OLD NATIONAL BANCORP
EMPLOYEE WELFARE BENEFITS PLAN

(As Amended and Restated Generally
Effective as of January 1, 2016)

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OLD NATIONAL BANCORP
EMPLOYEE WELFARE BENEFITS PLAN

ARTICLE I.
RESTATEMENT OF PLAN

The Old National Bancorp Employee Welfare Benefits Plan was originally adopted effective as of January 1, 2005, was amended and restated effective January 1, 2008, January 1, 2011, and January 1, 2012, is hereby amended and restated, effective as of January 1, 2016, except as otherwise noted herein, for the purpose of providing certain welfare benefits, and any such benefits as may be added from time to time, to Eligible Employees of an Employer as hereinafter provided.

ARTICLE II.
DEFINITIONS AND CONSTRUCTION

Section 2.01. Construction and Governing Law.

(a) Except to the extent superseded by ERISA or as otherwise provided under any insurance policy or arrangement under any Benefit Feature, the Plan shall be construed in accordance with the laws of the state of Indiana.

(b) Words used herein in the masculine gender shall be construed to include the feminine gender where appropriate and words used herein in the singular or plural shall be construed as being in the plural or singular where appropriate.

Section 2.02. Definitions. When the initial letter of a word or phrase is capitalized herein, the meaning of such word or phrase shall be as follows:

(a) "Administrative Period" means, as applicable, the period beginning on the day after the last day of an Eligible Employee's Initial Measurement Period and ending on the day immediately preceding the first day of his Initial Stability Period; or (ii) the 90-day period immediately preceding the Plan Year.

(b) "Administrator" means the Company, as provided in Section 8.01.

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

(d) "Benefit Feature" means one or more of the employee benefits identified in the Schedules of Benefits to the Plan.

(e) "Board" shall mean the Board of Directors of the Company.

(f) "Claim Reviewer" means a person, firm or company which has agreed to provide technical or administrative services and advice in connection with the operation of all or a part of a Benefit Feature, and perform such other functions, including the processing and payment of claims, as may be properly delegated to such Claim Reviewer. The Administrator may review claims appeals, as provided by the Benefit Feature.

(g) "COBRA" means the Consolidated Omnibus Budget Reconciliation of 1985, as amended.

(h) "Code" means the Internal Revenue Code of 1986, as amended.

(i) "Committee" means the Health and Welfare Administrative Committee appointed by the Board.

(j) "Company" means Old National Bancorp and its successors and assigns.

(k) "Covered Employee" means any Eligible Employee covered under a Benefit Feature.

(l) "Covered Person" means any individual other than an Eligible Employee covered under a Benefit Feature.

(m) "Denial" means any of the following: a denial, reduction, termination, or failure to provide or make payment (in whole or in part) for a benefit, including determinations based on eligibility, and, with respect to Medical Benefits, a denial, reduction, termination or failure to provide or make payment for a benefit based on utilization review, 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.

(n) "Domestic Partner" means, with respect to any Benefit Feature, the domestic partner of an Eligible Employee.

(o) "Eligible Employee" means any employee or retiree of an Employer who is eligible to participate under any Benefit Feature; provided, however, an Eligible Employee shall not include: (i) an individual classified by the Employer as an independent contractor (regardless of whether the person is later determined to be a common-law employee for tax purposes); (ii) a non-resident alien with no US-sourced earned income; (iii) a leased employee or a temporary or seasonal employee; (iv) an intern; (v) any member of the Board or any Committee appointed by the Board who is not an Eligible Employee; or (vi) any person who through written agreement provides not to be eligible to participate.

Notwithstanding the above provisions and to the extent not contrary with the requirements of ERISA, any individual eligible under a Benefit Feature pursuant to an employment or change in control agreement between such individual and an Employer, as determined by the Compensation Committee, shall be treated as an Eligible Employee for such purposes, regardless of the eligibility requirements required under such Benefit Feature.

(p) "ePHI" means "electronic protected health information" as defined at 45 CFR § 160.103, which, generally, means PHI that is transmitted by, or maintained in, electronic media. For this purpose, "electronic media" means: (1) electronic storage media including memory devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical disk, or digital memory card; or (2) transmission media used to exchange information already in electronic storage media.

(q) "Employer" means, severally, the Company and any Affiliate that participates in the Plan pursuant to Article XII.

(r) "ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

(s) "FMLA" means the Family and Medical Leave Act of 1993, as amended.

(t) "Full-Time Employee" means, for purposes of being eligible to receive Medical Benefits, an Eligible Employee that averages at least 30 Hours or more of Service per week during the Initial or Standard Measurement Period, as applicable.

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

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

(w) "Hour of Service" means each hour for which an employee is paid, or entitled to payment, for the performance of duties for an Employer, and each hour for which an employee is paid, or entitled to payment, by an Employer for a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or leave of absence, and any other "hour of service" required to be credited under the PPACA and the regulations and rulings thereunder.

(x) "Individual" means any Covered Person who is the subject of Protected Health Information.

(y) "Initial Measurement Period" means, with respect to an Eligible Employee that is not an Ongoing Employee, the 11-month period beginning on the first day of the month coincident with or next following his date of hire.

(z) "Initial Stability Period" means, with respect to an Eligible Employee that is not an Ongoing Employee, the 12-month period beginning on the first day of the month that is coincident with or immediately follows such Eligible Employee's Administrative Period.

(aa) "Medical Benefits" means the medical care provided under the group medical, and prescription drug coverages provided pursuant to Section 3.01.

(bb) "Ongoing Employee" means any Eligible Employee employed for at least one complete Standard Measurement Period.

(cc) "Plan" means the Old National Bancorp Employee Welfare Benefits Plan, as amended.

(dd) "Plan Year" means the 12-month period beginning each January 1 and ending the following December 31.

(ee) "Post-Service Claim" means, with respect to any Benefit Feature, any claim for Medical Benefits that is not an Urgent Care Claim or a Pre-Service Claim.

(ff) "PPACA" means the Patient Protection and Affordable Care Act of 2010.

(gg) "Pre-Service Claim" means, with respect to any Benefit Feature providing Medical Benefits, any claim for Medical Benefits whereby the Benefit Feature conditions receipt of such Medical Benefits, in whole or in part, on prior authorization of such Medical Benefits prior to obtaining medical care.

(hh) "Privacy Regulations" mean the regulations under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Parts 160 and 164, as amended) issued under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and Title XIII of the American Recovery and Reinvestment Act, also known as the Health Information Technology for Economic and Clinical Health Act ("HITECH"), governing the use and disclosure of PHI and ePHI to the extent applicable to the Plan.

(ii) "PHI" means "protected health information" as defined at 45 CFR § 160.103 which, generally, means information (including demographic information) that: (1) identifies an Individual (or with respect to which there is a reasonable basis to believe the information can be used to identify an Individual); (2) is created or received by a health care provider, a health plan, or a health care clearinghouse; and (3) relates to the past, present, or future physical or mental health or condition of an Individual, the provision of health care to an Individual, or the past, present, or future payment for the provision of health care to an Individual. For purposes of this Plan, PHI shall only include information related to a Benefit Feature that: (1) provides medical care benefits (including Medical Benefits or other coverage affecting any structure of the body) that is subject to the Privacy Regulations; and (2) provides PHI to an Employer.

(jj) "Rescission" or "Rescind" means a cancellation or discontinuance of coverage for Medical Benefits that has retroactive effect. A Rescission does not include the cancellation or discontinuance of coverage for Medical Benefits that: (1) is effectively prospectively; or (2) is effective retroactively to the extent such Rescission is attributable to a failure to timely pay required premiums or contributions toward the cost of such coverage.

(kk) "Schedule of Benefits" those welfare benefits described under Schedule A and Schedule B attached hereto and incorporated herein, and as amended from time to time.

