page

14. If you do not follow these claims procedures accordingly, you will have no right to review and no right to bring action, at law or in equity, in any court, and the denial of the claim will become final and binding. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court.

If it should happen that Plan fiduciaries misuses any assets of the Plan, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions. If you have any questions about the Plan, you should contact the 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 Administrator, you should contact the nearest 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.

SUPPLEMENT A

CLAIMS FOR MEDICAL BENEFITS – TIME LIMITATIONS

	TYPE OF CLAIM		
MAXIMUM TIME LIMITS	**Urgent Care Claims**	**Pre-Service Claims**	**Post-Service Claims**
Review/Determination of Initial Claim (if no additional information is needed)	No later than 72 hours after receipt of claim No extension available.	No later than 15 days after receipt of claim One time 15-day extension generally permitted **Note**: Claim Reviewer may or may not allow extension due to claimant's failure to provide needed information	No later than 30 days after receipt of claim
Notice to Claimant – If additional information is needed	No later than 24 hours after receipt of incomplete claim	N/A	N/A
Notice to Claimant – Failure to follow proper procedures	No later than 24 hours after receipt of improper claim	No later than five days after receipt of improper claim	N/A
Claimant – Deadline to Provide Necessary Information	Not less than 48 hours after receipt of notice from Claim Reviewer	At least 45 days after receipt of notice from Claim Reviewer *Note. Claim Reviewer may or may not request needed information from claimant.*	At least 45 days after receipt of notice from Claim Reviewer *Note: Claim Reviewer may or may not request needed information from claimant.*
Claim Reviewer - Deadline to Adjudicate Claim	No later than 48 hours after earlier of (i) receipt of additional information from claimant, or (ii) end of time period given to claimant to provide additional information (48 hours)	No later than 15 days after earlier of (i) receipt of additional information from claimant, if requested, or (ii) end of time period given to claimant to provide additional information (45 days)	No later than 15 days after earlier of (i) receipt of additional information from claimant, if requested, or (ii) end of time period given to claimant to provide additional information (45 days)
Claimant – Deadline to File Appeal	180 days after receipt of Denial. *If second level of appeal, claimant must have reasonable opportunity to pursue second appeal*	180 days after receipt of Denial. *If second level of appeal, claimant must have reasonable opportunity to pursue second appeal*	180 days after receipt of Denial. *If second level of appeal, claimant must have reasonable opportunity to pursue second appeal*
Claim Reviewer – Deadline to Adjudicate Appeal(s)	All appeals (first and/or second levels, as applicable) must be decided within 72 hours after receipt of appeal	One Level Appeal: 30 days after receipt of appeal. Two Level Appeal: *First level* – 15 days after receipt of first level appeal *Second level* – 15 days after receipt of second level appeal	One Level Appeal: 60 days after receipt of appeal. Two Level Appeal: *First level* – 30 days after receipt of first level appeal *Second level* – 30 days after receipt of second level appeal