OLD NATIONAL BANCORP TAX SAVER BENEFIT PLAN AND SUMMARY PLAN DESCRIPTION

A Benefit Feature Incorporated Under Plan Number 502

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OLD NATIONAL BANCORP TAX SAVER BENEFIT PLAN AND SUMMARY PLAN DESCRIPTION

PURPOSE OF PLAN/SPD

The Plan/SPD was originally adopted effective April 1, 1986, and most recently updated effective January 1, 2014. The Plan/SPD allows you to: (A) direct your Employer to pay for your cost of Health Coverage, Dental Coverage, Vision Coverage, and Life Coverage with pre-tax dollars; (B) save additional taxes through a Health Care Flexible Spending Account and/or a Dependent Care Flexible Spending Account; and (C) pay contributions to a Health Savings Account with pre-tax dollars.

If you participate in the Plan/SPD, you will not pay federal, state, local, or Social Security and Medicare taxes on these pre-tax amounts. Please be aware that this may reduce your future Social Security benefits. The Plan/SPD is intended to qualify as a "cafeteria plan" within the meaning of Code Section 125.

This Plan/SPD is part of the Old National Bancorp Employee Welfare Benefits Plan ("Employee Welfare Benefits Plan"). The terms of the Employee Welfare Benefits Plan will govern this Plan/SPD, except where Plan/SPD terms are different.

DEFINITIONS

Throughout this Plan/SPD the capitalized words have precise meanings. The special definitions of the capitalized words are defined here:

"Accounts" means a Participant's:

- "**Dependent Care Flexible Spending Account**" which account is used for reimbursement of Dependent Care Expenses.
- "**Health Care Flexible Spending Account**" which account is used for reimbursement of Qualifying Health Care Expenses.

"**Administrator**" means the Company, who serves as plan administrator under Section 3 of ERISA.

"**Board**" or "**Board of Directors**" means the Company's Board of Directors.

"**Calendar Year**" means the 12-month period beginning on each January 1 and ending on each December 31.

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

"**Code**" means the Internal Revenue Code of 1986, as amended.

“**Company**” means Old National Bancorp and its successors and assigns.

“**Compensation**” means the cash payments you receive, after you began participation in the Plan/SPD, from your Employer that is reportable as wages for federal income tax purposes, plus any elective deferrals or any other amounts excludable from taxable income because of an election under Code Section 125 or 401(k).

“**Debit Card**” means the card available for point of service direct debiting of your Health Care Flexible Spending Account for Qualifying Health Care Expenses and Dependent Care Flexible Spending Account for Dependent Care Expenses.

“**Dental Coverage**” means any coverage available under any group dental plan maintained by the Employer to which you make contributions.

“**Dependent Care Reimbursement**” means reimbursement for services that, if paid for by you, would be considered employment-related expenses under Code Section 21(b)(2).

“**Earned Income**” means earned income as defined in Code Section 32(c)(2), but excluding any amounts you paid or Incurred for Dependent Care Reimbursement under the Plan/SPD. If your spouse is a full-time student, or is physically or mentally incapable of caring for himself or herself, and shares your principal place of abode with you, your spouse will be deemed to have Earned Income of not less than:

- $250 per month if you have 1 Qualifying Individual; or
- $500 per month if you have 2 or more Qualifying Individuals.

“**Eligible Employee**” means any Employee of an Employer who is considered a Full-Time Employee or a Part-Time Level One Employee under the Employer’s standard personnel policies. Full-Time Employees and Part-Time Level One Employees are eligible for all benefits provided under the Plan/SPD.

The term “Eligible Employee” does not include (but is not limited to excluding the following): (1) Part-Time Level Two Employees; (2) an Early Retiree of the Company;(3) an Acquisition Retiree of the Company; (4) an Acquisition Director of the Company; (5) a temporary or seasonal Employee; (6) an intern; (7) any leased employees as defined under Code Section 414(n) or a contract employee; (8) any person who is a member of the Board of Directors or of any committee appointed by such Board of Directors who is not an Eligible Employee of an Employer; (9) any person employed pursuant to a written agreement that provides that such person will not be eligible for participation under the Plan/SPD; (10) any person designated in good faith by an Employer as an independent contractor, regardless of whether such person is later determined to be a common-law employee for tax purposes; or (11) nonresident aliens with no earned U.S. income.

Notwithstanding the paragraphs above, an Employee who is a participant in a High Deductible Health Plan may be an “Eligible Employee” for purposes of making an election under the Health Care Flexible Spending Account for Qualifying Health Care Expense coverage and receiving benefits. However, the Qualifying Health Care Expenses for which such an Eligible Employee may be reimbursed will be limited as set forth under “**Qualifying Health Care Expenses**”.

Notwithstanding the paragraphs above, for purposes of making an election under a Health Savings Account, an "Eligible Employee" must:

- be a participant in a High Deductible Health Plan ("HDHP"); and
- not, while covered under a HDHP, be covered under any other health plan that is not a HDHP and that provides coverage for any benefit that is covered under the HDHP (except as provided in Code Section 223(c)(1)(B).

"**Employee Medical Benefits Program**" means the Old National Bancorp Employee Medical Benefits Program consisting of the Basic PPO Plan, Package 002, the HDHP Plan, Package 005, and the HRA 1 Plan.

"**Employer**" means, severally, the Company and any affiliated employer that is a member of a controlled group of corporations, trades or businesses, affiliated service group, or other entity as provided under Code Section 414(b), (c), (m), and (0), that participates in the Employee Welfare Benefits Plan and this Plan/SPD.'

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

"**FMLA**" means the Family and Medical Leave Act of 1993, as amended.

"**Health Coverage**" means medical, prescription drug, and/or mental health/substance abuse coverage provided under the health plan maintained by the Employer, including High Deductible Health Plans to which you make contributions. It does not include coverage for qualified long-term care services (as defined in Code Section 7702(B)(c) or coverage for any product that is advertised, marketed, or offered as long-term care insurance.

"**Health Savings Account**" or "**HSA**" means a trust created or organized in the United States as a health savings account exclusively for the purpose of paying the qualified medical expenses of the account beneficiary that meets the requirements of Code Section 223(d) and that is recognized by the Employer, in its sole discretion and reflected on Exhibit A, as eligible to receive salary reduction contributions.

"**High Deductible Health Plan**" or "**HDHP**" means a group health plan sponsored by an Employer that meets the requirements of Code Section 223.

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

"**Incurs**" or "**Incurred**" refers to the date after you become a Participant, that care or services are provided, not the date you are billed or pay for such care or services.

"**Life Coverage**" means optional life and/or voluntary accident life benefits for you under the life plan maintained by the Employer, to which you make contributions.

"**Part-Time Level Two Employee**" means any Employee of an Employer who is considered a Part-Time Level Two Employee under the Employer's standard personnel policies.

"**Participant**" means an Eligible Employee who has begun participation in the Plan/SPD and has not subsequently become ineligible to participate.

"**Plan/SPD**" means the Old National Bancorp Tax Saver Benefit Plan and Summary Plan Description, as set forth in this document, as amended from time to time.

"**Plan Supervisor**" means the company that processes reimbursements for the Participant's Accounts.

"**Qualified Benefit**" means the benefits for: (1) Health Coverage; (2) Dental Coverage; (3) Vision Coverage; and/or (4) Life Coverage.

"**Relative**" means your son, daughter, descendant of a son or daughter, stepson, stepdaughter, brother, sister, stepbrother, stepsister, father, mother, ancestor of a father or mother, stepfather, stepmother, nephew, niece, uncle, aunt, and in-laws.

"**Special Participant**" means an individual who is deemed to have elected coverage under the Plan (see **COBRA/RETIREE MEDICAL PREMIUMS** below).

"**USERRA**" means the Uniformed Services Employment and Reemployment Rights Act of 1994.

"**Vision Coverage**" means any coverage available under any group vision plan maintained by the Employer to which you make contributions.

"**Waiting Period**" means the number of continuous days of employment an Eligible Employee must satisfy before his or her coverage under the Plan/SPD becomes effective. See below for the specific Waiting Period.

PARTICIPATION IN THE PROGRAM

A. When Participation Begins. Each Eligible Employee may become a Participant under the Plan/SPD effective as of the first day of the month following one month of employment with the Employer. For an Eligible Employee who chooses not to participate within 31 days of first being eligible, such Eligible Employee must wait until the next January 1 to elect to participate or until a change in status or applicable event.

If you do not meet the definition of an Eligible Employee when you are first hired, and subsequently meet the definition of an Eligible Employee, you will be covered on the first day of the month following one month from your change to Eligible Employee status, provided you properly elect coverage.

Full-Time Employees and Part-Time Level One Employees are eligible for all benefits provided under the Plan/SPD.

In connection with the merger of United Bancorp, Inc. with and into the Company effective as of July 31, 2014 (the "Merger"), the United Bancorp, Inc. Flexible Spending Account Plan (the "United Plan") was merged with and into the Plan/SPD. Except as otherwise specifically provided in this Plan/SPD, Eligible Employees who participated in the United Plan prior to the Merger ("United Participants"), will participate in the Plan/SPD in accordance with the terms and provisions set forth in this Plan/SPD.

B. <u>When Participation Ends</u>. Except as required by COBRA, USERRA, or the section of the Plan/SPD entitled **COBRA/RETIREE MEDICAL PREMIUMS**, you will no longer be a Participant on the earliest to occur of:

- the date the Plan/SPD terminates;
- the last day of the month in which employment with an Employer has terminated or you retire;
- the last day of the month in which you are no longer an Eligible Employee(except as otherwise required by USERRA or the FMLA);
- with respect to pre-tax premium deductions for Qualified Benefits, the last day of the month in which coverage under the underlying Qualified Benefit ends or COBRA coverage begins; or
- the last day of the month in which you stop making required contributions.