(ll) "Security Incident" means a "security incident" as defined at 45 CFR § 164.304, which, generally, means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

(mm) "Spouse" means, with respect to any Benefit Feature, 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.

(nn) "Standard Measurement Period" means, with respect to an Ongoing Employee, the 12-month period ending on the day immediately preceding the first day of the Administrative Period associated with the following Plan Year.

(oo) "Tax Saver Plan" means the Old National Bancorp Tax Saver Benefit Plan.

(pp) "Urgent Care Claim" means, with respect to any Benefit Feature providing Medical Benefits, any claim for medical care or treatment where the failure to make a non-urgent care determination quickly: (1) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or (2) in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

(qq) "USERRA" means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

ARTICLE III.
BENEFITS

Section 3.01. Eligibility for Medical Benefits. The following provisions shall apply for purposes of receiving Medical Benefits:

(a) Full-Time Employees. As required by PPACA and other applicable law, all Full-time Employees, their Spouses and dependents will be offered coverage under the applicable Benefit Features providing Medical Benefits. The following provisions will apply in determining if an Eligible Employee is a Full-time Employee for purposes of receiving an offer of coverage providing Medical Benefits:

(i) New Employee. If an Employer expects an Eligible Employee will complete, on average, at least 30 Hours of Service per week, he will be treated as a Full-Time Employee as of his date of hire.

(ii) Ongoing Employee. If an Ongoing Employee completes, on average, at least 30 Hours of Service per week during the Standard Measurement Period, the Ongoing Employee will be treated as a Full-Time Employee and offered coverage providing Medical Benefits during the following Administrative Period. Such coverage will be effective beginning as of the first day of the Plan Year immediately following the Standard Measurement Period and will continue for such Plan Year, regardless of his actual Hours of Service during such Plan Year, so long as he is an Eligible Employee during that Plan Year.

(b) Part-Time Employees. An Eligible Employee that is not a Full-Time Employee will be treated as a Full-Time Employee in accordance with the following:

(i) New Employee. If an Eligible Employee is not expected to complete, on average, at least 30 Hours of Service per week during his Initial Measurement Period, he will not be treated as a Full-Time Employee as of his date of hire. However, if the Eligible Employee completes, on average, at least 30 Hours of Service per week during his Initial Measurement Period, the Eligible Employee will be treated as a Full-Time Employee as of the first day of his Initial Stability Period and receive an offer of coverage providing Medical Benefits during the Administrative Period associated with such Initial Stability Period which, if elected, will continue during his Initial Stability Period.

(ii) Ongoing Employee. In the case of an Eligible Employee who is not treated as a Full-Time Employee in accordance with (i), above, if the Eligible Employee completes, on average, at least 30 Hours of Service per week during the first full Standard Measurement Period commencing on or after his date of hire, the Eligible Employee will be treated as a Full-Time Employee on the first day of the Plan Year immediately following such Standard Measurement Period, where coverage providing Medical Benefits will be offered during the Administrative Period associated with such Standard Measurement Period and, if elected, such coverage will continue during the Plan Year associated with such Standard Measurement Period, subject only to the termination of any Benefit Feature providing such Medical Benefits.

(c) Leaves of Absence or Lay Off. Any Eligible Employee treated as a Full-Time Employee prior to a leave of absence or lay off shall be treated as a new employee and not an Ongoing Employee to the extent such Eligible Employee was not credited with an Hour of Service during the 13-week period immediately preceding his re-employment following such leave of absence or lay off.

The Company intends that this Section shall provide that all Full-Time Employees will receive an offer of coverage providing Medical Benefits so as to avoid any penalty or excise taxes imposed under Code

Section 4980H. The Administrator may make such rules and decisions relating to the administration of this Section as necessary to avoid such penalties.

Section 3.02. Insured Benefit Features.

(a) An Employer may enter into insurance policies issued by any insurance company qualified to do business in the United States or enter into contracts with any other benefit provider to provide those benefits specified under Schedule A. The text of any such insurance policy or contract, as amended, is hereby incorporated into the Plan by reference and made a part hereof. Any such insurance contract or policy may be changed by mutual agreement between such Employer and the insurance company or other benefit provider at any time. The Employer shall be the owner and policyholder of any such insurance contract or policy, unless otherwise provided in such contract or policy.

(b) Any Benefit Feature set forth in Schedule A shall be limited to the benefits provided under such insurance contract or policy, as amended. Except as may be otherwise specifically provided in the Plan, the rights, duties, obligations and responsibilities of the Employers and the Covered Persons concerning the benefits shall be limited to such rights, duties, obligations, and responsibilities as may be set forth in any such insurance contract or policy.

Section 3.03. Self-Insured Benefit Features.

(a) From time to time, an Employer may provide benefits to Covered Persons which are not fully insured, as set forth in Schedule B. In the event an Employer decides to provide such self-insured benefits, the following information shall be set forth in writing:

(i) the extent of such benefits, including periods during which benefits are provided;

(ii) the procedures governing elections, if any, for such benefits;

(iii) the eligibility requirements for such benefits;

(iv) the contributions from such Employer and Covered Persons, if applicable, required for such benefits or the formula for determining same;

(v) the conditions and limitations on such benefits, including conditions precedent and subsequent with regard to qualification for benefits;

(vi) the claims procedures; and

(vii) such other matters as required by law or that Company, in its sole discretion, may deem relevant or appropriate.

Such writing shall be kept on file with the Company, shall be made available to any Eligible Employee upon written request, and shall be incorporated herein by reference and made a part hereof.

(b) Any self-insured Benefit Feature set forth in Schedule B shall be limited to the benefits provided under such insurance contract or arrangement described thereunder. Except as may be otherwise specifically provided in the Plan, the rights, duties, obligations and responsibilities of the Employers and the Covered Persons concerning the benefits shall be limited to such rights, duties, obligations, and responsibilities as may be set forth in any such insurance contract or policy.

Section 3.04. Termination, Addition, and Modification of Benefit Features.

(a) The Board may terminate any Benefit Feature from the Plan by amending Schedule A or Schedule B accordingly, which revisions shall become a part hereof.

(b) The Committee may add to or modify any Benefit Feature under the Plan, by amending the Plan and/or adopting a revised Schedule A or Schedule B, as the case may be, and adding such additional Benefit Feature or modification thereto, which revisions shall become a part hereof. Any such additional Benefit Feature or modification thereto shall be subject to all of the terms and conditions of the Plan.

ARTICLE IV.
CONTINUATION COVERAGE

Section 4.01. Applicability. The Health Coverages shall comply with all COBRA requirements to the extent applicable, and as described below.

Section 4.02. Right to Continuation Coverage. A Qualified Beneficiary may elect to continue coverage after a Qualifying Event in accordance with the applicable Health Coverage.

Section 4.03. Qualified Beneficiary. Only Qualified Beneficiaries may elect continuation coverage under an applicable Health Coverage. For purposes of this Article, a "Qualified Beneficiary" is any individual that was a Covered Person under the applicable Benefit Feature on the day before a Qualifying Event (including dependents born to or placed for adoption with the Eligible Employee during the continuation coverage) who is:

(b) a Covered Employee;

(c) a Spouse or Domestic Partner of a Covered Employee; or

(d) a dependent child of a Covered Employee or Domestic Partner.

Section 4.04. Qualifying Events. The right to continuation coverage is triggered by any of the events set forth below (the "Qualifying Events") which, but for such continuation coverage, would result in a loss of coverage under the applicable Health Coverage. A "loss of coverage" includes ceasing to be covered under the same terms and conditions as in effect immediately before the Qualifying Event or an increase in the premium or contribution that must be paid by a Covered Person. "Qualifying Events" include:

(b) the death of a Covered Employee;

(c) the termination (other than by reason of gross misconduct) or reduction of hours that results in the termination of coverage under the applicable Health Coverage;

(d) the divorce or legal separation of a Covered Employee from his or her Spouse;

(e) the termination of the relationship between a Covered Employee and his or her Domestic Partner;

(f) a Covered Employee becoming entitled to Medicare benefits under Title XVIII of the Social Security Act; or

(g) the child of a Covered Employee or Domestic Partner ceasing to be an eligible dependent child under the applicable Health Coverage.

Section 4.05. Election of Continuation Coverage. Continuation coverage does not begin unless elected by a Qualified Beneficiary. Each Qualified Beneficiary who loses coverage as a result of a Qualifying Event shall have an independent right to elect continuation coverage, regardless of whether any other Qualified Beneficiary with respect to the same Qualifying Event elects continuation coverage. The election period shall begin no later than the date the Qualified Beneficiary would lose coverage under the applicable Health Coverage due to the Qualifying Event, and shall not end before the date that is 60 days following the later of: (1) the date the Qualified Beneficiary would lose coverage due to the Qualifying Event; or (2) the date on which notice of the right to continuation coverage is sent by the Administrator or its designee. The election of continuation coverage must be made on a form provided by the Administrator or its designee and payment for coverage, as described in the notice, must be made when due. An election is considered to be made on the date it is sent to the Administrator or its designee.

Section 4.06. Period of Continuation Coverage.

(a) In the case of a Qualifying Event caused by termination of employment or reduction in hours, the Qualified Beneficiary may elect to extend coverage for a period of up to 18 months from the date of the Qualifying Event, unless such coverage ends earlier as described under Section 4.08.

(b) If a second or additional Qualifying Event occurs during the initial 18-month continuation coverage period (or, in the event of disability, during the 29-month continuation coverage period), the Qualified Beneficiary may elect to extend the continuation coverage period for a period ending 36 months from the date of the earlier Qualifying Event. If the Covered Employee became entitled to Medicare within 18 months prior to a Qualifying Event caused by termination of employment or reduction in hours, Qualified Beneficiaries (other than the Covered Employee) may elect continuation coverage for a period of 36 months from the date of the Covered Employee's entitlement to Medicare benefits.

(c) If a Qualified Beneficiary is determined under Title II or XVI of the Social Security Act to be disabled within 60 days of the initial continuation coverage period due to termination of employment or reduction of hours (even if the disability commenced, or was determined to be a disability before the first 60 days of the initial 18-month continuation coverage period), all Qualified Beneficiaries may elect continuation coverage for a period of up to 29 months from the date of the Qualifying Event; provided, however, notice of such disability determination must be provided by the Qualified Beneficiary to the Administrator or its designee within 18 months of the Qualifying Event and within 60 days after the latest of: (1) the date of such disability determination; (2) the date the Qualifying Event occurs; (3) the date the Qualified Beneficiary loses or would lose coverage due to the Qualifying Event; or (4) the date on which the Qualified Beneficiary is notified of his or obligation to notify the Administrator.

(d) In the case of any Qualifying Event not otherwise described in this Section, a Qualified Beneficiary may elect continuation coverage for a period of up to 36 months from the date of the Qualifying Event, unless such coverage ends earlier as described under Section 4.07.

Section 4.07. End of Continuation Coverage. Continuation coverage shall end earlier than the period specified under Section 4.06 if:

(b) the first day (including any grace period) for which COBRA premium payments are not made on a timely basis;

(c) the Qualified Beneficiary first becomes covered under any other group health plan after electing continuation coverage;

(d) the Qualified Beneficiary first becomes entitled to Medicare benefits after electing continuation coverage;

(e) the Employer ceases to provide any Health Coverageto any employee; or

(f) the Covered Person ceases to be disabled, if continuation coverage is due to the disability.

Notwithstanding the foregoing, the Plan may also terminate the continuation coverage of a Qualified Beneficiary for cause on the same basis that the Plan could terminate for cause the coverage of a similarly-situated individual that is not a Qualified Beneficiary (e.g., submission of fraudulent claims to the Plan).

Section 4.08. Cost of Continuation Coverage. Each Qualified Beneficiary is responsible for paying the monthly cost of continuation coverage. This cost is called a "premium." Premiums must be paid each month. Failure to pay premiums on a timely basis will result in termination of coverage as of the date the premium is due.

The *initial* premium payment for the time period between the date of the Qualifying Event and the date you elected COBRA coverage, must be made ***within 45 days*** after the date of election. Failure to pay this initial premium by the due date will result in cancellation of coverage back to the initial date coverage would have been terminated. Payment of any subsequent premiums will be considered "timely" only if paid ***within 30 days*** after the due date.

The amount of the premium payments will be determined by the Administrator from time to time in accordance with the provisions of Code Section 4980B(f)(4). Notwithstanding the foregoing, if the Participant's termination of employment was the result of a military leave covered by the USERRA, the Participant's premium payment under this Section cannot be more than the normal premium amount for a similarly-situated employee if the military leave was for 30 or fewer days.

Section 4.09. Notification Requirements.

(a) General Notice to Covered Person. The Administrator will provide written notice to each Covered Employee and his or her Spouse or Domestic Partner of their rights to continuation coverage under each applicable Health Coverage. This general notice shall be provided not later than the earlier of: (1) 90 days following the date such Covered Person's begins coverage under an applicable Health Coverage, or (2) the date the Administrator is required to furnish a COBRA election to a Qualified Beneficiary under Section 4.09(d).

(b) Employer Notice to Administrator. The Employers will notify the Administrator or its designee in the event of a Covered Employee's: (1) death; (2) termination of employment (other than for reasons of gross misconduct); (3) reduction in hours; or (4) entitlement to Medicare benefits within 30 days of such Qualifying Event.

(c) Covered Employee/Qualified Beneficiary Notice to Administrator. A Covered Employee or Qualified Beneficiary must notify the Administrator or its designee if/upon: (1) the Covered Employee divorces or legally separates from his or her Spouse or terminates the relationship with his or her Domestic Partner; (2) a child ceases to be a dependent child under the applicable Health Coverage; (3) a second Qualifying Event; or (4) notice of disability entitlement or cessation of disability. Notification must occur as soon as possible, and for events under (1), (2), or (3) above, such notice must occur not later than 60 days following the later of: (1) the date of such Qualifying Event; (2) the date that the Qualified Beneficiary loses or would lose coverage due to

such Qualifying Event; or (3) the date the Qualified Beneficiary is notified of his or her obligation to provide such notice. See Section 4.06 for timing of notices applicable to disability determinations.

The Covered Employee, Qualified Beneficiary, or a representative acting on behalf of the Covered Employee or Qualified Beneficiary, may provide such notice. The provisions of notice by one individual shall satisfy any responsibility to provide notice on behalf of all related Qualified Beneficiaries with respect to the Qualifying Event. Failure to provide such timely notice shall result in the loss of any right to elect continuation coverage. A Qualified Beneficiary's failure to follow such procedures within the times prescribed above shall result in a denial of continuation coverage.

(d) Administrator Notice to Qualified Beneficiary. Upon receipt of a notice of Qualifying Event, the Administrator or its designee will notify each Qualified Beneficiary of his or her right to elect continuation coverage no later than 14 days after the date on which the Administrator or its designee received notice of such Qualifying Event. Any notification to a Qualified Beneficiary who is the Spouse or Domestic Partner of a Covered Employee shall be treated as a notification to all other Qualified Beneficiaries residing with such spouse or Domestic Partner at the time such notification is made.

(e) Unavailability of Coverage. If the Administrator or its designee receives a notice of an applicable Qualifying Event or disability determination and determines that the person is not entitled to continuation coverage, the Administrator or its designee shall notify the person with an explanation as to why such coverage is not available within the time frame designated under (c) above.