C. <u>Reinstatement of Participation by Former Participants</u>. If you participate in the Plan/SPD, terminate employment with an Employer, and then return to employment with an Employer following your termination of employment, you must again satisfy the eligibility requirements and make a new election under the Plan/SPD for the remainder of the calendar year.

D. <u>Unpaid Leaves of Absence that Qualify under the FMLA</u>.

(1) **Stopping Your Contributions**. If you take an unpaid FMLA leave of absence, you may stop your contributions for your benefits (health, dental, vision, life, flexible spending account benefits, and HSA) for the duration of the FMLA leave. Payments may be made on a catch up basis when you return. You may then again elect coverage when you return from unpaid FMLA leave during the same calendar year. To qualify as Dependent Care Expenses, the expenses Incurred must be expenses that allow you and your spouse (if applicable) to work and to care for certain qualified dependents. Therefore, under most all circumstances, Dependent Care Expenses that you incur during a leave of absence would not be considered “qualified” because they are not being Incurred in order for you and your spouse (if applicable) to work (i.e., in the event of illness). Therefore, you will want to carefully consider this in your decision.

If you stop making contributions to the Health Care Flexible Spending Account while on unpaid FMLA leave, you will not be entitled to reimbursement of Qualifying Health Care Expenses that are Incurred during the period you stopped making contributions to the Health Care Flexible Spending Account. If you return from FMLA leave during the same calendar year, your coverage level will be reduced by any prior reimbursements made from your Account and you may:

- resume coverage at the same level before the FMLA leave and make up any unpaid contributions; or
- resume coverage at a level that is reduced on a pro rata basis for the period no contributions were made and resume payments at the level before the leave.

(2) **Continuing Your Contributions**. If you decide to continue contributions and coverage while on an unpaid FMLA leave, payments will be made in a manner consistent

with the Company's leave practices. In addition, when you return from an unpaid FMLA leave, you may make a new election for the remainder of the calendar year as allowed under the "**Change in Status**" rules below.

AVAILABLE BENEFITS

A. Pre-Tax Benefits. Once you become eligible to participate in the Plan/SPD as an Eligible Employee and are eligible for the Qualified Benefits, you will be presumed to elect, on a pre-tax basis, per pay period, an amount equal to your cost for Health Coverage, Dental Coverage, Vision Coverage, and/or Life Coverage, unless you elect not to participate. The cost may change each year. You will be informed of the amount of contributions for Health, Dental, Vision, or Life Coverage benefits. Your share of the benefit costs will be deducted from your pay in equal amounts in 24 of the 26 pay periods in a calendar year.

You may also reduce your salary, on a pre-tax basis, to participate in the Health Care Flexible Spending Account and/or Dependent Care Flexible Spending Account. You will not be required to pay federal, state, or local income taxes, Social Security or Medicare taxes on any pre-tax reduction amounts.

EXAMPLE

Suppose your annual salary is $45,000, you are married and claim one withholding allowance and your spouse does not work. See what happens if you do participate in the Plan/SPD compared to what happens if you don't:

If You DON'T Participate		If You DO Participate
$ 45,000.00	Annual Pay	$ 45,000.00
- N/A	Pre-Tax Payments (under the Plan/SPD)	- 2,000.00
$ 45,000.00	Taxable Pay	$ 43,000.00
- 440.00	County Withholding	- 420.00
- 4,007.00	Federal Income Withholding	- 3,707.00
- 1,496.00	State Tax Withholding	- 1,428.00
- 2,790.00	Social Security	- 2,666.00
- 652.50	Medicare	- 623.50
- 2,000.00	After-Tax Payments (not under the Plan/SPD)	- N/A
$ 33,614.50	Spendable Pay	$ 34,155.50
	Savings	**$541.00**

In this example you would be spending the same $2,000, but by making your premium payments on a pre-tax basis, you increase your "spendable" pay by $541.00.

Effective January 1, 2008, if you:

- are a participant in a HDHP, <u>and</u>
- while covered under a HDHP, are not covered under any other non-HDHP that provides coverage for any benefit covered under the HDHP,

you may elect to reduce your salary, on a pre-tax basis per pay period, to pay for contributions to a Health Savings Account. Employees who are enrolled in or are

participants in any health coverage other than a High Deductible Health Plan, will not be eligible under the Health Savings Account. Such election must be filed within the applicable election period.

B. **Elections and Election Period**. To make an election for the calendar year in which you first become a Participant, you must make an election for Qualified Benefit coverage during the online enrollment process *within 31 days* after your hire date. Solely with respect to the Calendar Year ending December 31, 2014, United Participants' qualified benefit elections which were in effect under the United Plan as of day prior to the Merger will remain in effect for the remainder of such Calendar Year, subject to the occurrence of any "change in status" or "applicable events" (described in Part C. of the section entitled Available Benefits) prior to the last day of such Calendar Year. Expenses Incurred by United Participants during the Calendar Year ending December 31, 2014 may be reimbursed using amounts credited to the United Participants' pursuant to the qualified benefit elections under the United Plan.

If, in your initial year of eligibility, you elect not to participate in the Plan/SPD on or before the specified due date, you will be deemed to have elected:

- **not** to receive pre-tax Health Coverage, Dental Coverage, Vision Coverage, or Life Coverage;
- **not** to have your salary reduced to participate in the Health Care Flexible Spending Account and/or Dependent Care Flexible Spending Account; and
- **not** to have your salary reduced for contributions to a Health Savings Account.

For each calendar year after you become a Participant (your "annual enrollment"), Participants will receive on-line open enrollment materials, as will Eligible Employees who have not yet elected coverage. At open enrollment you may make an election to:

- change your current coverage;
- stop your coverage; or
- begin coverage, by completing the online open enrollment process.

The online open enrollment process will generally take place up to 60 days before the first day of the next calendar year. Your deduction will be effective on the first payroll in the next calendar year.

If you do not access the online enrollment process on or before the specified due date for the next calendar year, you will be deemed to have made:

- a **re-election of the same coverage** for Health Coverage, Dental Coverage, Vision Coverage, and/or Life Coverage benefits, if any, as in effect for the current calendar year; provided, however, if such coverage is not available you will not receive such coverage;

- an election **not** to participate under the Health Care Flexible Spending Account and/or Dependent Care Flexible Spending Account (regardless of any election in effect for the current calendar year); and

- an election **not** to have your salary reduced for contributions to a Health Savings Account (regardless of any election in effect for the current calendar year).

In any event, if you do not access the online enrollment process as required above and the Qualified Benefit coverage option in which you participate in is no longer offered, then you will be deemed to have made an election not to participate in the Qualified Benefit option for which previous coverage was eliminated, nor under the Health Care Flexible Spending Account and/or Dependent Care Flexible Spending Account and/or Health Savings Account.

EXAMPLE

In the current calendar year you have coverage under a Health Coverage option, Life Coverage, and participate in the Health Care Flexible Spending Account. Assume you do not make an online enrollment for the next calendar year and the Employer no longer offers the Health Coverage option in which you currently participate. In the next calendar year, you will be deemed to have elected: (i) no Health Coverage; (ii) Life Coverage; and (iii) no Health Care Flexible Spending Account coverage.

C. Changes in Election During the Year.

Note, you may change or revoke your HSA election at any time during the calendar year. Therefore your HSA election changes are NOT restricted to the events described in this Section C.

An election may only be changed as of the beginning of each calendar year unless:

- there is a "change in status;" or
- another "applicable event" occurs.

To change or end an annual election due to a "**change in status**" or another "**applicable event**," you must access the online portal and submit your request for change within 31 days of the "change in status" or the "applicable event" (60 days in the event of a status change described in the second paragraph under the section of this summary entitled Special Enrollment). The election change will be effective the first of the month following the later of: (1) the date of the change in status or applicable event; or(2) the date of your new election, provided the online open enrollment process is completed. (Note: for birth/adoption or placement for adoption, the effective date will be the date of the birth/adoption or placement for adoption).

(1) "**Change in Status**"

You may change and make a new election or cancel an election to participate in the Plan/SPD **during the year** if you have a "change in status." The change, election, or cancellation must be on account of the change in status, necessary or appropriate as a result of the status change, and consistent with the terms and conditions of the Health, Dental, Vision, or Life Coverage.

"Changes in status" include:

- a change in your legal **marital status**, including
    - divorce,
    - marriage,
    - legal separation or annulment of your marriage;

- a change in the number of your **dependents**, including
    - the death of a spouse or dependent, or
    - the birth or adoption (or placement for adoption) of your child;

- a change in your, your spouse's, or *your dependent's* **employment status**, including
    - the termination or commencement of employment,
    - a change from part-time to full-time or full-time to part-time employment,
    - a commencement of or return from an unpaid leave of absence, or
    - a change in worksite that affects eligibility;

- your dependent satisfying or ceasing to satisfy the definition of "**dependent**" under the Health Coverage, Dental Coverage, Vision Coverage, or Life Coverage, including attainment of a certain age; or

- your, your spouse's, or your dependent's change in the place of residence that affects eligibility.

(2) **Other "Applicable Events"**

There are other situations in which you can change your election mid-year before the annual open enrollment process. These situations include:

- Significant Change in Cost or Coverage
- Addition or Significant Improvement of Benefit Program Option Providing Similar Coverage
- Change in or Loss of Coverage Under Other Employer's Plan or Other Group Health Plan
- Loss of Coverage under Governmental Educational Group Health Plan • Special Enrollment
- Entitlement to Medicare or Medicaid
- Court Order/Medical Child Support Order

Significant Change in Cost or Coverage (Does ***Not*** Apply to Health Care Flexible Spending Account Elections).