(f) Notice of Termination of Coverage. The Administrator or its designee shall notify each Qualified Beneficiary of any termination of continuation coverage which is effective earlier than the end of the maximum continuation coverage period applicable to an Qualifying Event, as soon as practicable following the Administrator's determination that continuation coverage should terminate.

Section 4.10. Continuation Coverage Benefits. The continuation coverage provided to a Qualified Beneficiary who elects continued coverage shall be identical to the coverage provided to similarly-situated persons under the applicable Health Coverage. If benefits under such Health Coverage are modified, the benefits under such Health Coverage shall be modified in the same manner for all Qualified Beneficiaries.

If any Health Coverage provides an open enrollment period during which similarly-situated active employees may choose to be covered under another group health plan or under another benefit package within the applicable Benefit Feature, or to add or eliminate coverage of family members, the applicable Benefit Feature shall provide the same opportunity to Qualified Beneficiaries who have elected continuation coverage.

Section 4.11. Bankruptcy Proceedings. Notwithstanding any of the preceding Sections, in the event of a bankruptcy proceeding under Title XI of the United States Code which results in loss of coverage or substantial elimination of coverage with respect to a Covered Employee who retired prior to the date of the loss or substantial elimination of coverage (and any Spouse, Domestic Partner, dependent child, surviving Spouse or surviving Domestic Partner who was a Covered Person under the applicable Health Coverage on the day before the bankruptcy proceeding), such Covered Employee and individuals described above will be Qualified Beneficiaries with respect to any applicable Health Coverage to the extent required under ERISA Sections 602 through 607 and Code Section 4980B.

Section 4.12. Continuation Coverage under USERRA. A Covered Employee who is absent from work for more than 31 days in order to fulfill a period of duty in the "uniformed services" of the United States (as determined under USERRA) will be treated as experiencing a Qualifying Event under Section 4.04 as of the first day of his absence for that duty. However, the maximum period of coverage under Section 4.06 will be the lesser of (i) 24 months following the date the Qualifying Event was deemed to occur, or (ii) the day after the date such Covered Employee fails to timely apply for or return to active employment with an Employer following his discharge from active military duty in the uniformed services.

ARTICLE V.
LAWS AFFECTING BENEFIT FEATURES

Section 5.01. HIPAA Compliance. Any Benefit Feature that constitutes a group health plan (as defined under HIPAA) shall comply with HIPAA, as amended from time to time, and any regulations issued thereunder, to the extent required thereunder, and to the extent not otherwise inconsistent with any federal law or regulations governing such Benefit Feature.

Section 5.02. FMLA Compliance. To the extent subject to FMLA, participation under any Plan shall comply with FMLA, as amended from time to time, and any regulations issued thereunder, to the extent required thereunder, and to the extent not otherwise inconsistent with any federal law or regulations governing such Benefit Feature. If a Covered Employee goes on a qualifying unpaid leave as described under the FMLA, the Covered Employee may, to the extent required under the FMLA, elect to continue coverage under any applicable Benefit Feature during the leave. If the Covered Employee fails to continue coverage during the leave or fails to make a required contribution for the cost of coverage if continued coverage was elected, coverage under such Benefit Feature will stop at that time and no benefits will be paid for claims incurred after the coverage stops. Upon return from the leave, the Covered Employee will re-enter the Plan on the same basis the Covered Employee was participating under such Benefit Feature(s) prior to the leave. If a Covered Employee goes on any other approved unpaid leave of absence, coverage under any Benefit Feature will be suspended during the leave unless the Covered Employee elects to continue coverage under the procedures established for individuals on an FMLA leave of absence.

Section 5.03. PPACA Compliance. Any Benefit Feature providing Medical Benefits under this Plan shall comply with all mandates applicable to such Benefit Feature under PPACA. Any disclosures required by to be made to Covered Persons under such Benefit Features shall be included in the insurance policy and other documents implementing such Benefit Feature and any written materials distributed to Covered Person describing such Medical Benefits.

ARTICLE VI.
PROTECTED HEALTH INFORMATION

Section 6.01. General. This Article is intended as good faith compliance with the requirements of HIPAA and will be construed in accordance with HIPAA and guidance issued thereunder. Application of this Article is limited to those Benefit Features which: (a) provide medical care (including any Medical Benefits or other coverage affecting any structure of the body) that are subject to the Privacy Regulations; and (b) provide PHI to an Employer.

Section 6.02. Supersession of Inconsistent Provisions. This Article shall supersede the provisions of the Plan to the extent those provisions are inconsistent with the provisions of this Article.

Section 6.03. Use and Disclosure of PHI and ePHI. The Administrator, will establish and maintain a privacy plan and a security plan that will describe the policies, practices and procedures that

will be maintained and followed by the Plan to comply with the applicable requirements of the Privacy and Security Regulations. Such privacy and security plans will (i) include a description of the permitted and required uses and disclosures of any PHI or ePHI created or obtained by the Plan, including disclosures to an Employer; (ii) provide for adequate separation between the Plan and an Employer; and (iii) require the Employers to reasonably and appropriately safeguard ePHI created, received, maintained or transmitted to or by the Employers on behalf of the Plan.

The privacy plan will:

(a) Describe specific rules for limiting disclosures of PHI and ePHI. The rules will require any insurance issuer under the Plan to limit the disclosure of PHI and ePHI to an Employer for the sole purpose of allowing the Employer to perform enrollment and disenrollment functions with respect to the Plan. Summary health information (as defined in Privacy Regulations) may also be disclosed to an Employer for the purpose of obtaining premium bids or modifying, amending or terminating the Plan. The Plan will make reasonable efforts to limit the disclosure to the minimum necessary to accomplish the purpose of either intended use.

(a) Designate the Plan's "privacy officer."

(b) Ensure that a risk assessment and breach notification procedure is in place in order to meet the Plan's obligations, pursuant to the HITECH and regulations promulgated thereunder, to notify affected individuals covered by the Plan in circumstances where a breach of unsecured PHI or ePHI has occurred.

The security plan will:

(a) Designate the Plan's "security officer."

(b) Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that the Employers create, receive, maintain, or transmit on behalf of the Plan.

(c) Ensure that adequate separation between the Employers and the Plan is supported by reasonable and appropriate security measures.

(d) Ensure that any agent to whom an Employer provides ePHI agrees to implement reasonable and appropriate security measures to protect such ePHI.

(e) Report any security incident to the Administrator.

ARTICLE VII.
FUNDING POLICY AND EMPLOYER CONTRIBUTIONS

The Administrator shall be responsible for establishing and carrying out the funding policy of the Plan for the provisions of benefits consistent with the objectives of the Plan. The premiums and other charges for coverage under a Benefit Feature will be paid by the Employers and, to the extent determined by the Administrator, by the Participants. The Administrator may set different contribution rates from time to time in its sole and absolute discretion for each Benefit Feature and for different Covered Employees and Covered Persons or groups of Covered Employees and Covered Persons. Certain contributions made by Covered Employees shall be treated as Employer contributions consistent with the Tax Saver Plan.

ARTICLE VIII.
PLAN ADMINISTRATION

Section 8.01. Administrator. The Company, or a committee appointed by the Board, shall be the Administrator of the Plan within the meaning provided under ERISA Section 3(16)(A); provided, however, the Board or its duly authorized officers may, from time to time, designate a person, committee, Claim Reviewer, or organization to perform certain responsibilities of the Administrator. Any such individual, subcommittee, or organization shall perform the delegated functions until removal by the Board, which removal may be without cause and without advance notice. Except as otherwise specifically provided in the Plan or any contract, policy or arrangement implements a Benefit Feature, the Administrator shall have full, discretionary authority to control and manage the operation and administration of the Plan, and shall be named fiduciary of the Plan. The Administrator shall have all power necessary or convenient to enable the Administrator to exercise such authority. The Administrator or its designee may provide rules and regulations relating to the operation and management of the Plan. The Administrator shall have the full discretion, power, and the duty to take all action necessary or proper to carry out the duties required under ERISA. The Administrator is authorized to accept service of legal process for the Plan. The Company may appoint a carrier, person, entity or corporation to provide consulting services to the Company or Administrator in connection with the operation of the Plan, and it may perform such other functions and services, including the processing and payment of claims, as may be delegated to it by the Company.

Section 8.02. Claim Reviewer. The Company may appoint or remove a Claim Reviewer with respect to any or all of the Benefit Features under the Plan.

Section 8.03. Administrator Discretionary. Except as may be otherwise specifically provided in the Plan or in any Benefit Feature, the Administrator or its designee shall have full, discretionary authority necessary to carry out its duties under the Plan including, but not limited to, determining the eligibility of any person to participate under the Plan and to construe the terms of the Plan and to determine all questions of fact or law arising hereunder. The Administrator or its designee shall have all power necessary or convenient to enable the Administrator to exercise such authority. Subject to Section 8.04, all such determinations and interpretations shall be final, conclusive, and binding on all persons affected thereby. The Administrator or its designee shall have full, discretionary authority to correct any defect, supply any omission or reconcile any inconsistency and resolve ambiguities in the Plan in such manner and to such extent as it may deem expedient, and the Administrator or its designee shall be the sole and final judge of such expediency. The Administrator is authorized to accept service of legal process for the Plan and shall be named fiduciary of the Plan. Benefits under the Plan shall be paid only if the Administrator and/or its designee decides in its discretion that a Covered Person is entitled to such benefits.

Section 8.04. Claims Procedures.

(a) Coordination of Claims Procedures. The following procedures shall apply only: (1) to the extent a Benefit Feature has no claims provisions and is subject to the requirements of ERISA Section 503; and (2) to the extent the claim procedures of the Benefit Feature do not comply with the requirements of ERISA Section 503 but such compliance is legally required.

(b) Claims for Disability Benefits.

(i) Claim for Long-Term Disability Benefits. Any claim for long-term disability benefits under the appropriate Benefit Feature must be filed with the Claim Reviewer within the designated time period on the designated form, and will be deemed filed upon receipt. The claimant must submit any required physician statements on the appropriate form establishing that the claimant is disabled (as defined and set forth under the applicable disability Benefit

Feature). If the Claim Reviewer disagrees as to a claimant's initial or continuing disability, the terms of the applicable long-term disability Benefit Feature will be followed in resolving any such dispute. Upon a finding of a disability, the claimant will be deemed disabled as of the commencement of such disability.

(ii) Review of Claim For Long-Term Disability Benefits. When a claim for insured long-term disability benefits has been properly filed, the claimant will be notified of the approval or Denial within 45 days after the claim is received. If special circumstances require an extension of time for processing the claim, the 45-day period may be extended for up to two different extension periods, each consisting of 30 additional days. Written notice of the extension(s) will be furnished to the claimant prior to the expiration of the initial 45-day period and the first 30-day extension period, as applicable, and will: (A) specify the reasons for the extension(s) and when a final decision will be reached; and (B) explain the standards for payment, the unresolved issues that prevent a decision, and the information needed to resolve those issues. The claimant will have 45 days to provide any specified information to the Claim Reviewer.

(iii) Denial of Claim For Long-Term Disability Benefit Claims. If any claim for long-term disability benefits is partially or wholly denied, the claimant will be given notice which will contain: (A) the specific reasons for the Denial; (B) references to applicable Benefit Feature provisions upon which the Denial is based; (C) a description of any additional material or information needed and why such material or information is necessary; (D) a description of the review procedures and time limits, including a statement of the claimant's right to bring a civil action under ERISA Section 502(a); (E) the specific internal rule, guideline, protocol, or other similar criterion, if any, relied upon in making the Denial, or a statement that such rule, guideline, protocol, or other similar criterion was relied upon, with a copy free of charge upon request; and (F) if the Denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge upon request.

(iv) Appeal Denial of Claim for Long-Term Disability Benefits. A claimant may appeal the Denial of a claim for long-term disability benefits by filing a written claim appeal with the Claim Reviewer within 180 days after the claimant receives notice of the Denial, and will be deemed filed upon receipt. If the request is not timely, the decision of the Claim Reviewer will be the final decision of the applicable Benefit Feature, and will be final, conclusive, and binding on all persons.

The claimant will receive notice of the Claim Reviewer's decision on appeal within 45 days after receipt of the claimant's appeal request, unless special circumstances require an extension of time to process the appeal and the Claim Reviewer notifies the claimant: (A) of the extension; and (B) when a final decision will be reached (which will not be later than 90 days after receipt of such appeal). If the claim is denied on appeal, the claimant will be given notice containing the information listed in paragraph (iii) above. A decision on review will be final, conclusive, and binding on all persons.

(c) Claims for Medical Benefits.

(i) Initial Claim for Benefits. Any claim relating to Medical Benefits must be filed with the Claim Reviewer within the designated time period on the designated form, and will be deemed filed upon receipt. If a claimant fails to follow the claims procedures outlined herein for filing an *Urgent Care Claim* or a *Pre-Service Claim*, the claimant will be notified orally (unless the claimant requests written notice) of the proper procedures to follow, not

later than 24 hours for *Urgent Care Claims* and five days for *Pre-Service Claims*. This special timing rule applies only to *Urgent Care Claims* and *Pre-Service Claims* that: (A) are received by the person or unit customarily responsible for handling benefit matters; and (B) specify a claimant, a medical condition or symptom, and a specific treatment, service, or product for which approval is requested. The claimant must submit any required physician statements on the appropriate form (as required under the applicable Benefit Feature). If the Claim Reviewer disagrees with the physician statement, the terms of the applicable Benefit Feature will be followed in resolving any such dispute.

(ii) Review of Claim for Medical Benefits. When a claim for Medical Benefits has been properly filed, the claimant will be notified of the approval or Denial within the time periods set forth in the chart under Supplement A.

(iii) Denial of Claim for Medical Benefits. If any claim for Medical Benefits is partially or wholly denied, the claimant will be provided a notice containing those items described in paragraph 7.04(b)(iii) above, and for *Urgent Care Claims*, a description of the expedited review process applicable to such claims. For *Urgent Care Claims*, the information in the notice may be provided orally if the claimant is given notification within three days after the oral notification.

(iv) Appeal of Denial of Claim for Medical Benefits. A claimant may appeal the Denial of a claim for benefits by filing a written claim appeal with the Claim Reviewer within the time period set forth in Supplement A, which will be deemed filed upon receipt. If the request is not timely, the decision of the Claim Reviewer will be the final decision of the applicable Benefit Feature, and will be final, conclusive, and binding on all persons. For Urgent Care Claims, a claimant may make a request for an expedited appeal orally or in writing, and all necessary information will be transmitted by telephone, facsimile, or other similarly expeditious method.

The claimant will receive notice of the Claim Reviewer's decision on appeal within the time periods set forth in Supplement A. The Plan may involve a single-level or two-level appeal review with respect to the various Benefit Features offered under the Plan. If the claim is denied on appeal, the claimant will be given notice containing the information listed in paragraph 7.04(b)(iii) above. A decision on review will be final, conclusive, and binding on all persons, except as set forth in subsection (c) below.

(v) Ongoing Treatments. If the Claim Reviewer has approved an ongoing course of treatment to be provided to a claimant over a certain period of time or for a certain number of treatments, any reduction or termination under of such course of treatment before the approved period of time or number of treatments end will constitute a Denial. The claimant will be notified of the Denial in accordance with subsection (c), below, before the reduction or termination occurs to allow the claimant a reasonable time to file an appeal and obtain a determination on the appeal.

For an *Urgent Care Claim*, any request by a claimant to extend the ongoing treatment beyond the previously approved period of time or number of treatments will be decided 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.