- *Significant Cost Increase or Decrease*. If you elect to participate in the Plan/SPD and your **cost** for Health, Dental, Vision, or Life Coverage, or

Dependent Care Flexible Spending Account coverage **significantly** increases **or decreases** during the calendar year, then you may either:

- make a corresponding increase or decrease in your payments; or
- if there is a significant cost increase, revoke your existing election and elect to receive coverage, on a prospective basis, under another benefit package option providing similar coverage (if available), or if not available, drop coverage entirely; or
- if there is a significant cost decrease, begin participation in the Plan/SPD and elect the coverage that significantly decreased in cost.

These changes will be allowed under the Dependent Care Flexible Spending Account **only** if the cost change is required by a dependent care provider who is **not** your Relative.

- *Cost Increase or Decrease*. If you elect to participate in the Plan/SPD and your cost for Health, Dental, Vision, or Life Coverage, or Dependent Care Flexible Spending Account coverage increases or decreases during the calendar year, and you are required to make a corresponding change in your premium payments, the Plan/SPD may make a prospective increase or decrease, as appropriate, in premium payments. These changes will be allowed under the Dependent Care Flexible Spending Account only if the cost change is required by a dependent care provider who is not your Relative.

- *Coverage is Significantly Reduced (with a Loss of Coverage)*. If you, your spouse, or your dependent have a significant reduction in coverage that results in a "loss of coverage," then you may cancel your election for coverage and elect to receive coverage, on a prospective basis, under another benefit package option providing similar coverage (if available), or drop such coverage if no other benefit package option providing similar coverage is available under the Plan/SPD.

- A "loss of coverage" includes:

  - elimination of a benefit package option;
  - loss of all coverage due to hitting a lifetime or
  - annual coverage limit; or o a PPO ceasing to be available where you reside.

- *Coverage is Significantly Reduced (without a Loss of Coverage)*. If you, your spouse, or your dependent have a significant reduction in coverage but not a "loss of coverage" (for example, a significant increase in deductible, copayment, or out-of-pocket limit), then you may cancel your election for coverage and elect to receive coverage, on a prospective basis, under another coverage option providing similar coverage. Coverage under the Plan/SPD is "significantly reduced" only if there is an overall reduction in coverage provided under the Plan/SPD.

Addition or Significant Improvement of Benefit Program Option Providing Similar Coverage. (Does Not Apply to Health Care Flexible Spending Account Elections). If your Employer adds a new benefit plan option or other coverage option (or significantly improves an existing benefit option or other coverage option), you may cancel your existing option and elect the newly-added option or the significantly improved option providing similar coverage, on a prospective basis.

EXAMPLE

If the Employer were to offer another health plan option (e.g., a new PPO plan) mid-year, you would be allowed to make a mid-year change to the new option.

Change in or Loss of Coverage Under Other Employer's Plan or Other Group Health Plan. (Does ***Not*** Apply to Health Care Flexible Spending Account Elections). You may make an election change that is on account of and corresponds with a change made under the plan of your spouse, former spouse, or dependent's employer if:

- the other plan permits Participants to make an election change; or
- this Plan/SPD permits Participants to make an election for a period of coverage that is different from the period of coverage under the other plan.

EXAMPLE

You participate in this Plan/SPD for the *January 1, 2011* to *December 31, 2011* calendar year for employee-only health coverage. Your spouse elects coverage under her health plan effective *October 1, 2010* to *September 30, 2011*. In making her new election for the calendar year beginning *October 1, 2011* under her plan, she could elect "no coverage" under her plan. This Plan/SPD would then allow you to elect (mid-year) to cover her under this Plan/SPD from *October 1, 2011* to *December 31, 2011*.

Loss of Coverage Under Governmental/Educational Group Health Plan (Does ***Not*** Apply to Health Care Flexible Spending Account). You may make an election to add Health, Dental or Vision Coverage for you, your spouse, or your dependent if any of you lose coverage under any group health coverage sponsored by a governmental or educational institution (including a State children's health insurance program, medical program of an Indian Tribal government, a state health benefits risk pool, or a foreign government group health plan).

Special Enrollment (Does ***Not*** Apply to Dependent Care Flexible Spending Accounts). If you, your spouse, or your dependent are entitled to HIPAA special enrollment under the Plan/SPD - due to the loss of coverage or the addition of a new dependent by adoption, placement for adoption, birth, or marriage - you may make a mid-year change to your election consistent with your change in enrollment.

Eligible individuals may also be enrolled in the Plan/SPD during special enrollment periods if: (1) the eligible individual is covered under a Medicaid plan under Title XIX of the Social Security Act, or a state children's health plan under Title XXI of the Social Security Act; and (2) coverage under such plans is lost due to a loss of eligibility for such coverage.

In addition, an eligible individual may be enrolled under the Plan/SPD if the eligible individual becomes eligible for premium assistance under such Medicaid plan or a state children's health plan (including any waiver or demonstration project conducted under or in relation to such plan), to the extent required by HIPAA.

Entitlement to Medicare or Medicaid (Does ***Not*** Apply to Dependent Care Flexible Spending Accounts). If you, your spouse, or your dependent are covered under the Plan/SPD and become entitled to coverage under Medicare or Medicaid (other than coverage solely under the program for distribution of pediatric vaccines), you may change your election to cancel or reduce coverage under the Plan/SPD for the entitled person. If there is a loss of coverage under Medicare or Medicaid, you may elect to begin or increase coverage under the Plan/SPD for the affected person.

Court Order/Medical Child Support Order (Does ***Not*** Apply to Dependent Care Flexible Spending Accounts). If you are subject to a judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order), you may make a consistent change in your Health, Dental, Vision, and/or Life Coverage election under the Plan/SPD to either: (1) cover the child; or (2) cancel coverage of the child, as applicable.

D. Irrevocability of Elections. An election once made, will remain in effect until the earliest of:

- the date you are no longer a Participant;
- the effective date of a new election;
- the date the Plan/SPD or the Qualified Benefit is terminated;
- the end of the calendar year, unless otherwise provided under E below.

Except as provided above, or as otherwise required by law, an election may be changed only as of the beginning of the calendar year after the election is made.

E. Failure to Make Employee Contributions. Generally, coverage under the Plan/SPD will end if you do not make the required employee contributions for benefits elected under the Plan/SPD (except in the case of an unpaid FMLA leave of absences- see **Unpaid Leaves of Absence that Qualify Under the FMLA**). In this situation, you may not make a new benefit election under the Plan/SPD for the remaining portion of that calendar year. If you want to again participate, you must wait until the annual election.

EXAMPLE

If you participate in the Plan/SPD and do not make your pre-tax contribution in June 2011, you will have to make your July-December 2011 contributions on an after-tax basis and cannot make a new election to make pre-tax contributions until January 2012.

F. Authority of Administrator to Cancel or Revise Certain Elections. To the extent required by Code Section 125, the following nondiscrimination rules will apply:

- the Plan/SPD will not discriminate in favor of highly compensated employees(as defined by Code Section 125(e)) as to *eligibility* to participate or as to *contributions or benefits*; and
- the benefits provided to key employees (as defined by Code Section 416(i)(1)) will not exceed 25% of the aggregate benefits provided to all Participants.

If the Administrator determines that the Plan/SPD may fail to satisfy any applicable nondiscrimination requirement, the Administrator will cancel or revise the elections of key employees and/or highly compensated employees to the extent necessary to satisfy the nondiscrimination requirements.

G. Adjustments to Prevent Discrimination. Not more than 25% of the amounts paid or reimbursed under the Dependent Care Flexible Spending Account during any calendar year may be provided to Participants (or their spouses or dependents) who own more than 5% of the stock of the Employer on any day of the calendar year. The Dependent Care Flexible Spending Account will be administered to be in compliance with all applicable nondiscrimination requirements. The Administrator may limit the amounts paid or reimbursed to Participants to the extent necessary to satisfy the nondiscrimination requirements.

HEALTH CARE FLEXIBLE SPENDING ACCOUNT

A. Establishment of Health Care Flexible Spending Account. You will have a separate Health Care Flexible Spending Account for each calendar year if you elect benefits under the Health Care Flexible Spending Account. Health Care Flexible Spending Accounts will be maintained for bookkeeping purposes only (with no interest or earnings credited), and such amounts will remain part of the general assets of the Company until paid.

B. Maximum Reimbursement to Health Care Flexible Spending Account. There will be credited to your Health Care Flexible Spending Account, as of the beginning of the calendar year (or as of the later effective date of your election), the annualized amount that you have elected to have your Compensation reduced for the calendar year for the reimbursement of Qualifying Health Care Expenses. The maximum amount that you may elect to have credited to your Health Care Flexible Spending Account for a calendar year is $2,500; however, if you and your spouse are both Participants, you may each elect to have $2,500 credited to your Health Care Flexible Spending Account. The minimum annual amount that must be credited to your Health Care Flexible Spending Account is $240.

EXAMPLE

If you become a participant in the Plan on January 1, 2014 and elect to have $2,500 contributed to your Health Care Flexible Spending Account for the year, you will have $2,500 available to you on January 1, 2014 from which to receive reimbursement.

C. Crediting Your Health Care Flexible Spending Account. As of the date of any payment, your Health Care Flexible Spending Account will be debited by the amount of the payment, subject to the annualized amount credited to the Health Care Flexible Spending Account for the calendar year.

D. Qualifying Health Care Expenses.

Participants (Excluding Those Enrolled in a HDHP)

"Qualifying Health Care Expenses" are certain health, dental, or vision expenses (as defined in Code Section 213(d) and as allowed under Code Section 105 and 106(f) and such applicable rulings and regulations) that you or your dependents have an obligation to pay and that can be reimbursed for out of your Health Care Flexible Spending Account, but excluding expenses other than dental and vision expenses if you are enrolled in the HDHP. Also, you or your dependents must not otherwise be entitled to reimbursement for the expense through insurance or otherwise, and reimbursement may occur only to the extent that the Qualifying Health Care Expense does not include any premium paid for Health Coverage, Dental Coverage, Vision Coverage, or qualified long-term care services as defined in Code Section 7702(B)(c) or coverage for any provider which is advertised, marketed, or offered as long-term care insurance. For these purposes, your "dependent" is someone who is eligible to be your dependent under the Health Coverage, as long as they are also described in Code Section 105(b) (which generally means your spouse and your children who are under age 26).

Qualifying Health Care Expenses do not include over-the-counter drug expenses, unless the drug is insulin or is prescribed by a physician.

Examples of Qualifying Health Care Expenses *could* include:

- custodial care expenses
- hearing aids
- coinsurance amounts
- deductibles
- amounts in excess of the maximums allowed by the health, dental, or vision plans
- certain over-the-counter (OTC) drugs that are either prescribed or insulin

Examples of expenses that cannot be reimbursed include (but are not limited to):

- charges that exceed "reasonable and customary" guidelines
- certain cosmetic surgery
- premiums for health, dental, or vision coverage
- travel expenses
- fees for health clubs
- vitamins
- qualified long-term care services
- over-the-counter drugs that are not prescribe or are not insulin

You should contact the Plan Supervisor for additional information and examples.

Participants Enrolled in HDHP

"Qualifying Health Care Expenses" are limited <u>only</u> to dental or vision expenses that can be reimbursed out of your Health Care Flexible Spending Account. These dental and vision expenses generally include items which are considered "medical care" under the Code and are expenses which are not otherwise reimbursed or covered by insurance.

E. <u>Ceasing to be a Participant with Respect to the Health Care Flexible Spending Account</u>. If you stop being a Participant during a calendar year, you will be entitled to reimbursements from your Health Care Flexible Spending Account for Qualifying Health Care Expenses that were Incurred before you stopped being a Participant. In addition, you will not be entitled to reimbursement of Qualifying Health Care Expenses for any dependent after the person is no longer a dependent.

Also, to the extent required by COBRA, if you stop being a Participant and agree to pay the premium for COBRA continuation coverage (see the Continuation of Coverage section of this summary), you will be treated as a Participant to the extent required by COBRA, and coverage under the Health Care Flexible Spending Account will continue as long as such premiums are paid, if applicable, but not beyond the end of the calendar year in which the COBRA qualifying event occurs.

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

A. <u>Establishment of Dependent Care Flexible Spending Account</u>. You will have a separate Dependent Care Flexible Spending Account for each calendar year you elect benefits under the Dependent Care Flexible Spending Account. Dependent Care Flexible Spending Accounts will be maintained for bookkeeping purposes only (with no interest or earnings credited), and such amounts will remain part of the general assets of the Company until paid.

B. <u>Reimbursement Amounts</u>. The maximum amount that you may elect to have credited to your Dependent Care Flexible Spending Account for any calendar year is $5,000 (or $2,500 if you are married and do not file a joint federal income tax return for the year). This $5,000 could be less if your Earned Income for the year - or if you are married, the actual or deemed Earned Income of your spouse for the year - is less than $5,000. The minimum annual amount that must be credited to your Dependent Care Flexible Spending Account is $240.

C. <u>Crediting Your Account</u>. Your Dependent Care Flexible Spending Account will be credited, as of *each <u>payroll date</u>* (**not** on an annual basis), with the amount deducted from your Compensation. Any expenses paid out of your Dependent Care Flexible Spending Account during the calendar year will be reflected in your Dependent Care Flexible Spending Account balance. No reimbursement of Dependent Care Expenses will exceed the balance of your Dependent Care Flexible Spending Account at the time of the reimbursement. If you do not have enough in your Dependent Care Flexible Spending Account to pay for Dependent Care Expenses, those Dependent Care Expenses will be

held and will be reimbursed at a later date if there is a sufficient balance in your Dependent Care Flexible Spending Account.

EXAMPLE

Assume you elected to have $5,000 contributed to your Dependent Care Flexible Spending Account for the 2011 calendar year. As of April 1, 2011 you have made salary reduction contributions of $1,750 (and have not applied for any reimbursements). Consequently, as of April 1, 2011 you may only file for reimbursement for up to $1,750 (the amount you have actually contributed to the Dependent Care Flexible Spending Account).

D. <u>Dependent Care Expenses</u>. "**Dependent Care Expenses**" are expenses that can be reimbursed out of your Dependent Care Flexible Spending Account. To qualify as Dependent Care Expenses, the expenses must:

- allow you and your spouse to be gainfully employed or to search for gainful employment; *AND*
- be for the care of a "Qualifying Individual"

"Qualifying Individual" means:

- your "qualifying child" as defined in section 152(a)(1) of the Code who is under age 13; or
- your dependent (under Code Section 152 but not subsections (b)(1), (b)(2) and (d)(1)(B)) or spouse who is physically or mentally incapable of caring for himself or herself and who shares a household with you for more than % of the year and regularly spends at least 8 hours a day in your household.

A child of divorced or separated parents is a "Qualifying Individual" of the custodial parent if:

- the child is in the custody of one or both parents more than 1/2 of the year;
- the child receives over % of his/her support from his/her parents; and
- the parents are legally divorced or separated, or have lived apart at all times during the last 6 months of the calendar year.

Note: Your child who is under age 13 or is physically or mentally incapable of caring for himself or herself may be deemed to be a Qualifying Individual even if the former spouse, and not you, may be entitled to claim a personal exemption deduction with respect to the child.

Additionally, you will not be entitled to reimbursements unless both you and your spouse work or your spouse is a full-time student or is mentally or physically unable to care for himself or herself.

Expenses will not be reimbursed as Dependent Care Expenses unless their main purpose is to assure the Qualifying Individual's well-being and protection.

Examples of expenses that are *not* considered Dependent Care Expenses include, but are not limited to:

- services not required by your employment, such as baby sitters for leisure activity
- overnight camps
- care provided by a person you claim as a dependent on your federal income tax return
- amounts paid for food, clothing, or education
- transportation expenses for a dependent care provider
- care when you are on vacation, holiday, or sick leave
- custodial care
- expenses payable to Relatives

When the expense Incurred includes expenses for other benefits that are incident to and an inseparable part of the care, the full amount of the expense is considered to be for such care.

EXAMPLES

- The full amount paid to a nursery school that a child is enrolled in is considered to be a Dependent Care Expense, even though the school also furnishes lunch and educational services.

- Educational expenses Incurred for a child in the first grade or higher are not treated as eligible Dependent Care Expenses.

- Child care provided by a housekeeper whose services include child care and house cleaning are covered.

- *Special rules apply to child care centers*. Services provided by a child care center are generally covered. The child care center must be a center that provides dependent care for more than 6 individuals (who do not live at the center on a regular basis during the year) and receives a fee for providing the services. Such centers must comply with all applicable State and local laws and regulations.

You should contact the Plan Supervisor for additional guidance for determining whether a particular expense qualifies as a Dependent Care Expense.

. If you stop being a Participant during a calendar year, you will be entitled to reimbursement of Dependent Care Expenses Incurred during the calendar year you ceased to be a Participant, but not to exceed the credit balance in your Dependent Care Flexible Spending Account at the time you cease to be a Participant.

. You are provided a limited **tax** credit for Dependent Care Expenses. As a general rule, the amount of the tax credit is 35% of the Dependent Care Expenses, reduced (but not below 20%) by one percentage point for each $2,000 (or fraction thereof) by which your adjustable gross income for the taxable year exceeds $15,000, up to a maximum credit of

$3,000 (for one Qualified Individual) or $6,000 (for two or more Qualified Individuals). **Participation in this Plan/SPD affects this credit because the dependent care credit is not available for non-taxable reimbursements that you receive from your Dependent Care Flexible Spending Account under this Plan/SPD**. Under certain circumstances, the *credit* would be more valuable than the tax savings provided under this Plan/SPD. ***Therefore, you may wish to consult with your tax advisor before making use of your Dependent Care Flexible Spending Account.***

PROVISIONS APPLICABLE TO BOTH THE HEALTH CARE AND DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS

A. Reimbursement of Qualifying Health Care Expenses and Dependent Care Expenses. You may request reimbursement of Qualifying Health Care Expenses and Dependent Care Expenses Incurred during the calendar year by: (1) submitting a written claim form to the Plan Supervisor *not later than the last day of February after the end of the calendar year* in which the Expenses were Incurred; or (2) using your Debit Card. However, prescribed over-the-counter drugs cannot be purchased using your Debit Card, except at a pharmacy where 90% of the gross receipts during the prior taxable year consist of medical expenses under Code Section 213(d), in which case you must submit the prescription to the Administrator for a substantiation, or as otherwise allowed by law. The claim for reimbursement may be made before or after you have paid the Qualifying Health Care Expense or the Dependent Care Expense, but not before the expense has been Incurred.