(vi) External Review of Claims for Medical Benefits. A claimant who is dissatisfied with the outcome of his appeal may be eligible for External Review of that outcome by an Independent Review Organization ("IRO") pursuant to federal law. Denials that are eligible for External Review include: 1) Denials which, in the opinion of the external reviewer,

are based on medical judgment (excluding those Denials that involve only contractual or legal interpretation without any use of medical judgment); and 2) Denials related to a rescission of coverage. External Review of eligible Denials is available after the mandatory first level appeal.

Requests for External Review must be submitted to the Claims 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 that it is not reasonable to require a written statement. Claimants do not have to re-send the information that was submitted for internal appeal, but are permitted to submit any additional information that the claimant determines is important for review.

For pre-service claims involving urgent/concurrent care, a claimant 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 appeal process. The claimant or his 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, the claimant or his authorized representative must contact the Claims Reviewer at the number shown in the applicable Benefit Feature, and provide at least the following information:

- the identity of the claimant;
- the date(s) of the medical service;
- the specific medical condition or symptom;
- the provider's name
- the service or supply for which approval of benefits was sought; and
- any reasons why the appeal should be processed on a more expedited basis.

All other requests for 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 a claimant 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 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 Subject to ERISA. This subsection shall apply to all claims for welfare benefits not otherwise described in this Section (the "Other Welfare Benefits").

(i) Claim for Other Welfare Benefits. Any claim for Other Welfare Benefits must be filed with the Claim Reviewer within the designated time period on the designated form, and will be deemed filed upon receipt.

(ii) Initial Review of Claim for Other Welfare Benefits. A claim for Other Welfare Benefits will be evaluated and the claimant will be notified of the approval or Denial within ninety (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 the claimant prior to the termination of the initial 90-day period specifying 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).

(iii) Denial of Claim for Other Welfare Benefits. If any claim for Other Welfare Benefits is partially or wholly denied, the claimant will be receive a notice containing those items described in paragraph 7.04(b)(iii), above.

(iv) Appeal of Claim For Other Welfare Benefits. A claimant may appeal the Denial of a claim for Other Welfare Benefits by filing a written appeal request with the Claim Reviewer within 60 days after the claimant receives notification of the Denial, which will be deemed filed upon receipt. If the request is not timely, the decision of the Claim Reviewer will be the final decision of the applicable Benefit Feature, and will be final, conclusive, and binding on all persons.

The claimant will receive notice of the Claim Reviewer's decision on appeal within sixty days after receipt of the claimant's appeal request, unless special circumstances require an extension of time to process the appeal and the Claim Reviewer notifies the claimant: (A) of the extension; and (B) when a final decision will be reached (which will not be later than 120 days after receipt of such appeal). If the claim is denied on appeal, the claimant will be given notice containing the information listed in paragraph 7.04(b)(iii) above. A decision on review will be final, conclusive, and binding on all persons.

(e) Authorized Representative. The Plan and any underlying Benefit Feature shall not prevent an authorized representative of a claimant from acting on behalf of the claimant in pursuing a benefit claim or appeal, pursuant to reasonable procedures. In the case of an *Urgent Care Claim*, a Health Care Professional with knowledge of a claimant's medical condition shall be permitted to act as the authorized representative of the claimant.

(f) Calculating Time Periods. The period of time within which an initial benefit determination or a determination on an appeal is required to be made will begin when a claim or appeal is filed regardless of whether the information necessary to make a determination accompanies the filing.

Solely for purposes of initial *Pre-Service Claims*, *Post-Service Claims*, and long- term disability claims, if the time period for making the initial benefit determination is extended (in the Claim Reviewer's discretion) because the claimant failed to submit information necessary to decide the claim, the time period for making the determination will be suspended from the date notification of the extension is sent to the claimant until the earlier of: (1) the date on which response from the claimant is received; or (2) the end of the time period given to the claimant to provide the additional information (at least 45 days).

Solely for purposes of appeals of claims for benefits other than Medical Benefits, if the time period for making the determination on appeal is extended (in the Claim Reviewer's discretion) because the claimant failed to submit information necessary to decide the appeal, the time period for making the determination on appeal will be suspended from the date notification of the extension is sent to the claimant until the earlier of: (1) the date on which a response from the claimant is received; or (2) the end of the time period given to the claimant to provide the additional information (at least 45 days).

(g) Full and Fair Review. Upon request and free of charge, the claimant or his or her duly authorized representative will be given reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim, or may submit to the appropriate person or entity written comments, documents, records, and other information relating to the claim.

If timely requested, review of a denied claim will take into account all comments, documents, records, and other information submitted by the claimant or his or her duly authorized representative relating to his or her claim without regard to whether such information was submitted or considered in the initial benefit determination.

Appeals of claims for: (1) insured disability benefits; or (2) Medical Benefits will be reviewed by an appropriate named fiduciary of the Plan who is neither the individual nor subordinate of the individual who made the initial determination. The Claim Reviewer will not give any weight to the initial determination. In the case of a two-level appeal, the second level reviewer shall not afford deference to the first level review, nor shall the second level reviewer be the same individual or the subordinate of the first level reviewer. If the appeal is based, in whole or in part, on a medical judgment, the Claim Reviewer will consult with an appropriate Health Care Professional who is neither the individual nor subordinate of the individual who was consulted in connection with the initial determination (including the initial determination, or the first level if a two-level appeal process is used). The Claim Reviewer will identify any medical or vocational experts whose advice was obtained without regard to whether the advice was relied upon in making the benefit determination.

Claimants and this Plan may have other voluntary alternative dispute resolution options, such as mediation. For available options, claimants could contact their local U.S. Department of Labor Office and their state insurance regulatory agency.

(h) Exhaustion of Remedies. If a claimant fails to file a request for review of a Denial, in whole or in part, of benefits in accordance with the procedures herein outlined, such claimant 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 on all persons for all purposes.

ARTICLE IX.
SUBROGATION AND REIMBURSEMENT RIGHTS

Section 9.01. Right of Subrogation and Reimbursement. The following provisions shall apply to the subrogation and reimbursement rights of this Plan, as well as any Benefit Feature. For purposes of this Article, "Plan" shall refer to the Plan and any underlying Benefit Feature. The Plan has the right to full subrogation and reimbursement of any and all amounts paid by the Plan to, or on behalf of, a Covered Person, for which a third party is allegedly responsible. The Plan shall have a lien against such funds, and the right to impose a constructive trust upon such funds, and shall be reimbursed therefrom.

Section 9.02. Funds to Which Subrogation and Reimbursement Rights Apply. The Plan's subrogation and reimbursement rights apply if the Covered Person receives, or has the right to receive, any sum of money, regardless of whether it is characterized as amounts paid for medical expenses or otherwise, paid or payable from any person, plan, or legal entity that is legally obligated to make payments as a result of a judgment, settlement, or otherwise, arising out of any act or omission of any third party, (whether a third party or another Covered Person under the Plan): (a) who is allegedly wholly or partially liable for costs or expenses incurred by the Covered Person, in connection for which the Plan provided benefits to, or on behalf of, such Covered Person; or (b) whose act or omission allegedly caused injury or sickness to the Covered Person, in connection for which the Plan provided benefits to, or on behalf of, such Covered Person.

Section 9.03. Agreement to Hold Recovery in Trust. If a payment is made under this Plan, and the person to or for whom it is made recovers monies from a third party described in Section 9.02 as a result of settlement, judgment, or otherwise, that person shall hold in trust for the Plan the proceeds of such recovery and reimburse the Plan to the extent of its payments.

Section 9.04. Disclaimer of "Make Whole" Doctrine. The Plan has the right to be paid first and in full from any settlement or judgment, regardless of whether the Covered Person has been "made whole." The Plan's right is a first priority lien, which rights shall continue until the Covered Person's obligations hereunder to the Plan are fully discharged, even though the Covered Person does not receive full compensation or recovery for Injuries, damages, loss or debt. The Plan's right to subrogation *pro tanto* shall exist in all cases.

Section 9.05. Disclaimer of Common Fund Doctrine. The Covered Person shall be responsible for all expenses of recovery from such third parties or other persons, including but not limited to, all attorneys' fees incurred in collection of such third-party payments, or payments by other persons. Any attorneys' fees and/or expenses owed by the Covered Person shall not reduce the amount of reimbursement due to the Plan.

Section 9.06. Obligations of the Covered Person. The Covered Person shall furnish any and all information and assistance requested by the Administrator. If requested, the Covered Person shall execute and deliver to the Administrator a subrogation and reimbursement agreement before or after any payment of benefits by the Plan. The Covered Person shall not discharge or release any party from any alleged obligation to the Covered Person or take any other action that could impair the Plan's rights to subrogation and reimbursement without the written authorization of the Administrator.

Section 9.07. Right to Subrogation. If the Covered Person or anyone acting on his or her behalf has not taken action to pursue his or her rights against a third party described in Section 9.01 above or any other persons to obtain a judgment, settlement or other recovery, the Administrator or its designee, upon giving 30-day advance written notice to the Covered Person, shall have the right to take such action in the name of the Covered Person to recover that amount of benefits paid under the Plan; provided, however, that any such action taken without the consent of the Covered Person shall be without prejudice to such Covered Person.

Section 9.08. Enforcement of Right to Reimbursement. If a Covered Person fails or refuses to comply with these provisions by reimbursing the Plan as required herein, the Plan has the right to impose a constructive trust over such any and all funds received by the Covered Person, or as to which the Covered Person has the right to receive. The Plan, through the Administrator, has the authority to pursue any and all legal and equitable relief available to enforce the rights contained in this Article, against any and all appropriate parties who may be in possession of the funds described herein.

Section 9.09. Withholding of Payments for Benefits. The Plan may withhold payment of benefits for an Injury when a party other than the Covered Person or the Plan may be liable for expenses for that Injury until liability is legally determined. In the event that any payment is made under the Plan for which any party other than the Covered Person or the Plan may be liable, the Plan shall be subrogated to all rights of recovery of the Covered Person to the extent of payments by the Plan and shall have the right to be reimbursed as set forth in this Article.

Section 9.10. Failure to Comply. If a Covered Person fails to comply with the requirements under this Article, the Covered Person shall not be eligible to receive any benefits, services or payments under the Plan for any sickness or injury until there is compliance, regardless of whether such benefits are related to the act or omission of such third party or other persons.

Section 9.11. Future Claims Excluded. If the Covered Person receives any sum of money described in Section 9.02 above, the Plan shall have no further obligation to pay benefits relating in any way to future claims for the same or related injuries, including but not limited to any complications

thereof, for which the Covered Person received such sum of money, and benefits for such future claims shall be excluded.

Section 9.12. Discretionary Authority of Administrator. The Plan, through the Administrator, shall have full discretionary authority to interpret the provisions of this Article, and to administer and pursue the Plan's subrogation and reimbursement rights. It shall be within the discretionary authority of the Administrator to resolve, settle, or otherwise compromise its subrogation and reimbursement rights when appropriate. The Administrator is under no legal obligation to reduce its lien or reimbursement rights unless, in its sole discretion, it determines that doing so is appropriate.

ARTICLE X.
EMPLOYERS AND AFFILIATES

Section 10.01. Participation by Affiliates. Any Affiliate may adopt the Plan for the benefit of its employees by (i) filing a certified copy of a resolution of its board of directors or similar governing body to that effect with the Company; and (ii) obtaining the Company's consent to such adoption of the Plan.

Section 10.02. Withdrawal by Employers. Any Employer may withdraw from the Plan by delivering to the Committee a resolution of its governing body authorizing its withdrawal as an Employer hereunder subject to approval of the Board; or, in the event of a sale of an Employer, as provided under the sale document between the parties, as of the effective date set forth in such sale document.

ARTICLE XI.
AMENDMENT OR TERMINATION

The Company, by action of the Committee, shall have the right in its sole discretion to modify or amend the Plan, the Schedule of Benefits or any underlying Benefit Feature. Such modification or amendment shall be duly incorporated in writing. The Company, by action of the Board, shall have the right in its sole discretion to terminate the Plan or any Benefit Features (or any portion of a Benefit Feature) at any time. Any such amendment or termination shall be effective in accordance with the time limitations provided under ERISA, or such later date as the Company, by action of the Board or the Committee, as applicable, will determine. To the extent permitted under ERISA, any such amendment may be effective retroactively.

ARTICLE XII.
MISCELLANEOUS

The following provisions shall apply only to the extent such provisions are not set forth in a similar provision of a Benefit Feature provided under the Plan and/or are not inconsistent with the provisions thereof.

Section 12.01. Nonalienation. Except as otherwise required under ERISA Section 609, no benefit under the Plan and underlying Benefit Feature shall be subject to any debt, liability, contract, engagement, or tort of any employee, dependent, or his beneficiary, nor subject to anticipation, sale, assignment (except in the case of Medical Benefits), transfer, encumbrance, pledge, charge, attachment, garnishment, execution, alienation, or any other voluntary or involuntary alienation or other legal or equitable process, nor transferable by operation of law except as may be provided in the Benefit Feature.

Section 12.02. Headings. Any headings or subheadings in the Plan are inserted for convenience of reference only and shall be ignored in the construction of any provisions of the Plan.

Section 12.03. Employment of Advisors. The Administrator, or a fiduciary named by the Administrator pursuant to the Plan, may employ one or more persons to render advice with regard to their respective responsibilities under the Plan.

Section 12.04. Designation of Fiduciaries. The Administrator may designate another person or persons to carry out any fiduciary responsibility of the Administrator under the Plan. The Administrator shall not be liable for any act or omission of such person in carrying out such responsibility, except as may be otherwise provided under ERISA.

Section 12.05. Fiduciary Responsibilities. To the extent permitted under ERISA, no fiduciary of the Plan shall be liable for any act or omission in carrying out his or her responsibilities under the Plan.

Section 12.06. Allocation of Fiduciary Responsibilities. To the extent permitted under ERISA, each fiduciary under the Plan shall be responsible only for the specific duties assigned under the Plan and shall not be directly or indirectly responsible for the duties assigned to another fiduciary.

Section 12.07. Limitation of Rights and Obligations. Neither the establishment nor maintenance of the Plan nor any amendment thereof, nor the purchase of any Benefit Feature, including any benefit contract or insurance policy, nor any act or omission under the Plan or resulting from the operation of the Plan shall be construed:

(a) as conferring upon any Covered Person or beneficiary, or any other person any right or claim against an Employer, Claim Reviewer, or the Administrator, except to the extent that such right or claim shall be specifically expressed and provided in the Plan or provided under ERISA;

(b) as creating any responsibility or liability of an Employer, Administrator, or the Claim Reviewer for the validity or effect of the Plan;

(c) as a contract or agreement between an Employer and any Covered Person or other person;

(d) as being consideration for, or an inducement or condition of, employment of any Eligible Employee or other person, or as affecting or restricting in any manner or to any extent whatsoever the rights or obligations of an Employer or any Eligible Employee or other person to continue or terminate the employment relationship at any time; or

(e) as giving any Eligible Employee or any other person the right to be retained in the service of an Employer or to interfere with the right of an Employer to discharge any Eligible Employee at any time.

Section 12.08. Notice. Any notice given under the Plan shall be sufficient if given to the Administrator, when addressed to its office; if given to the Claim Reviewer, when addressed to its office; or if given to a Covered Person, when addressed to the Covered Person at his or her address as it appears in the records of the Administrator or the Claim Reviewer.