The written claim form must include:

1. the amount, date, and nature of the Qualifying Health Care Expense or Dependent Care Expense;

2. the name of the person, organization, or entity to which the Qualifying Health Care Expense was or is to be paid;

3. the name, address, and taxpayer identification number of the person, entity, or organization performing the services subject to Dependent Care Expense reimbursement;

4. the name of the person for whom the Qualifying Health Care Expense was Incurred and, if the person requesting the benefits is not you, the relationship of the person to you;

5. a written statement (bill or invoice) from the individual delivering the service stating that the Qualifying Health Care Expense or Dependent Care Expense has been Incurred and the amount of expense;

6. a written statement that the Qualifying Health Care Expense or Dependent Care Expense has not been reimbursed and is not reimbursable under any other health plan coverage (or, if the Qualifying Health Care Expense or Dependent Care Expense has been partially reimbursed or is partially reimbursable, the amount of the reimbursement);

7. a written statement that you are legally obligated to pay for the Qualifying Health Care Expense or Dependent Care Expense; and

8. any other information reasonably requested by the Administrator or Plan Supervisor.

You must also submit with the claim form all relevant bills, receipts, or other statements with respect to the Qualifying Health Care Expenses or Dependent Care Expenses, together with any additional documentation that the Plan Supervisor or Administrator may request. If you have a dispute regarding a claim for benefits, see the section labeled **CLAIMS PROCEDURE**. If you submit the written claim form and documentation required and your request for reimbursement is approved, your claim will be paid.

Upon request by the Plan Supervisor, your Debit Card claim must be submitted for review and substantiation on a form supplied by the Plan Supervisor unless the charge is for a copayment or a recurring expense or the charge is substantiated at the point of sale by the provider. All reimbursements requiring substantiation are considered conditional until substantiated. In the event a conditional claim is not substantiated, the Plan Supervisor will notify you of the improper payment and request repayment. The Plan Supervisor reserves the right to offset future reimbursements due under your Account(s) if repayment is not received, and to deactivate the Debit Card if the improper payment has not been collected after you receive notice of the improper payment. The Plan Supervisor will deactivate the Debit Card and may refer the claim to the Company for handling as any other business debt if the improper payment is not recovered. Substantiation of a conditional claim includes submission of the information described above. If you use your Debit Card and the transaction is approved, the Plan Supervisor will automatically debit your Account(s) for the expenses Incurred. The amount debited will not exceed the amount credited to your Account(s) at the time of the transaction.

Reimbursements will be made at least bi-weekly and can be made by check or direct deposit. The amount of any reimbursement will not exceed the amount credited to your Accounts at the time of the reimbursement. Any dispute regarding a claim for reimbursement will be governed by the **CLAIMS PROCEDURE** section of this summary.

B. Forfeiture of Unused Amounts.

Except as provided below, Federal law requires that the amount credited to your Accounts be used only to reimburse you for Qualifying Health Care Expenses or Dependent Care Expenses Incurred during the Calendar Year for which your election is applicable, with any balance remaining in your Accounts (after all allowable reimbursements for the Calendar Year have been made) **to be forfeited**. In other words, if you do not use up the amounts in your Health Care Flexible Spending Account or Dependent Care Flexible Spending Account by the end of the Calendar Year, you will lose those amounts. Therefore, it is very important to be conservative when deciding how much you will contribute to these Accounts.

Notwithstanding the general forfeiture rule described above, beginning in 2015, an amount not to exceed $500.00 which remains unused in your Health Care Flexible

Spending Account as of the last day of February following the end of the immediately preceding Calendar Year to which the credited amounts relate will be carried over and used to reimburse Qualifying Health Care Expenses Incurred during such following Calendar Year. Please note that if you elect to enroll in HDHP coverage for the following Calendar Year reimbursement of Qualifying Health Care Expenses in the following Calendar Year will be limited **only** to dental or vision expenses.

The amount carried over, if any, will equal the lesser of (1) unused amounts credited to your Health Care Flexible Spending Account, or (2) $500.00. Any amount remaining in excess of the lesser of (1) or (2) **will be forfeited**. In addition, any amounts carried over will be used to reimburse Qualifying Health Care Expenses prior to any amounts credited to your Health Care Flexible Spending Account for the then-current Calendar Year. Lastly, if an amount carried over is not used to reimburse Expenses Incurred prior to the end of the then-current Calendar Year, such carried amount will be forfeited.

EXAMPLE

As of December 1, 2014, you have $1,000 remaining in your Health Care Flexible Spending Account. On December 15, 2014 you Incur a Qualifying Health Care Expense of $200. For the Calendar Year ending December 31, 2014, (1) you will be reimbursed $200 from your Account; (2) $500 of the amount remaining as of the last day of February 2015 will be carried over for reimbursement of Expenses Incurred during the 2015 Calendar Year (and will be limited to dental and vision expense reimbursement if you elect to enroll in HDHP coverage for the 2015 Calendar Year); and (3) the remaining unused $300 will be forfeited ($1,000 - $200 reimbursement - $500 carry over).

ADMINISTRATION OF THE PLAN/SPD

A. Administrator. The Company is the Administrator of the Plan/SPD within the meaning of ERISA; however, the Board of Directors or its duly authorized officers may from time to time designate a person, subcommittee, Plan Supervisor, or organization to perform certain responsibilities as delegated to it, until removal by the Board of Directors, which removal may be without cause and without advance notice. The Administrator will have full, discretionary authority to control and manage the operation and administration of the Plan/SPD, and will be named fiduciary. The Administrator will have all power necessary or convenient to enable the Administrator to exercise such authority. The Administrator or its designee may provide rules and regulations, not inconsistent with the provisions hereof, for the operation and management of the Plan/SPD, and may from time to time amend or rescind such rules or regulations. The Administrator will 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 and to the 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.

B. Discretionary Authority of Administrator. Except as may be otherwise specifically provided in the Plan/SPD or in any plan providing Qualified Benefits, the Administrator or its designee will have full, discretionary authority to enable it to carry out its

duties under the Plan/SPD, including, but not limited to, the authority to determine eligibility under the Plan/SPD, to construe the terms of the Plan/SPD, and to determine all questions of fact or law arising hereunder. The Administrator or its designee will have all power necessary or convenient to enable the Administrator to exercise such authority. All such determinations and interpretations will be final, conclusive, and binding on all persons affected thereby. The Administrator or its designee will have full, discretionary authority to correct any defect, supply any omission or reconcile any inconsistency, and resolve ambiguities in the Plan/SPD in such manner and to such extent as it may deem expedient, and the Administrator or its designee will be the sole and final judge of such expediency. The Administrator is authorized to accept service of legal process for the Plan/SPD and will be named fiduciary of the Plan/SPD. Benefits under the Plan/SPD will be paid only if the Administrator and/or its designee decides in its discretion that you are entitled to such benefits.

CLAIMS PROCEDURE

Please see your Health, Dental, Vision, and Life Coverage Summaries for claims procedures applicable to those benefits. A brief summary of the claims process for the Plan/SPD is outlined below. All notifications for claim review, denial, approval, and appeal may be done in writing or electronically, unless otherwise designated.

Whenever we refer to "you" in this Article, this will mean any claimant such as you, your spouse, or your dependent.

A. Claims for Health Care Flexible Spending Account.

(1) **Initial Claim**. Any claim to receive reimbursement for Qualifying Health Care Expenses must be filed with the Plan Supervisor by the last day of February after the end of the calendar year in which the claim was Incurred. You must submit with the claim relevant information as required under the **Reimbursement of Qualifying Health Care Expenses and Dependent Care Expenses** section of this summary.

(2) **Initial Review**. When a claim has been properly filed, you will be notified of the approval or denial no later than 30 days after the Plan Supervisor receives the claim, unless the Plan Supervisor needs an extension of 15 days. If additional information is needed, the claimant will have 45 days to provide the information. Thereafter, the claim will be decided within 15 days of the Plan Supervisor receiving this information.

(3) **Initial Denial**. If any claim for reimbursement is partially or wholly denied, you will be given a notice. The notice will include:

- the reasons for the denial;
- reference to the language from the Plan/SPD that supports the denial decision;
- a description of any additional information needed and why;
- a description of the review procedures and time limits;
- the specific internal rule, guideline, or protocol relied on in the denial, with a free copy, at request; and

- if the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the judgment or a statement that an explanation will be provided free, at request.

(4) **Appeal of Claim Denial**. You may appeal a claim denial by filing a written appeal with the Administrator within 180 days after receipt of the denial. If your request is not timely, the decision of the Administrator will be final and binding.

Appeals of claims for reimbursement of Qualifying Health Care Expenses will be reviewed by the Administrator, who will:

- be the named fiduciary of the Plan/SPD;
- not be the individual or subordinate of the individual who made the initial determination; and
- not give any weight to the initial determination.

If the appeal is based, in whole or in part, on a medical judgment, the Administrator will consult with an appropriate health care professional. This person will not be the individual or subordinate of the individual who was consulted in connection with the initial determination. The Administrator will identify any medical or vocational experts it uses.

(5) **Denial of Appeal**. You will receive notice of the Administrator's decision on appeal within 60 days after the Administrator receives the appeal. In addition, if your claim appeal is denied, you will be given a notice with a statement 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 reasons for the denial;
- reference to the language from the Plan/SPD that supports the denial decision; and
- the specific internal rule, guideline, or protocol relied on in the denial, with a free copy, at request

This decision will be final and binding.

B. <u>Claims for Dependent Care Flexible Spending Account</u>.

(1) **Initial Claim**. Any claim to receive reimbursement of Dependent Care Expenses must be filed with the Plan Supervisor by the last day of February after the end of the calendar year in which the claim was Incurred. You must submit with the claim relevant information as required under the **Reimbursement of Qualifying Health Care Expenses and Dependent Care Expenses** section of this summary.

(2) **Initial Review**. When a claim has been properly filed, you will be notified of the approval or denial within 90 days after the Plan Supervisor receives the claim, 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).

(3) **Initial Denial**. If any claim for reimbursement is partially or wholly denied, you will be given a notice. The notice will include:

- the reasons for the denial;
- reference to the language from the Plan/SPD that supports the denial decision;
- a description of any additional information needed and why; and
- a description of the review procedures and time limits.

(4) **Appeal of Claim Denial**. You may appeal a claim denial by filing a written appeal with the Administrator within 60 days after you receive notification of the denial. If your request is not timely, the Administrator's decision will be final and binding.

(5) **Denial of Appeal**. You will receive notice of the Administrator's decision on appeal within 60 days after the Company receives the appeal request, unless special circumstances require an extension of time to process the appeal. If so, the Administrator or its designee will notify you: (i) of the extension; and (ii) when a final decision will be reached (which will not be later than 120 days after receipt of such appeal).

If your claim appeal is denied, you will be given notice with a statement 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 reasons for the denial; and
- reference to the language from the Plan/SPD that supports the denial decision.

A decision on review will be final and binding.

C. <u>Claims Provisions Applicable to Both Health Care Flexible Spending and Dependent Care Flexible Spending Accounts</u>.

(1) **Authorized Representative**. You may have a representative act on your behalf in pursuing a benefit claim or appeal.

(2) **Calculating Time Periods**. Claims time periods will begin when a claim or appeal is filed, even if all necessary information is not with the filing. If you fail to provide certain needed information, these time periods may be put on hold. See the Administrator or the Plan Supervisor for details.

(3) **Full and Fair Review**. You will have reasonable access to, and copies of, all documents, records, and other information relating to your claim, free of charge. You may submit written comments, documents, records, and other information relating to the claim.

If your review request is timely, the review of your denied claim 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.

(4) **Mediation**. Claimants and this Plan/SPD may have other voluntary alternative dispute resolution options, such as mediation. For available options, please

contact your local U.S. Department of Labor Office and your State insurance regulatory agency.

(5) **Definitions**.

- **Denial** means a denial, reduction, termination, or failure to provide or make payment for a benefit, including determinations based on eligibility, and, with respect to health benefits, 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.

- **Health care professional** means a physician or other health care professional licensed, accredited, or certified to perform health services consistent with State law.

(6) **Exhaustion of Remedies**. If you fail to file a request for review of a denial of benefits in whole or in part, as required by these procedures, or fail to follow 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 of the claim will become final and binding for all purposes.

PROTECTED HEALTH INFORMATION

A. Your Protected Health Information. Federal privacy rules govern how the Plan/SPD may use and disclose your Protected Health Information and when it may be shared with employees. Protected Health Information ("PHI") generally means information (including demographic information) that:

- identifies an individual (or provides a reasonable basis to believe the information can be used to identify an individual);
- is created or received by a health care provider, a health plan, or certain other entities of the health care industry; and
- relates to the past, present, or future physical or mental health or condition of an individual, information regarding health care provided to an individual, or the past, present, or future payment for an individual's health care.

The Plan/SPD may use and disclose PHI for purposes related to health care treatment, payment for health care, and for other purposes relating to operating the Plan/SPD and providing benefits to you.

B. Disclosures of PHI. PHI may need to be disclosed to certain employees of the Employer from time to time. The Plan/SPD may:

- Disclose Summary Health Information to the Employer, if the Employer requests the Summary Health Information for the purpose of:
  - Obtaining premium bids from health plans for providing health insurance coverage under the Plan/SPD; or
  - Modifying, amending, or terminating the Plan/SPD.

"Summary Health Information" generally means health information that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom the Employer has provided health benefits under a group health plan. However, identifiers (such as names, addresses, and social security numbers) that can directly link the health information to a particular individual are removed from the information.

- Disclose to the Employer information on whether you or your dependent(s) are participating in the Plan/SPD, or are enrolled in or have disenrolled from the Plan/SPD.
- Disclose PHI to the Employer to carry out Plan/SPD administration functions.
- With your authorization, disclose PHI to the Employer for purposes related to the administration of other employee benefit features and fringe benefits sponsored by the Employer.

In any event, the Plan/SPD may not:

- Permit a health insurance issuer or HMO to disclose PHI to the Employer except as permitted by this Section;
- Disclose (and may not permit a health insurance issuer or HMO to disclose) PHI to the Employer unless a statement is included in the Plan/SPD's Notice of Privacy Practices that the Plan/SPD (or a health insurance issuer or HMO with respect to the Plan/SPD) may disclose PHI to the Employer; or
- Disclose, without your authorization, PHI to the Employer for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit feature of the Employer.

C. Uses and Disclosures by the Employer. When the Plan/SPD gives the Employer your PHI, the Employer may not use or disclose PHI for employment-related decisions or for its other benefit features without authorization. The Employer may use and disclose PHI without your authorization for Plan/SPD administrative functions including payment activities and health care operations, or as required by law. If the Employer uses an agent or subcontractor to assist it in performing these activities (such as the Plan Supervisor), the agent's or subcontractor's use and disclosures of PHI will be limited in the same manner as those applicable to the Employer.

The Employer must report any known improper use or disclosure of PHI to the Plan/SPD. The Employer must also make its records available to federal regulators who are in charge of ensuring that the Plan/SPD is protecting your PHI. In addition, the Employer must also assist the Plan/SPD in administering rights that you have to your PHI as described in the Plan/SPD's notice of privacy practices. When the Employer no longer needs the PHI, it must destroy it or return it to the Plan/SPD. If return or destruction is not feasible, it must continue to maintain the PHI in accordance with this Article.

The only employees who will have access to your PHI without your authorization are:

- Company Benefits Department;
- Applicable Company HR business partners;
- Applicable HR Services personnel;
- Applicable payroll personnel;
- Internal audit personnel; and • Applicable legal personnel.

AMENDMENT AND TERMINATION

The Company, through appropriate action of the Health and Welfare Administrative Committee, will have the right in its sole discretion to amend the Plan/SPD at any time and from time to time to any extent that it may deem advisable. The Company, through appropriate action of its Board of Directors, will have the right in its sole discretion to terminate the Plan/SPD at any time and to the extent that it may deem advisable. Amendment or termination of the Plan/SPD will be effective in accordance with the time limitations under ERISA and the Code. To the extent allowed by the ERISA and the Code, any such modification and/or amendment may be effective retroactively.

CONTINUATION OF COVERAGE

These COBRA continuation provisions, along with the provisions under ***Ceasing to be a Participant with Respect to the Health Care Flexible Spending Account***, apply to your Health Care Flexible Spending Account.

A. Qualified Beneficiaries. Only "qualified beneficiaries" may choose to continue coverage. You are a qualified beneficiary if you are covered under the Plan/SPD under the Health Care Flexible Spending Account on the day before a "qualifying event" and you are:

- a Participant;
- a spouse of a Participant; or
- a dependent child of a Participant (including dependents born to or placed for adoption with you during the continuation coverage).

B. Qualifying Events. If one of the following "qualifying events" should occur that would cause you to lose coverage under the Health Care Flexible Spending Account, you have the right to choose to continue benefit coverage under the Health Flexible Spending Account through COBRA. You are considered to "lose coverage" if you stop being covered under the same terms and conditions as in effect immediately before the qualifying event or have an increase in the premium or contribution that you must pay. These qualifying events are:

- your **death**;
- your **termination of employment** (other than by reason of gross misconduct) or reduction of hours that results in a termination of coverage under the Health Care Flexible Spending Account;
- your divorce or legal separation;
- you becoming **entitled** to **Medicare** benefits; or

- your child **ceasing** to be considered **a dependent child**. (In this instance, your child would be eligible for COBRA, but your coverage under the applicable benefit plan would not change).

C. Electing COBRA Coverage. To obtain continuation coverage, a qualified beneficiary must elect it on a form provided by the Plan Supervisor. The period to elect COBRA benefits ends 60 days after the later of:

- the date the qualified beneficiary would lose coverage due to the qualifying event; or
- the date the COBRA notice is sent by the Plan Supervisor

The election form explains the terms and payments for coverage. Your election is considered to be made on the date the Plan Supervisor receives the election form.

D. Paying for COBRA Coverage. The qualified beneficiary is responsible for paying the monthly cost of continuation coverage. This cost is called a "premium." Premiums must be paid each month.

After a qualifying event, the qualified beneficiary will receive a notice specifying:

- the amount of the premium;
- to whom the premium is to be paid; and
- the date each monthly payment is due.

Failure to pay premiums on a timely basis will result in termination of 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 it is made ***within 30 days*** after the due date.

The *initial* premium payment, which is 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.

E. Length of COBRA Coverage. COBRA coverage in the Health Care Flexible Spending Account will extend only until the end of the calendar year in which the qualified beneficiary's qualifying event occurs.

F. When COBRA Continuation Coverage Ends. COBRA continuation coverage will end earlier than the end of the calendar year in which the qualifying event occurs if:

- the first day (including any grace period) for which COBRA premium payments are not made on a timely basis;
- the qualified beneficiary *first* becomes covered under any other group health plan after electing COBRA coverage. If the other plan contains a limitation with respect to any pre-existing condition that impacts the qualified beneficiary, coverage will not terminate;

- the qualified beneficiary first becomes entitled to benefits under Medicare *after* electing COBRA coverage; or
- the Employer ceases to provide any group health plan to any employee.

Coverage may also terminate "for cause" (*e.g.*, the qualified beneficiary submits fraudulent claims). You will be notified, as soon as possible after your continuation coverage is terminating, if such coverage terminates prior to the maximum period set forth above.

G. Notification Requirements.

(1) **General Notification to Participant and Spouse**. The Plan Supervisor will give written notice to you and your spouse of your rights to continuation coverage. This notice will be provided to you and your spouse not later than the earlier of: (i) 90 days after your coverage begins; or (ii) the date you would otherwise receive an election form due to a qualifying event (see ***Plan Supervisor Notification to Qualified Beneficiary*** below).