Section 12.09. Disclaimer of Liability. Nothing contained herein shall confer upon a Covered Person any claim, right, or cause of action, either at law or at equity, against the Plan, the

Administrator, an Employer, or the Claim Reviewer for the acts or omissions of any provider of services or supplies for any benefits provided under the Plan.

Section 12.10. Right of Recovery. If an Employer, the Administrator, or the Claim Reviewer makes any payment that according to the terms of the Plan and the benefits provided hereunder as defined in the Schedules of Benefits should not have been made, the Employer, the Administrator, or the Claim Reviewer may recover that incorrect payment, whether or not it was made due to the Employer's, the Administrator's, or the Claim Reviewer's own error, from the person to whom it was made, or from any other appropriate party. If any such incorrect payment is made directly to a Covered Person, then the Employer, the Administrator, or the Claim Reviewer may deduct it when making future payments directly to that Covered Person.

Section 12.11. Legal Counsel. The Administrator and/or its designee, may from time to time consult with counsel, who may be counsel for the Company, and shall be fully protected in acting upon the advice of such counsel.

Section 12.12. Evidence of Action. All orders, requests, and instructions to the Administrator or the Claim Reviewer by an Employer or by any duly authorized representative, shall be in writing and the Administrator and the Claim Reviewer shall act and shall be fully protected in acting in accordance with such orders, requests, and instructions.

Section 12.13. Bonding. Except as otherwise required under ERISA, each fiduciary of the Plan shall be bonded in an amount not less than ten percent of the amounts of assets of the Plan handled by such fiduciary; provided, however, such bond shall not be less than $1,000 and need not be for more than $500,000. The expense of such bond shall be paid from the assets of the Plan unless paid by the Company.

Section 12.14. Protective Clause. Neither the Company, an Employer, nor the Administrator shall be responsible for the validity of any contract of insurance or other benefit contract or policy by any benefit provider issued to the Company or Employer or for the failure on the part of any insurance company or other benefit provider to make payments thereunder.

Section 12.15. Receipt and Release. Any payments to any Covered Person shall, to the extent thereof, be in full satisfaction of the claim of such Covered Person being paid thereby, and the Administrator may condition payment thereof on the delivery by the Covered Person of the duly executed receipt and release in such form as may be determined by the Administrator.

Section 12.16. Legal Actions. If the Administrator is made a party to any legal action regarding the Plan, except for a breach of fiduciary responsibility of such person or persons, any and all costs and expenses, including reasonable attorneys' fees, incurred by the Administrator in connection with such proceeding shall be paid from the assets of the Plan unless paid by the Company.

Section 12.17. Reliance. The Administrator shall not incur any liability in acting upon any notice, request, signed letter, telegram, or other paper or document believed by the Administrator to be genuine or to be executed or sent by an authorized person.

Section 12.18. Qualified Medical Child Support Orders. The Plan shall provide benefits under the applicable Benefit Features in accordance with the applicable requirements of a qualified medical child support order ("QMCSO"), as required by ERISA Section 609. If the Plan receives a medical child support order, the Administrator shall promptly notify the Eligible Employee, and each child of the Eligible Employee identified in the order, of the receipt of such order and the Plan's procedures for determining whether the order is a QMCSO. Within a reasonable time after receipt

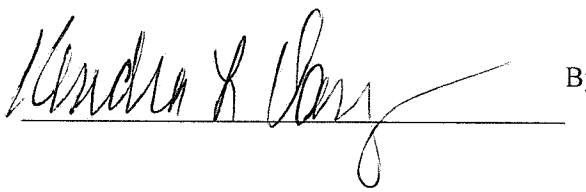
of such order, the Administrator shall determine whether the order is a QMCSO and notify the Eligible Employee and each child involved of the determination. The Administrator shall establish written procedures in accordance with ERISA Section 609 to determine whether a medical child support order received by the Plan constitutes a QMCSO.

Section 12.19. Counterparts. The Plan may be executed in any number of counterparts, each of which shall be deemed to be an original. All counterparts shall constitute but one and the same instrument and shall be evidenced by any one counterpart.

Section 12.20. Entire Plan. The Plan and the documents incorporated by reference herein shall constitute the only legally governing documents for the Plan. No oral statement or other communication shall amend or modify any provision of the Plan as set forth herein.

IN WITNESS WHEREOF, the Committee has caused the Plan to be executed as of this 2nd day of August 2016, to be effective as of the date identified above.

HEALTH AND WELFARE ADMINISTRATIVE COMMITTEE

By: 

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SCHEDULE A

INSURED BENEFITS

Effective as of January 1, 2016

Benefit Feature	Insurance Company/Provider	Policy Number or Contract Number
1. Dental Insurance	Health Resources	606020670333
2. Dental Insurance	Health Resources	606030970333
3. Dental Insurance	Delta Dental	0789
4. Vision Insurance	Vision Service Plan	12126113
5. Employee Life and Accidental Death Insurance (basic life)	Reliance	GL141754
6. Dependent Life Insurance	Reliance	GL141701
7. Supplemental Life Insurance	Reliance	GL141701
8. Long-Term Disability Insurance	Reliance	LTD 115702
9. Accident Death & Dismemberment Insurance	Reliance	VAR 203834
10. Critical Illness Insurance	Reliance	VCI 800083
11. Supplemental Accident Plan	Reliance	VAI 825591
12. Anthem Medicare Preferred (PPO) Group Plan (retiree medical)	Anthem	00218702-0000

SCHEDULE B

OTHER BENEFITS

Effective as of January 1, 2016

Benefit Feature	Administrator
1. 4 PPO Options and 3 HDHP Options	Anthem
2. Old National Bancorp Employees' Supplemental Severance Pay Plan	Old National Bancorp
3. Old National Bancorp Severance Pay Plan	Old National Bancorp
4. Tax Saver Plan	Employee Plans, LLC
5. Employee Assistance Program	ACI Specialty Benefits
6. Employer Sponsored Wellness Center	Activate Healthcare

SUPPLEMENT A

CLAIM FOR MEDICAL BENEFITS – TIME LIMITATIONS

TYPE OF CLAIM	Initial Claim	Notice to Claimant – if additional information needed	Notice to Claimant - failure to follow claim procedures	Claimant - Deadline to provide necessary materials	Claim Reviewer – Deadline to Adjudicate Claim	Claimant – Deadline to file appeal	Claim Reviewer – Deadline to adjudicate appeal
Urgent Care Claims	No later than 72 hours after receipt of claim. No extension available.	No later than 24 hours after receipt of incomplete claim	No later than 24 hours after receipt of improper claim	Not less than 48 hours after receipt of notice from Claim Reviewer	No later than 48 hours after earlier of receipt of additional information from claimant or end of the time period for claimant to provide additional information (48 hours)	180 days after receipt of Denial If second level of appeal applies – claimant must have reasonable opportunity to pursue second appeal	All appeals must be decided within 72 hours after receipt of appeal
Pre-Service Claims	No later than 15 days after receipt of claim by the Claim Reviewer. 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.	N/A	No later than 5 days after receipt of improper claim	At least 45 days after receipt of notice from Claim Reviewer *Note*: Claim Reviewer may or may not request needed information from claimant.	No later than 15 days after earlier of receipt of additional information from claimant, if requested, or end of the time period for claimant to provide additional information (45 days)	180 days after receipt of Denial If second level of appeal applies – claimant must have reasonable opportunity to pursue second 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
Post-Service Claims	No later than 30 days after receipt of claim by the Claim Reviewer	N/A	N/A	At least 45 days after receipt of notice from Claim Reviewer *Note*: Claim Reviewer may or may not request needed information from claimant.	No later than 15 days after earlier of receipt of additional information from claimant, if requested, or end of the time period for claimant to provide additional information (45 days)	180 days after receipt of Denial If second level of appeal applies – claimant must have reasonable opportunity to pursue second 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 request