(2) **Employer Notification to Plan Supervisor**. In addition, the Employer will notify the Plan Supervisor or its designated representative in the event of your death, termination of employment (other than gross misconduct), reduction in hours, or entitlement to Medicare benefits within 30 days after the date of the qualifying event.

(3) **Participant/Qualified Beneficiary Notification to Plan Supervisor**. If you are a Participant or a qualified beneficiary, **you** must notify the Plan Supervisor if: (i) you divorce or legally separate from your spouse; or (ii) if a child ceases to be a dependent child, as soon as possible, but no later than 60 days after the later of:

- the date of the qualifying event;
- the date the qualified beneficiary would lose coverage due to such qualifying event; or
- the date you are notified of your notice obligation.

Failure to provide notice within this time frame will result in the loss of your right to elect continuation coverage.

(4) **Procedures for Participant/Qualified Beneficiary Notification**.

Who Are the Individuals Required to Give Notice?

- The qualified beneficiary,
- The Participant, or
- The representative acting on behalf of the Participant or qualified beneficiary.

What Events Require Me to Give Notice?

- A divorce or legal separation of the covered employee from his or her spouse, or
- A child ceasing to be a dependent child under the eligibility requirements of the applicable benefit plan under the Plan/SPD.

How Am I to Give Notice? The notice that you are required to provide must be in writing and submitted on the form provided by the Plan Supervisor. Oral notice, including notice by telephone, is not acceptable. You must request (either in person, via telephone, or via e-mail) a copy of the notice form from the Plan Supervisor. You must complete the notice form (including any attachments described below) and then return the notice form (either by hand-delivery or mail) to the Plan Supervisor by the time period set forth in **Participant/Qualified Beneficiary Notification to Plan Supervisor** above in order to receive COBRA continuation coverage. If mailed, the notice form must be postmarked no later than the last day of the required notice period (as set forth in **Participant/Qualified Beneficiary Notification to Plan Supervisor** above) in order to receive COBRA continuation coverage.

If you do not complete and return this notice form within this required time period, no continuation coverage will be provided to you.

What Information Will You Need to Provide on Notice Form? On the notice form, you must indicate the name of the Plan/SPD, the name and address of the Participant under the Plan/SPD, the name(s) and address(es) of any qualified beneficiary(ies), the qualifying event or disability information (whichever is applicable), and the date of the qualifying event or necessary disability information (whichever is applicable). If the qualifying event is a divorce, you must attach a copy of the divorce decree to the notice form. Your notice of disability determination or cessation must attach a copy of the Social Security Administration's determination.

(5) **Plan Supervisor Notification to Qualified Beneficiary**. Upon notification of a qualifying event, you, your spouse, and your dependents will be notified by the Plan Supervisor of your right to elect continuation coverage within 14 days of the date its designee received notice of the qualifying events.

In addition, if you are not entitled to receive continuation coverage, you will be notified of this and will be provided with an explanation as to why you are not entitled to this continuation coverage. You will also be notified if your continuation coverage is terminated prior to the end of the calendar year in which your qualifying event occurs.

Any notification to a qualified beneficiary who is the spouse of the Participant will be treated as a notification to all other qualified beneficiaries residing with the spouse when notification is made.

H. About the Coverage Provided Under COBRA. The COBRA coverage provided will be identical to the coverage provided to similarly situated persons who have not experienced a qualifying event. If coverage is modified for any group of similarly situated beneficiaries, coverage will also be modified in the same manner for all qualified beneficiaries.

COBRA/RETIREE MEDICAL PREMIUMS

Any contributions received by an Employer from a former employee of the Company (and/or his or her applicable dependents) (referred to as "Special Participants") under the

Employee Medical Benefits Program, for retiree medical coverage or COBRA coverage, will be made on an after-tax basis under this Plan/SPD.

Elections for such coverage will remain in place until the earliest of:

- the date the Plan/SPD ends;
- the date the underlying coverage ends or is exhausted for the Special Participant; or
- the date the Special Participant revokes or stops coverage or fails to make timely contributions for coverage.

While coverage is in force, the Special Participant may make changes in the coverage as allowed under the underlying coverage, but only if:

- the change is on account of a "change in status" (as defined in this summary);
- such change is necessary or appropriate as a result of the "change in status,"(pursuant to the retiree medical provisions of such program), or the COBRA continuation coverage requirements; and
- such change must be requested by the Special Participant within 31 days after the change in status, to be effective on the later of the status change or the request for it.

A Special Participant will not be considered a Participant for any other purpose of this Plan/SPD.

ENTRY AND WITHDRAWAL OF EMPLOYERS/TRANSFERRED EMPLOYEES

A. Entry of Employers. Any organization classified by the Company as an Employer may become a party to the Plan/SPD as set forth in the applicable acquisition/merger document between the parties. Such organization will become an Employer as of the date set forth in the acquisition/merger document, or if not addressed in that document, as of the date approved by the Health and Welfare Administrative Committee. Such consent may be issued retroactively by the Health and Welfare Administrative Committee as of any effective date.

B. Withdrawal from the Plan/SPD. Any Employer may withdraw from the Plan/SPD by delivering to the Health and Welfare Administrative Committee a resolution of its governing body authorizing a withdrawal as an Employer, subject to approval of the Board of Directors; or, in the event of a sale of an Employer, as provided in the sale document between the parties, as of the effective date set forth in such sale document.

C. Transferred Employees. If, as the result of an acquisition/merger, the Company hires the employees of an acquired organization ("Transferred Employees"), such Transferred Employees will become participants in the Plan/SPD as set forth in the applicable acquisition/merger document between the parties. Transferred Employees will become participants as of the date set forth in the acquisition/merger document, or if not addressed in the document, as of the date approved by the Health and Welfare

Administrative Committee, subject to applicable law. Whether credit will be given to Transferred Employees for prior service with the acquired organization will be determined by the applicable acquisition/merger document, or if not addressed in the document, by the Health and Welfare Administrative Committee.

MISCELLANEOUS

A. Report to Participants on or before January 31 of Each Year. On or before January 31 of each year, the Administrator will furnish to each Participant who has received Dependent Care Reimbursement during the prior calendar year a written statement (on the Form W-2) showing the amount of all Dependent Care Reimbursement provided by the Employer or through Eligible Employee pre-tax contributions on behalf of the Participant during the prior calendar year.

B. Taxes or Penalties. If there are any taxes or penalties payable by the Employer on your behalf, such taxes or penalties will be payable by you to the extent such taxes would have been originally payable by you had this Plan/SPD not been in existence.

C. No Guarantee of Tax Consequences. Neither the Administrator nor the Employer makes any commitment or guarantee that any amounts paid to you or for your benefit under the Plan/SPD will be excludable from your gross income for federal, state, or local income tax purposes or for Social Security tax purposes, or that any other federal or state tax treatment will apply to or be available to you. It will be your obligation to determine whether payment under the Plan/SPD is excludable from your gross income for federal, state, and local income tax purposes, and Social Security tax purposes, and to notify the Employer if you have reason to believe that any such payment is not excludable.

D. Indemnification Of Employer By Participants. If you receive one or more reimbursements under your Dependent Care Flexible Spending Account that are not for Dependent Care Expenses, or under your Health Care Flexible Spending Account that are not for Qualifying Health Care Expenses, you will indemnify and reimburse the Employer for any liability it may incur for failure to withhold federal, state, or local income tax or Social Security tax from the reimbursements. However, your indemnification and reimbursement will not exceed the amount of additional federal, state, or local income tax that you would have owed if the reimbursements had been made to you as regular cash compensation, plus your share of any Social Security tax that would have been paid on that compensation, less any such additional income and Social Security tax actually paid by you

E. Eligibility for Medicaid Benefits. Benefits will be paid in accordance with any assignment of rights made by or on your behalf as required by a state plan for medical assistance approved under Title XIX, Section 1912(a)(1)(A) of the Social Security Act. For purposes of enrollment and entitlement to benefits, your or your dependent's eligibility for or receipt of medical benefits under a state plan for medical assistance approved under Title XIX of the Social Security Act will not be taken into account. The state will have a right to any payment made under a state plan for medical assistance approved under Title XIX of the Social Security Act when the Plan/SPD has a legal liability to make such payment.

F. Federal Laws. The Plan/SPD will comply with the Newborns' and Mothers' Health Protection Act of 1996, the Women's Health and Cancer Rights Act of 1998, the

Mental Health Parity Act of 1996, the FMLA, USERRA, and the applicable provisions of PPACA.

G. **HIPAA Compliance**. To the extent required under HIPAA, the Plan/SPD will comply with the requirements under HIPAA, including:

- the issuance of certificates of coverage;
- compliance with certain special enrollment periods;
- nondiscrimination benefits requirements; and
- privacy and security requirements (as described above and in the Employee Welfare Benefits Plan) to the extent required and to the extent not otherwise inconsistent with the requirements under Code Section 125 and any regulations issued thereunder.

H. **Limitation of Rights and Obligations**. Neither the establishment nor maintenance of the Plan/SPD, nor any amendment thereof, nor any act or omission under the Plan/SPD or resulting from the operation of the Plan/SPD, will be construed:

(1) as conferring upon you, your dependent, your beneficiary, or any other person a right or claim against any Employer, the Plan Supervisor, or the Administrator, except to the extent that such right or claim will be specifically expressed or provided in the Plan/SPD or provided under ERISA;

(2) as creating any responsibility or liability of any Employer, the Plan Supervisor, or the Administrator for the validity or effect of the Plan/SPD;

(3) as a contract or agreement between any Employer and you or any other person;

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

(5) as to give you, or any other person, the right to be retained in the service of any Employer, or to interfere with the right of any Employer to discharge you or any other person at any time.

I. **Forms and Proofs**. You must complete all forms and furnish all proofs, receipts, and releases as may be required by any Employer, the Plan Supervisor, or the Administrator.

J. **Assignment of Benefits**. Except as provided pursuant to a Qualified Medical Child Support Order under ERISA Section 609, no benefit under the Plan/SPD prior to actual receipt thereof by you, your dependent, or your beneficiary, will be subject to any debt, liability, contract, engagement, or tort of you, your dependent, or your 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.

K. **Misrepresentation**. If you, your spouse, your dependent child, or your beneficiary make a material misrepresentation in making application for coverage or receipt of benefits, your coverage will be null and void for all purposes. In addition, any failure by such individual's to notify the Administrator that your spouse or dependent is no longer eligible for coverage under the Plan, will be deemed by the Administrator to be an intentional misrepresentation which will render coverage null and void.

L. **Employment of Consultants**. The Administrator, or a fiduciary named by the Administrator pursuant to the Plan/SPD, may employ one or more persons to render advice with regard to their respective responsibilities under the Plan/SPD.

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

N. **Fiduciary Responsibilities**. To the extent permitted under ERISA, no fiduciary of the Plan/SPD will be liable for any act or omission in carrying out the fiduciary's responsibilities under the Plan/SPD.

O. **Allocation of Fiduciary Responsibilities**. To the extent permitted under ERISA, each fiduciary under the Plan/SPD will be responsible only for the specific duties assigned under the Plan/SPD and will not be directly or indirectly responsible for the duties assigned to another fiduciary.

P. **Counterparts**. The Plan/SPD may be executed in any number of counterparts, each of which will be deemed to be an original. All counterparts will constitute but one and the same instrument and will be evidenced by anyone counterpart.

Q. **Notice**. Any notice given under the Plan/SPD will be sufficient if given to the Administrator or Plan Supervisor, when addressed to its office; or, if given to you, when addressed to you at your address as it appears in the records of the Administrator or the Plan Supervisor.

R. **Disclaimer of Liability**. Nothing contained herein will confer upon you any claim, right, or cause of action, either at law or in equity, against the Plan/SPD, Administrator, Plan Supervisor, or any Employer, for the acts or omissions of any provider of services or supplies for any benefits provided under the Plan/SPD.

S. **Right of Recovery**. If an Employer, Plan Supervisor, or Administrator, or its designee, makes any payment that according to the terms of the Plan/SPD should not have been made, it may recover that incorrect payment, whether or not it was made due to the Employer's, the Plan Supervisor's, or the Administrator's or its designee'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 you, the Employer, the Plan Supervisor, or the Administrator or its designee may deduct it when making future payments directly to you.

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

U. Evidence of Action. All orders, requests, and instructions to the Administrator or its designee by an Employer, or by any duly authorized representative will be in writing and the Administrator or its designee will act and will be fully protected in acting in accordance with such orders, requests, and instructions.

V. Audit. If an audit of the Plan/SPD is required under ERISA for any Plan/SPD Year, the Administrator will engage an independent qualified public accountant. Such audit will be conducted in accordance with the requirements of Section 103 of ERISA.

W. Bonding. Each fiduciary of the Plan/SPD, unless exempted under ERISA, will be bonded in an amount not less than 10% of the amounts of assets of the Plan/SPD handled by such fiduciary; provided, however, such bond will not be less than $1,000 and need not be for more than $500,000. The expense of such bond will be paid from the assets of the Plan/SPD unless paid by the Company.

X. Protective Clause. Neither the Employer nor the Administrator will be responsible for the validity of any contract of insurance or other benefit contract or policy by any benefit provider or for the failure on the part of any insurance company or other benefit provider to make payments thereunder.

Y. Receipt and Release. Any payments to you will, to the extent thereof, be in full satisfaction of your claim being paid and the Administrator may condition payment on your delivery of the duly executed receipt and release in such form as may be determined by the Administrator.

Z. Benefits Solely from General Assets. Except as may otherwise be required by law:

(1) the benefits provided hereunder will be paid solely from the general assets of the Employer;

(2) nothing herein will be construed to require any Employer or the Administrator to maintain any fund or segregate any amount for your benefit; and

(3) no Participant or other person will have any claim against, right to, or security or other interest in, any fund, account, or asset of any Employer from which any payment under the Plan/SPD may be made.

AA. Legal Actions. If the Administrator is made a party to any legal action regarding the Plan/SPD, 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 will be paid by the Company.

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

CC. Qualified Medical Child Support Orders. The Plan/SPD will provide benefits in accordance with the applicable requirements of a qualified medical child support order, as required by ERISA Section 609, received by the Plan/SPD. If the Plan/SPD receives a medical child support order, the Administrator will promptly notify you, and each of your children identified in the order, of the receipt of such order and the Plan/SPD's procedures for determining whether the order is a qualified medical child support order. Within a reasonable time after receipt of such order, the Administrator will determine whether the order is a qualified medical child support order and notify you and your children involved of the determination. The Administrator will establish written procedures in accordance with ERISA Section 609 to determine whether a medical child support order received by the Plan/SPD is a qualified medical child support order under ERISA.

DD. Participant Incapacitation. When you are under legal disability or, in the Employer's opinion, are in any way incapacitated so as to be unable to manage your affairs, the Employer may cause your benefits to be paid to your legal representative for your benefit. The payment of benefits will completely discharge the liability of the Employer for the benefits.

EE. Participant Death. In the event of your death, your spouse (or, if none, your executor or administrator) may apply on your behalf for reimbursement of Qualifying Health Care Expenses or Dependent Care Expenses as applicable. The payment of benefits will completely discharge the liability of the Employer for the benefits.

FF. Rules of Interpretation. The Plan/SPD is to be administered consistent with Code Section 125, and with respect to the Health Care Flexible Spending Account, consistent with ERISA. The Health Care Flexible Spending Account is to comply with the requirements of Code Sections 105, 106, 125, and 4980B and the Dependent Care Flexible Spending Account is to comply with the requirements of Code Section 129. Eligibility to make contributions to a Health Savings Account will be interpreted to be in compliance with Code Section 223.

GG. Entire Plan/SPD. The Plan/SPD document and the documents incorporated by reference herein will constitute the only legally governing documents for the Plan/SPD. All statements made by any Employer or Administrator will be deemed representations and not warranties. No oral statement or other communication will void or reduce coverage under the Plan/SPD, or amend or modify the terms of the Plan/SPD, or be used in defense to a claim, unless in writing signed by the Administrator.

RIGHTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

As a participant in the Health Flexible Spending Account Benefit set forth in this Plan/SPD, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan/SPD participants will be entitled to:

A. Receive Information About Your Benefits and Plan/SPD. Examine, without charge, at the Administrator's office and at other specified locations, such as worksites, all documents governing the Plan/SPD, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Plan/SPD 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/SPD, including insurance contracts, and copies of the latest annual report (Form 5500 series) and an updated summary plan description. The Administrator may make a reasonable charge for the copies.

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

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

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

D. 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 example, if you request a copy of the plan documents or the latest annual report from the Plan/SPD 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 outlined in this Plan/SPD. If you do not follow these 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/SPD'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.

Although unlikely, if it should happen that Plan/SPD fiduciaries should misuse the Plan/SPD's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay those costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your welfare benefit plans, 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.

GENERAL INFORMATION

A.	**Plan Name:**	Old National Bancorp Tax Saver Benefit Plan and Summary Plan Description
B.	**Plan Sponsor:**	Old National Bancorp One Main Street, P.O. Box 328 Evansville, IN 47702 (812) 468-7895
C.	**Sponsor's Identification Number:**	35-1539838
D.	**Plan/SPD Number assigned by the Administrator:**	502
E.	**Type of Plan/SPD:**	Flexible benefit program with salary reduction and contributions and dependent care and health reimbursement accounts for eligible employees and eligible dependents.
F.	**Administration of the Plan/SPD:**	The Plan/SPD is administered by Old National Bancorp, One Main Street, P.O. Box 328, Evansville, Indiana, 47702.
G.	**Agent of Services For Legal Process:**	Old National Bancorp One Main Street, P.O. Box 328 Evansville, IN 47702
H.	**Source of Financing the Plan/SPD:**	Company and employee contributions in amounts to be determined under the provisions of the Plan/SPD.
I.	**Health Insurance Issuer Information:**	Benefits under the Plan/SPD are not guaranteed under a contract of insurance.
J.	**Plan Supervisor:**	Employee Plans, L.L.C. P.O. Box 2362 Fort Wayne, IN 46801-2362 (636) 728-7799 (800-467-5982) www.mbicard.com
K.	**Benefits:**	(1) Health Care Flexible Spending Accounts, (2) Dependent Care Flexible Spending Accounts, (3) Health Coverage, Dental Coverage, Vision Coverage, and Life Coverage, and (4) Contributions to Health Savings Account
L.	**Participating Employers**	The Company and any affiliated employer that is a member of a controlled group of corporations, trades or businesses, affiliated service group, or other entity as provided under Code Section 414(b), (c), (m), and (o)

IN WITNESS WHEREOF, the Company has caused this instrument to be executed by its duly authorized officers this _____ day of January, 2012

"COMPANY"

OLD NATIONAL BANCORP

By: ___________________________________

Printed:________________________________

Title: _________________________________

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EXHIBIT A

HEALTH SAVINGS ACCOUNT

Old National Bancorp, as the custodian of the Health Savings Account(s) will, at your election, direct salary deferral contributions under the Plan/SPD.